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Australian Institute of
Health and Welfare

National Health Data Dictionary
Version 16

2012

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Health and Welfare

Authoritative information and statistics
to promote better health and wellbeing

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Version 16

2012

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The Australian Institute of Health and Welfare is a major national agency which provides reliable, regular and relevant information and statistics on Australia's health and welfare. The Institute's mission is *authoritative information and statistics to promote better health and wellbeing*.

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Summary of updates to National Health Data Dictionary (NHDD) since version 15

The purpose of this document is to inform users of updates to the National Health Data Dictionary (NHDD) version 16 published August 2012. This update reflects changes to the national health data standards between 1 July 2010 and 30 April 2012. During this time ten data set specifications, twenty three data element clusters, a hundred and seventy seven data elements, one classification and twenty glossary items have been added. Other changes include the revision of twelve national minimum datasets, two data set specification, eighty three data elements, five classifications and three glossary items. As a result of these revisions, tweleve national minimum data sets, two data set specifications, ninety six data elements, five classifications and three glossary items have been superseded. Three national standards have been retired since version 15 of the NHDD was published.

These new standards have been agreed to and endorsed by the National Health Information Standards and Statistics Committee (NHISSC).

Table 1: Summary of table of updates to the NHDD since version 15

Registration status	National Minimum Data Sets	Data Set Specifications	Data element clusters	Data elements	Classifications	Glossary items
Standards (new)	0	10	23	177	1	20
Standards (revised)	12	2	0	83	5	3
Superseded	12	2	0	96	5	3
Retired	0	3	0	0	0	0

Table 2: Revised national minimum data sets

NMDS	Description of change	Data elements revised	Data elements added	Data elements removed
Admitted patient care NMDS 2011-2012	Revisions made to one data element due to version change of related classification	Area of usual residence	Nil	Nil
Admitted patient care NMDS 2012-2013	Revisions made to four data elements due to version change of related classification and changes in property and value domains. Thirteen new data elements added to new elective surgery waiting times cluster.	Area of usual residence Country of birth Inter-hospital contracted patient status Mental health legal status Patient funding source	Area of usual residence (SA2) Australian postcode code (address) Clinical urgency Medicare eligibility status Extended wait	Nil

NMDS	Description of change	Data elements revised	Data elements added	Data elements removed
			patient Indicator procedure Listing date for care Establishment identifier Overdue patient Record identifier Surgical specialty Waiting time at removal from elective surgery waiting list	
Admitted patient mental healthcare NMDS 2011-2012	Revisions made to one data element due to version change of related classification.	Area of usual residence	Nil	Nil
Admitted patient mental healthcare NMDS 2012-2013	Revisions of three data elements. Updates of classifications and new area of usual residence data element added.	Area of usual residence Country of birth Mental health legal status	Area of usual residence (SA2)	Nil
Admitted patient palliative care NMDS 2011-2012	Revisions made to one data element due to version change of related classification.	Area of usual residence	Nil	Nil
Admitted patient palliative care NMDS 2012-2013	Revisions made to one data element due to version change of related classification. New area of usual residence data element added.	Country of birth	Area of usual residence (SA2)	Nil
Alcohol and other drug treatment services NMDS 2011-2012	Revisions made to one data element due to version change of related classification	Area of usual residence	Nil	Nil
Alcohol and other drug treatment services NMDS 2012-2013	Revisions made to five data elements due to version change of related classification. New area of usual residence data element added. Statistical linkage key cluster has been added.	Other drug of concern Principle drug of concern Country of birth Preferred language Geographic location	Area of usual residence (SA2) Letters of family name Letters or given name Statistical linkage key 581 Date accuracy indicator	Nil

NMDS	Description of change	Data elements revised	Data elements added	Data elements removed
Community mental health care NMDS 2011-2012	Revisions made to one data element due to version change of related classification. New target population data element added.	Area of usual residence	Target population group	Nil
Community mental health care NMDS 2012-2013	Revisions made to two data elements. Eight new data elements have been added and two organisation identifier data elements have been removed.	Mental health legal status Country of birth	Ambulatory service unit identifier Ambulatory service unit name Area of usual residence (SA2) Organisation identifier Organisation name Region name Service unit cluster identifier Service unit cluster name	Establishment identifier Establishment number
Elective surgery waiting times (census data) DSS 1 January 2012-30 June 2012	Revisions have been made to two data elements and one data element has been removed.	Overdue patient status Waiting time at a census date	Nil	Extended wait patient indicator
Elective surgery waiting times (census data) 2012-2013	Revisions have been made to one data elements. Patient listing status, readiness for care data element has been added.	Indicator procedure	Patient listing status	
Elective surgery waiting times (removals data) DSS 1 January 2012-30 June 2012	Revisions have been made to three data elements and one data element has been removed.	Overdue patient status Reason for removal from elective surgery waiting list Waiting time at removal from elective surgery waiting list	Nil	Extended wait patient indicator
Elective surgery waiting times (removals data) 2012-2013	Revisions have been made to one data element.	Indicator procedure	Nil	Nil
Mental health establishments NMDS 2011-2012	Revisions made to one data element due to version change of related classification. One data element has been added.	Area of usual residence	Non-government non-profit indicator	Nil
Mental health establishments NMDS 2012-2013	One data element has been revised. Sixteen new data elements have been added including new ASGS data element.	Supported mental health housing places	Admitted patient service unit identifier Admitted patient	Nil

NMDS	Description of change	Data elements revised	Data elements added	Data elements removed
			service unit name Ambulatory service unit identifier Ambulatory service unit name Area of usual residence (SA2) Full-time equivalent staff-nurses Region name Service unit cluster identifier Service unit cluster name Hospital identifier Hospital name Organisation identifier Organisational name Number of clients receiving services Residential service unit identifier Residential service unit name	
Non-admitted patient emergency department care NMDS 2011-2012.	Revisions made to five data elements due to version change of related classifications, changes to guide for use, changes to definition and updated ASGC code.	Area of usual residence Emergency department service episode end status Emergency department episode end time Length of non-admitted patient emergency department service episode Triage category	Nil	Nil
Non-admitted patient emergency department care NMDS 2012-2013	Revisions made to nine data elements due to version change of related classifications and object class changes. New Area of usual residence data element added.	Emergency department clinical care commencement date Emergency department clinical care commencement	Area of usual residence (SA2)	Nil

NMDS	Description of change	Data elements revised	Data elements added	Data elements removed
		time Country of birth Area od usual residence Date patient presents Time patient presents Emergency department arrival mode-transport Type of visit to emergency department Emergency department waiting time to clinical care commencement		
Perinatal NMDS 2011-2012	Revisions made to one data element due to version change of ASCG code.	Area of usual residence	Nil	Nil
Perinatal NMDS 2012-2013	Revisions made to one data element due to version change of relevant classifications. New ASGS data element added and old version removed.	Country of birth	Area of usual residence (SA2)	Area of usual residence
Public hospital establishments NMDS 2011-2012	Revisions made to one data element due to version change ASCG code.	Area of usual residence	Nil	Nil
Public hospital establishments NMDS 2012-2013	One new area of usual residence data element added.	Nil	Area of usual residence (SA2)	Nil
Residential mental health care NMDS 2011-2012	Revisions made to one data element due to version change ASCG code.	Area of usual residence	Nil	Nil
Residential mental health care NMDS 2012-2013	Revisions made to one data element due to version change ASCG code. Five new data elements have been added.	Country of birth	Area of usual residence (SA2) Organisation identifier Organisation name Residential service unit identifier Residential service unit name	Nil

Table 3: Revised data set specifications

DSS	Description of change	Data elements revised	Data elements added	Data elements removed
Cancer (clinical) DSS	Review and restructure of Cancer clinical data elements. Addition of treatment-specific data element clusters and implementation of updated classifications. Eleven data elements have been removed.	Cancer staging—M stage code Cancer staging—N stage code Cancer staging—T stage code Cancer staging—TNM stage grouping code Cancer treatment type Date of diagnosis of cancer Date of surgical treatment for cancer Histopathological grade Laterality of primary cancer Morphology of cancer Most valid basis of diagnosis of cancer Number of regional lymph nodes examined Outcome of initial treatment Primary site of cancer (ICDO-3 code) Received radiation dose Regional lymph nodes positive Staging scheme source edition number Staging scheme source Staging basis of cancer Surgical treatment procedure for cancer Systemic therapy agent name Tumour size at diagnosis (solid tumours)	Cancer staging—stage grouping other Cancer status Chemotherapy completion date Chemotherapy cycles administered Chemotherapy start date Date accuracy indicator Date of diagnosis of first recurrence as distant metastasis Date of diagnosis of first recurrence as locoregional cancer Date of last contact Hormone therapy completion date Cancer staging—stage grouping other Cancer status Chemotherapy completion date Chemotherapy cycles administered Chemotherapy start date Date accuracy indicator Date of diagnosis of first recurrence as distant metastasis Date of last contact Hormone therapy completion date	Cancer initial treatment completion date Cancer initial treatment starting date Cancer treatment—target site (ICD-10-AM) Cancer treatment—target site (ICDO-3) Date of diagnosis of first recurrence Intention of treatment for cancer Oestrogen receptor assay result Cancer initial treatment completion date Cancer initial treatment starting date Cancer treatment—target site (ICD-10-AM) Cancer treatment—target site (ICDO-3) Date of diagnosis of first recurrence

DSS	Description of change	Data elements revised	Data elements added	Data elements removed
			Hormone therapy start date HPI-O Immunotherapy completion date Immunotherapy start date Most valid basis of diagnosis of recurrence Other cancer treatment Systemic therapy agent or protocol, eviQ Radiotherapy completion date Radiotherapy fractions administered	Intention of treatment for cancer Oestrogen receptor assay result Primary site of cancer (ICD-10-AM code) Progesterone receptor assay results Region of first recurrence Tumour thickness at diagnosis (melanoma)
			Radiotherapy start date Radiotherapy target site Radiotherapy treatment type Region of first recurrence as distant metastasis Region of first recurrence as locoregional cancer Surgery target site Systemic therapy procedure date Systemic therapy procedure Systemic therapy agent or protocol Underlying cause of death	Date of diagnosis of first recurrence Intention of treatment for cancer Oestrogen receptor assay result Primary site of cancer (ICD-10-AM code) Progesterone receptor assay results Region of first recurrence Tumour thickness at diagnosis (melanoma)

DSS	Description of change	Data elements revised	Data elements added	Data elements removed
Non-admitted patient DSS 2012-13	Revision of two data elements due to version change of related classifications. New area of usual residence data element added.	Area of usual residence Country of birth	Area of usual residence (SA2)	Nil

Table 4: New data set specifications

Name	Description
Indigenous primary healthcare DSS	The Indigenous primary healthcare DSS is primarily designed to support the collection of aggregate information from Indigenous-specific primary health care services.
Medical indemnity DSS	The Medical indemnity DSS describes the data items and standardised data outputs for medical indemnity claims for the medical indemnity national collection. These claims fit into two categories: • Actual claims • Potential claims.
Perinatal DSS	The Perinatal DSS collects data on all births, both live and stillborn, of at least 20 weeks gestation or 400 grams birth weight, in Australian hospitals.
Prison clinic contact DSS	The Prison clinic contact DSS describes data on the visits by prisoners to the prison clinic during the National Prisoner Health Census reporting period.
Prison entrants DSS	The Prison entrants DSS describes the data on all persons aged 18 years and over entering prison system during the National Prisoner Health Census reporting period.
Prison establishments DSS	The Prison establishments DSS describes the data on services provided in prison health clinics.
Prisoner health DSS	The Prisoner health DSS describes data collected from all private and public prisons throughout Australia on prison entrants, prisoners who visit a prison clinic, prisoners who are taking repeat medication while in custody, prison clinic services and staffing levels.
Prisoners in custody repeat medications DSS	The Prisoners in custody repeat medication DSS includes all prescribed medications administered on one day during the National Prisoner Health Census period and depot medications.
Public hospital establishment address DSS	The Public hospital establishment address details DSS is used to collect information pertaining to the address of the hospital establishments reported in the Public hospital establishments NMDS.
Radiotherapy waiting times DSS	The Radiotherapy waiting times DSS describes the information collected for two time periods in the treatment pathway for radiotherapy services in Australia. This includes: • The time between the date a patient's first referral is received at a particular establishment by a radiation oncologist to the date of the patient's first consultation at that establishment with a radiation oncologist; and • The time between the patient's ready-for-care date and the date of the first megavoltage external beam radiotherapy treatment

Table 5: New data clusters

Name	Description
Audit score of risky alcohol consumption cluster	The Audit score of risky alcohol consumption cluster provides a score on the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT) screening instrument. It comprises of three data elements which record: • The frequency of alcohol consumption; • The number of standard drinks consumed on a typical day when drinking; and • Frequency of consuming six or more standard drinks on one occasion.
Chemotherapy for cancer cluster	The Chemotherapy for cancer cluster consists of data elements recommend for collection best practice when the patient is administered chemotherapy as part of the initial course of treatment for cancer. It includes information on: • The chemotherapy agent or protocol; • The number of cycles administered; and • The start and finish dates of treatment.
Chronic condition cluster	The Chronic condition cluster determines the number of prison entrants who have ever been told that they have arthritis, asthma, cancer, cardiovascular disease or diabetes and the number of prison entrants who currently have at least one of the se chronic conditions.
Elective surgery waiting times cluster	The Elective surgery waiting time's cluster measures patients on the elective surgery waiting lists managed by public acute hospitals. This will include public patients treated in public hospitals and may include public patients treated in private hospitals.
Full- time equivalent prison staff cluster	This Full-time equivalent prison staff cluster determines the number of full-time equivalent health staff working within a prison. It comprises of two components: • Number of full time equivalent staff, total number • Health worker type, occupation code
Health service non- utilisation cluster	The Health service non-utilisation cluster is used to determine the non-utilisation of health service in the community and in prison by prison entrants in the last 12 months.
Health service utilisation cluster	The Health service utilisation cluster is used to determine the utilisation of health services in the community and in prison by prison entrants in the last 12 months and gain a better understanding of the health seeking behaviours of prison entrants.
Hormone therapy for cancer cluster	The Hormone therapy for cancer cluster consists of data elements recommended for collection as best practice when the patient is administered hormone therapy as part of the initial course of treatment for cancer. The cluster collects information on the hormone therapy agent or protocol and the start and finish dates of treatment.
Hospital transfer cluster	The Hospital transfer cluster determines the number of planned and unplanned transfers between prison and a community-based hospital during the National Prisoner Health Census period.
Immunotherapy for cancer cluster	The Immunotherapy for cancer cluster consists of data elements recommended for collection as best practice when the patient is administered immunotherapy as part of the initial course of treatment for cancer. The cluster collects information on the immunotherapy agent or protocol and the start and finish dates of treatment.
Incarceration history cluster	The Incarceration history cluster provides information on the total number of times a prison entrant has been in custody in a juvenile detention centre or a prison. It is determined through two components that record: • The type of corrective services facility; and • The number of times in prison or juvenile detention.
Non- school qualification cluster	The Non-school qualification cluster determines whether a person has a non-school qualification and if so the level of that qualification. It is determined through two components that record: • The non-school qualification indicator ; and • The level of highest non-school qualification

Name	Description
Opioid pharmacotherapy treatment cluster	The Opioid pharmacotherapy treatment cluster is used to determine the number of prison entrants who have been on, or are currently on, an opioid pharmacotherapy treatment program and the type of opioid pharmacotherapy treatment program a prison entrant has been on or is on currently.
Pregnancy status cluster	The Pregnancy status cluster consists of data elements that determine whether a female prison entrant has ever been pregnant and if so, the age of her first pregnancy.
Prisoner health discharge summary cluster	The Prisoner health discharge summary cluster determines the number of sentenced and remand prisoners that were released from a prison during the National Prisoner Health Census period and the number of sentenced and remand prisoners who have a health related discharge summary on file at the time of their release.
Radiotherapy for cancer cluster	The Radiotherapy for cancer cluster collects information on the radiotherapy type, dose, fractions, target site and the start and finish dates for each course of treatment.
Sex of prison entrant cluster	The Sex of prison entrant's cluster describes the number of male and female prison entrants into a prison during the National Prisoner Health Census period.
Smoking status cluster	The Smoking status cluster determines the history and current smoking status of a person. It comprises four components: • Ever smoked a full cigarette indicator; • Tobacco smoking start age; • Current smoking status indicator; and • Tobacco smoking frequency.
Statistical linkage key 581 cluster	The Statistical linkage key 581 cluster facilitates the bringing together of data from different sources to gain a greater understanding of a situation or individual from the combined (or linked) dataset.
Substances used illicitly cluster	The Substances used illicitly cluster captures information on whether a person had possessed an illegal substance, or used a substance in an illegal manner, and the type of substance used illicitly.
Surgery for cancer cluster	The Surgery for cancer cluster captures information on cancer-directed surgery performed as part of the initial course of treatment for cancer.
Systematic therapy procedure for cancer cluster	The Systematic therapy procedure for cancer cluster consists of data elements recommended for collection as best practice when the patient receives a systemic therapy procedure as part of the initial course of treatment for cancer.
Vaccines administered cluster	The Vaccines administered cluster comprises of data elements that describe the number of hepatitis B, human papillomavirus (HPV) and meningococcal vaccines administered to prisoners during the National Prisoner Health Census period

Table 6: New data elements

Short name	Technical name
ACCHO/AMS service provider type	Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service provider type, occupation code (ANZSCO 1st edition) N[NNN]{NN}
ACCHO/AMS visitation frequency	Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medial service visitation frequency, code N
Additional body function or structure of patient affected	Patient—additional body function or structure affected, body function or structure code N[N]
Additional clinician speciality involved in health-care incident	Health-care incident—additional clinician speciality involved in health-care incident, clinical specialities code N[N]
Additional incident or allegation type	Medical indemnity claim—additional incident or allegation type, health care code NN[N]

Short name	Technical name
Admitted patient service unit identifier	Specialised mental health service—admitted patient service unit identifier, XXXXXX
Admitted patient service unit name	Specialised mental health service—admitted patient service unit name, Text XXX[(97)]
Alcohol consumption frequency	Person—alcohol consumption frequency, AUDIT alcohol consumption frequency code
Alcohol consumption status recorded indicator	Person—alcohol consumption status recorded indicator, yes/ no code N
Ambulatory service unit identifier	Specialised mental health service—ambulatory service unit identifier, XXXXXX
Antenatal care visits	Female—number of antenatal care visits, total N[N]
At risk of suicide or self-harm	Prison entrant—at risk of suicide or self-harm indicator, yes/ no code N
Australian state/ territory identifier of address	Address—Australian state/ territory identifier, code AA[A]
Birth weight	Birth—birth weight, code N
Birth weight recorded indicator	Person—birth weight recorded indicator, yes/ no code N
Blood pressure measurement result less than or equal to 130/ 80 mmHg indicator	Person—blood pressure measurement result less than or equal to 130/ 80 mmHg indicator, yes/ no code N
Blood pressure measurement result recorded indicator	Person—blood pressure measurement result recorded indicator, yes/ no code N
Blow to the head indicator	Person—blow to the head indicator, yes/ no/ not stated/ inadequately described code N
Body mass index recorded indicator	Person—body mass index recorded indicator, yes/ no code N
Cancer staging- M stage code	Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours, 7th edition) code X[XX]
Cancer staging- stage group other	Person with cancer—extent of primary cancer, stage grouping other, code X[XXXXX]
Cancer status	Patient—cancer status, code N
Cardiovascular disease recorded indicator	Person—cardiovascular disease recorded indicator, yes/ no code N
Care type, derived subacute	Non-admitted patient service event—care type, subacute (derived) code N
Carer responsibility indicator	Person—Carer responsibility indicator, yes/ no/ not stated/ inadequately described, code N
Cervical screening	Female—cervical screening indicator, yes/ no/ not stated/ inadequately described
Chemotherapy completion date	Cancer treatment—chemotherapy completion date, DDMMYYYY
Chemotherapy cycles administered	Cancer treatment—chemotherapy cycles administered
Chemotherapy start date	Cancer treatment—chemotherapy start date, DDMMYYYY
Chronic condition indicator	Person—chronic condition indicator, yes/ no code N
Chronic obstructive pulmonary disease recorded indicator	Person—chronic obstructive pulmonary disease recorded indicator, yes/ no code N
Class action indicator	Medical indemnity claim management episode—class action indicator, yes/ no code N
Clinical emergency indicator	Patient—clinical emergency indicator, yes/no code N
Clinical service context	Health-care incident—clinical service context, code N
Clinical service context text	Health-care incident—clinical context, text X[X (39)]
Current opioid pharmacotherapy	Person—current opioid pharmacotherapy treatment program indicator, yes/ no code

Short name	Technical name
treatment program indicator	N
Current smoking status	Person—current smoking status indicator, yes/ no/ not stated/ inadequately described code N
Date health-care incident occurred	Health-care incident—date health-care incident occurred, DDMMYYYY
Date of diagnosis of first recurrence as distant metastasis	Patient—diagnosis of first recurrence as distant metastasis, DDMMYYYY
Date of diagnosis of first recurrence as loco regional cancer	Patient—diagnosis date of first recurrence as locoregional cancer, DDMMYYYY
Date of last contact—cancer patient	Patient—date of last contact, DDMMYYYY
Date patient presents—emergency department	Emergency department stay—presentation date, DDMMYYYY
Distress related to current imprisonment indicator	Prison entrant—distress related to current imprisonment indicator, yes/ no/ not applicable code N
Education attendance status 30 days prior to imprisonment	Prison entrant—education attendance status 30 days prior to imprisonment, education attendance status code N
Estimated glomerular filtration rate (eGFR) recorded indicator	Person—estimated glomerular filtration rate (eGFR) recorded indicator, yes/ no code N
Ever smoked a full cigarette indicator	Person—ever smoked a full cigarette indicator, yes/ no/ not stated/ inadequately described code N
Extent of harm from a health-care incident	Patient—extent of harm from a health-care incident, code N[N]
First health service contact date	Health service event—first service contact date, DDMMYYYY
First time in prison or juvenile detention indicator	Prison entrant—first time in prison or juvenile detention indicator, yes/ no code N
Frequency consumed 6 or more standard drinks on one occasion	Person—consumption of 6 or more standard drinks on one occasion, AUDIT consumption of 6 or more standard drinks code N
Full time equivalent staff- nurses	Establishment—full-time equivalent staff (paid) (nurses), average NNNN.NN
Fully immunised recorded indicator	Child—fully immunised recorded indicator, yes/ no code N
Funding source for hospital patient	Episode of care—source of funding, patient funding source code NN
Geographic remoteness—admitted patient care	Establishment—geographic remoteness, admitted patient care remoteness classification (ASGC-RA)N
Geographic remoteness	Health-care incident—geographic remoteness, remoteness classification (ASGC-RA)N
Glycosylated haemoglobin level	Person—glycosylated haemoglobin level, code N
Glycosylated haemoglobin measurement result recorded indicator	Person—glycosylated haemoglobin measurement result recorded indicator, yes/ no code N
GP management plan indicator	Person—GP management plan (MBS Item 721) indicator, yes/ no code N
Group session indicator	Non-admitted patient service event—group session indicator, yes/ no code N
Health service request received date	Health service event—service request date, DDMMYYYY
Health service setting	Health- care incident—service delivery setting, health service setting code N[N}
Highest yeah of school completed	Person—highest level of school completed, code N
Hormone therapy completion date	Cancer treatment—hormone therapy completion date, DDMMYYYY
Hormone therapy start date	Cancer treatment—hormone therapy start date, DDMMYYYY

Short name	Technical name
Hospital identifier	Hospital—hospital identifier, XXXXX
Hospital name	Hospital—hospital name, text XXX[X (97)]
HPI-O	Healthcare provider—organisation identifier, N(16)
Hysterectomy indicator	Female—hysterectomy indicator, yes/ no code N
Immunotherapy completion date	Cancer treatment—immunotherapy completion date, DDMMYYYY
Immunotherapy start date	Cancer treatment—immunotherapy start date, DDMMYYYY
Imprisonment in the last 12 months indicator	Prison entrant—imprisonment in the last 12 months indicator, yes/ no code N
Influenza immunisation indicator	Person—influenza immunisation indicator, yes/ no code N
Initiator of prison clinic visit	Health service event—prison health clinic visit initiator, code N
Intention of treatment	Patient—intention of treatment, code N
Labour force status 30 days prior to imprisonment	Prison entrant—labour force status 30 days prior to imprisonment, code N
Legal status of prison entrant	Prison entrant—legal status of prisoner, code N
Legal status of prisoner	Person—legal status of a prisoner, as represented by a code N
Letters of family name	Person—letters of family name, text XXX
Letters of given name	Person—letters of given name, text XXX
Letters of highest non- school qualification	Person—level of highest non- school qualification, code N
MBS health assessment for Aboriginal and Torres Strait Islander people (MBS Item 715) indicator	Person—MBS health assessment for Aboriginal and Torres Strait Islander people (MBS Item 715) indicator, yes/ no code N
Medical indemnity claim commencement date	Medical indemnity claim—medical indemnity claim commencement date, DDMMYYYY
Medical indemnity claim finalisation	Medical indemnity claim—medical indemnity claim finalisation mode, code N[N]
Medical indemnity claim finalisation date	Medical indemnity claim management episode—medical indemnity claim finalisation date, DDMMYYYY
Medical indemnity claim identifier	Medical indemnity claim—medical indemnity claim identifier, XXXXXX[X(14)]
Medical indemnity claim reserve size	Medical indemnity claim management episode—reserve size, range code N[N]
Medical indemnity claim size	Medical indemnity claim—medical indemnity claim size, code N[N]
Medical indemnity claim state territory identifier	Medical indemnity claim management episode—Australian state/ territory, code N
Medical indemnity claim status	Medical indemnity claim—medical indemnity claim status, code NN
Medical indemnity payment recipient	Medical indemnity claim management episode—medical indemnity payment recipient type, code N
Medication for mental health disorder indicator	Person—medication for mental health disorder indicator, yes/ no code N
Medication type	Person—medication type, medication type (ATC/ DDD) code A [{NN} AA {NN}]
Mental health disorder indicator	Person—mental health disorder indicator, yes/ no code N
Mental health service referral	Prison entrant—mental health service referral, yes/ no/ not stated/ inadequately described
Microalbumin urine test result	Person—microalbumin urine test result
Most valid basis of diagnosis of	Person with cancer-—most valid basis of diagnosis of the first recurrence, code N

Short name	Technical name
recurrence	
Non- government non- profit indicator	Specialised mental health service—non government non- profit indicator, yes/ no code N
Non- school qualification indicator	Person—non- school qualification indicator, yes/ no/ not stated/ inadequately described code N
Number of clients receiving services	Specialised mental health service—number of clients receiving services, total NNNNNN
Number of full- time equivalent	Establishment (prison)—full- time equivalent staff, total number N[N]
Number of hospital transfers	Establishment (prison)—number of hospital transfers, number N[NN]
Number of pregnant prisoners	Establishment (prison)—number of pregnant prisoners, number N[NN]
Number of prison entrants	Establishment (prison)—number of prison entrants, number N[NN]
Number of prisoners released	Establishment (prison)—number of prisoners released, number N[NN]
Number of service contacts	Specialised mental health service—number of service contacts, Total NNNNNN
Organisation identifier	Specialised mental health service organisation—organisation identifier, XXXX
Organisation name	Specialised mental health service organisation—organisation name, Text XXX[X(97)]
Other cancer treatment	Cancer treatment—other cancer treatment, text [X(150)]
Outpatient clinic type—non-admitted patient	Non-admitted patient service event—outpatient clinic type, code N[N]
Patient relationship to health-care service provider	Patient—relationship to health-care provider, code N
Planned hospital transfer indicator	Establishment (prison)—planned hospital transfer indicator, yes/ no code N
Pneumococcal disease immunisation indicator	Person—pneumococcal disease immunisation indicator, yes/ no code N
Previous opioid pharmacotherapy treatment program indicator	Person—previous opioid pharmacotherapy program indicator, yes/ no code N
Primary body function or structure of patient affected	Patient—primary body function or structure affected, body function or structure code NN
Primary incident or allegation type	Medical indemnity claim—primary incident or allegation type, health-care code NN[N]
Principal clinician speciality involved in the health- care incident	Health-care incident—principal clinician speciality involved in health- care incident, clinical specialities code N[N]
Principle diagnosis—patient	Patient—principle diagnosis, (ICD-10AM 7th edn) ANN{.N[N]}
Principle source of funding	Non-admitted patient service event—principle source of funding, code NN
Prison entrant age at first detention	Prison entrant—age at first detention, total years NN
Prison entrant number of times in prison or juvenile detention	Prison entrant—number of times in prison or juvenile detention, total number N[N]
Prison establishment identifier	Establishment (prison)—organisation identifier, NNN
Prison health worker type	Establishment (prison)—health worker type, occupation code (ANZSCO 1st edition) N[NNN] {NN}
Prisoner health discharge summary indicator	Person—prisoner health discharge summary indicator, yes/ no code N
Prisoner location when service provider utilised	Health service event—prisoner location, code N
Prisoner location when service provider was needed, but not	Health service event—prisoner location when service provider was needed, but not utilised, prisoner location code N

Short name	Technical name
utilised	
Radio therapy fractions administered	Cancer treatment—radiotherapy fractions administered, total fractions N[N
Radio therapy treatment type	Cancer treatment—radiotherapy treatment type, code N[N]
Radiotherapy completion date	Cancer treatment—radiotherapy completion date, DDMMYYYY
Radiotherapy start date—cancer treament	Cancer treatment—radiotherapy start date, DDMMYYYY
Radiotherapy start date	Patient—radiotherapy start date, DDMMYYYY
Radiotherapy target site	Cancer treatment—radiotherapy target site, code N[N]
Ready-for-care date	Patient—ready-for-care date, DDMMYYYY
Reason for health clinic attendance	Person—reason for health clinic attendance, code NN
Reason for non- utilisation of health service	Prison entrant—reason for non- utilisation of health service, code NN
Record identifier	Record—identifier, X[X(14)]
Region name	Establishment—region name, Text XXX[X(57)]
Region of first recurrence as distant metastasis	Person with cancer—region of first recurrence as distant metastasis, topography code (ICD-O-3) ANN.N
Region of first recurrence as locoregional cancer	Person with cancer—region of first recurrence as locoregional cancer, topography code (ICD-O-3)ANN.N
Regular client indicator	Person—regular client indicator, yes/ no code N
Reserve placement date	Medical indemnity claim management episode-—reserve placement date, DDMMYYYY
Residential service unit identifier	Specialised mental health service—residential service unit identifier, XXXXXX
Residential service unit name	Specialised mental health service—residential service unit name, text XXX[(97)]
Secondary complex name	Address—secondary complex name, text X[50]
Self-harm ideation in the last 12 months	Person—self harm ideation in the last 12 months, yes/ no/ not stated/ inadequately described code N
Self-harm indicator	Person—self- harm indicator, yes/ no code N
Service delivery setting	Non-admitted patient service event—service delivery setting, code N
Service event date	Non-admitted patient service event—service date, DDMMYYYY
Service provider consulted indicator	Prison entrant—individual service provider consulted indicator, yes/ no code N
Service provider needed but not utilised indicator	Prison entrant—service provider needed but not utilised indicator
Service request received	Non-admitted patient service event—service request received date, DDMMYYYY
Service request source	Non-admitted patient service event—service request source, code N.N
Service unit cluster identifier	Establishment—service unit cluster identifier, XXXXX
Service unit cluster name	Establishment—service unit cluster name, text XXX[X(97)]
Smoking status recorded indicator	Person—smoking status recorded indicator, yes/ no code N
Specific chronic condition indicator	Person—specific chronic condition indicator, yes/ no code N
Statistical area level code	Address—statistical area, level 2 (SA2) code (ASGS 2011) N(9)
Statistical linkage key 581	Record—linkage key, code 581 XXXXXDDMMYYYYN
Substance used illicitly indicator	Person—substance used illicitly indicator, yes/ no/ not stated/ inadequately described code N

Short name	Technical name
Surgery target site	Cancer treatment—surgery target site, topography code (ICD-O-3) ANN.N
Surgical procedure date	Cancer treatment—surgical procedure date, DDMMYYY
Systemic therapy agent or protocol, eviQ	Cancer treatment—systemic therapy agent or protocol, eviQ protocol identifier, NNNNNN
Systemic therapy procedure	Cancer treatment—systemic therapy procedure, code N[N]
Systemic therapy procedure date	Cancer treatment—systemic therapy procedure date, DDMMYYYY
Team care arrangement (MBS Item 723) indicator	Person—team care arrangement (MBS Item 723) indicator
Time patient presents	Emergency department stay—presentation time, hhmm
Tobacco smoking frequency	Person—tobacco smoking frequency, current tobacco smoking frequency code N
Tobacco smoking start age	Person—tobacco smoking start age, total years N[NN]
Transgender	Person—transgender indicator, code
Type of chronic condition	Person—type of chronic condition, code N
Type of compensatory payment to other party	Medical indemnity claim—type of compensatory payment to other party, code N[N]
Type of compensatory payment to patient	Medical indemnity claim—type of compensatory payment to patient, code N[N]
Type of corrective services facility	Prison entrant—type of corrective services facility, code N
Type of opioid pharmacotherapy treatment	Person—type of opioid pharmacotherapy treatment, code N
Type of service provider consulted	Health service event—type of service provider consulted, occupation code (ANZSCO 1st edition) N[NNN] {NN}
Type of service provider consulted (prison entrant)	Prison entrant—type of service consulted, occupation code (ANZSCO 1st edition) N [NNN] {NN}
Type of service provider needed but not utilised	Prison entrant—type of service provider needed but not utilised, occupation code (ANZSCO 1st edition) N[NNN]{NN}
Type of substance used illicitly	Person—type of substance used illicitly, drug of concern (ASCDC 2000 extended) code NNNN
Type of vaccine administered	Establishment (prison)—type of vaccine administered, vaccine type, code N

Table 7: Revised data elements

Short name	Technical name	Description of change
Address site name	Address—address site name, text X[50]	Changes have been made to data element definition. Value domain has been increased form text X[30] to text X[50]. Guide for use has been updated.
Area of usual residence (SA2)	Person—area of usual residence, statistical area level 2 (SA2) code (ASGS 2011) N(9)	Revisions are a result of the release of the 2011 version of Australian Statistical Geography Standard extended.
Area of usual residence	Person—area of usual residence, geographical location code (ASGC 2011) NNNN	Revisions are a result of the release of the 2011 version of Australian Statistical Geography Classification.
Australian postcode (address)	Address—Australian postcode, code (Postcode data file) [NNNN]	Changes have been made to the data element definition. Guide for use has been updated.

Short name	Technical name	Description of change
Cancer staging scheme source edition number	Cancer staging—cancer staging scheme source edition number, code N[N]	Changes have been made to the data element definition and the code set for the value domain. Guide for use has been updated.
Cancer staging- M stage code	Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours, 7th edition) code X[XX]	Revisions are a result of the release of the 7th edition UICC TNM classification of Malignant tumours.
Cancer staging- N stage code	Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours, 7th edition) code X[XX]	Revisions are a result of the release of the 7th edition UICC TNM classification of Malignant tumours.
Cancer staging- T stage code	Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours, 7th edition) code X[XXX]	Revisions are a result of the release of the 7th edition UICC TNM classification of Malignant tumours.
Cancer staging- TNM grouping code	Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours, 7th edition) code X[XX]	Revisions are a result of the release of the 7th edition UICC TNM classification of Malignant tumours.
Cancer treatment type	Cancer treatment—cancer treatment type, code N[N]	Changes have been made to the data element definition. Value domain codes have been revised and supplementary values added. Guide for use has been updated.
Country of birth	Person—country of birth, code (SACC 2011) NNNN	Revisions are a result of the release of the 2011 version of Standard Australian Classification of Countries.
Country identifier	Person (address) — country identifier, code (SACC 2011) NNNN	Revisions are a result of the release of the Standard Australian Classification of Countries 2011. Short name has also been changed.
Complex road name	Address— complex road name, text X[45]	Value domain has increased text field from X[30] to X[45]. Changes made to property and object class. Guide for use has been updated.
Complex road number 1	Address—complex road number 1, road number X[6]	Value domain has decreased text field from X[12] to X[6]. Changes made to property and object class. Guide for use has been updated.
Complex road number 2	Address—complex road number 2, road number X[6]	Value domain has decreased text field from X[12] to X[6]. Changes made to property and object class. Guide for use has been updated.
Complex road type	Address—complex road type, code AA[AA	Changes made to property and object class. Value domain codes have been changed and extended. Guide for use has been updated with changes.
Date of diagnosis of cancer	Patient—diagnosis of cancer, DDMMYYYY	Changes have been made to the object class. Guide for use has been updated.
Date of triage	Non—admitted patient emergency department service episode— triage date ,DDMMYYYY	Changes have been made to data element definition and comments have been added to the guide for use.
Emergency department arrival mode- transport	Emergency department stay— transport mode (arrival), code N	Changes have been made to the data element concept.

Short name	Technical name	Description of change
Emergency department clinical care commencement time	Non-admitted patient emergency department service episode—clinical care commencement time, hhmm	Guide for use has been updated.
Emergency department of clinical care commencement date	Non-admitted patient emergency department service episode—clinical care commencement date, DDMMYYYY	Guide for use has been updated.
Emergency department departure date	Emergency department stay— physical departure date, DDMMYYYY	Guide for use and collection method has been updated.
Emergency department departure time	Emergency department stay—physical departure time, hhmm	Guide for use and collection method has been updated.
Emergency department episode end date	Non- admitted patient emergency department service episode—clinical care commencement day, DDMMYYYY	Guide for use has been updated.
Emergency department episode end time	Non- admitted patient emergency department service episode—episode end time, hhmm	Guide for use has been updated.
Emergency department service episode end status	Non- admitted patient emergency department service episode—episode end status, code N	Context has been added to data element.
Episode of residential care end date	Episode of residential care—episode end date, DDMMYYYY	Changes have been made to the data element definition.
Episode of residential care end mode	Episode of residential care—episode end mode, code N	Changes have been made to the data element definition. Value domain has been revised and guide for use has been updated.
Episode of residential care start date	Episode of residential care—episode start date, DDMMYYYY	Changes have been made to the data element definition.
Episode of residential care start mode	Episode of residential care—episode start mode, code N	Changes have been made to the data element definition. Value domain has been revised and guide for use has been updated.
First language spoken	Person—first language spoken, code (ASCL 2011) NN[NN]	Revisions are a result of the release of the 2011 Australian Standard Classification of Languages
Geographical location of service delivery outlet	Service delivery outlet—geographic location code (ASGC 2011) NNNNN	Revisions are a result of the release of the 2011 version of Australian Statistical Geography Classification.
Grants to non- government organisations- accommodation services	Specialised mental health service organisation—accommodation services grants to non- government organisations, total Australian currency N[N(8)]	Changes have been made to the data element definition and guide for use has been updated.
Histopathological grade	Person with cancer—histopathological grade, code N	Value domain has had code 5, 6, 7 and 8 removed. Guide for use has been updated.
Inter- hospital contracted patient	Episode of care— inter- hospital patient status, code N	Value domain has had code 4 and 5 added. Guide for use has been updated.
Indicator procedure	Elective care waiting list episode—indicator procedure , code NN	Changes made to the value domain and guide for use has been updated.
Laterality of primary cancer	Person with cancer—laterality of primary cancer, code [N]	Guide for use has included the valid international Classification of Diseases for Oncology values for paired organs and structures.

Short name	Technical name	Description of change
Level number identifier	Address—level number, identifier X[XXXX]	Changes have been made to the data element definition. Value domain has been changed from [NNNA] to X [XXXX]. Guide for use has been updated.
Leave days form residential care	Episode of residential care—number of leave days, total N[NN]	Guide for use has been updated..
Length of non-admitted patient emergency department service episode	Non- admitted patient emergency department service episode—service episode length, total minutes NNNNN	Context has been added to data element.
Main language other than English spoken at home	Person—main language other than English spoken at home, code (ASCL 2011) NN{NN}	Revisions are a result of the release of the 2011 Australian Standard Classification of Languages.
Medicare eligibility status	Person—eligibility status, Medicare code N	Additional information added to collection methods in relation to the primary method used for Medicare eligibility status.
Mental health legal status	Episode of care—mental health legal status, code N	Value domain code 3- Not permitted to be reported under legislative arrangements in the jurisdiction, has been replaced by code 9- Not reported/ unknown.
Morphology of cancer	Person with cancer—morphology of cancer, code (ICD-O-3) NNNN/ N	Changes have been made to the data element definition. Value domain has been revised to include the 5th digit behaviour code. Guide for use has been updated.
Most valid basis of diagnosis of cancer	Person with cancer—most valid basis of diagnosis of a cancer, code N	Revisions have been made to the data element definition and guide for use has been updated.
Number of episodes of residential care	Episode of residential care—number of episodes of residential care, total NNNN	Revisions have been made to the value domain and guide for use has been updated.
Number of regional lymph nodes examined	Person with cancer—number of regional lymph nodes examined, total N[N]	Changes made to the data element definition. Value domain has been changed to not stated/ inadequately described. Guide for use has been updated.
Outcome of treatment	Cancer treatment—outcome of treatment, code N.N	Revisions have been made to the value domain with supplementary values added. Guide for use has been updated.
Other drug of concern	Episode of treatment for alcohol and other drugs—drug of concern (other), ASDC 2011 extended) code NNNN	Revisions are a result of the release of the 2011 version of Australian Standard Drug Classification extended.
Overdue patient	Elective surgery waiting list episode—overdue patient status, code N	Guide for use has been updated.
Preferred language	Person—preferred language, code (ASCL 2011) NN[NN]	Revisions are a result of the release of the 2011 Australian Standard Classification of Languages.
Primary site of cancer (ICD-O-3 code)	Person with cancer—primary site of cancer, topography code (ICD-O-3) ANN.N	Changes have been made to the data element definition. Value domain maximum character length has increased to 6 and guide for use has been updated.
Principle drug of concern	Episode of treatment for alcohol and other drugs—drug of concern (principle), (ASDC 2011 extended) code NNNN	Revisions are a result of the release of the 2011 version of Australian Standard Drug Classification extended.

Short name	Technical name	Description of change
Radiation does administered	Cancer treatment—radiation dose administered, total Gray N[NN.NN]	Data element has been changed from dose received to dose administered. Changes have been made to the value domain and guide for use has been updated.
Reason for removal from elective surgery waiting list	Elective surgery waiting list episode—reason for removal form a waiting list, code N	Revisions have been made to the value domain.
Referral destination to further care (from specialised mental health residential care)	Episode of residential care—referral destination (mental health care), code N	Changes have been made to the object class.
Regional lymph nodes positive	Person with cancer—number of positive lymph nodes, total N[N]	Changes have been made to the data element definition. Value domain code has been changed and guide for use has been updated.
Road name	Address—road name, text X [45]	Changes made to property and object class. Value domain codes have been changed and extended. Guide for use has been updated.
Road number 1	Address—road number 1, road number X[6]	Changes made to property and object class. Value domain codes have been changed and decreased. Guide for use has been updated.
Road number 2	Address—road number 2, road number X[6]	Changes made to property and object class. Value domain codes have been changed and decreased. Guide for use has been updated.
Road type	Address—road type, code AA[AA]	Changes have been made to the property and object class. Value domain has been extended. Guide for use has been updated.
Service delivery mode	Non-admitted patient service event—service delivery mode, code N	Changes have been made to the data element definition. Value domain has been revised and changes have been made to the collection methods.
Specialised mental health service target population	Specialised mental health service—target population group code N	Value domain has been revised to include code 5- youth. Guide for use has been updated.
Staging basis of cancer	Cancer staging—staging basis of cancer, code A	Changes have been made to the data element definition. Guide for use has been updated.
Staging scheme source	Cancer staging—cancer staging scheme source, code N[N]	Changes have been made to the data element definition. Value domain has been extended and guide for use has been updated.
Sub-dwelling unit number	Address—sub-dwelling unit number, identifier [X(7)]	Changes have been made to the property and object class. Guide for use has been updated.
Suburb/town/locality name within address	Address—suburb/town/locality name, text X[46]	Changes have been made to the object class. Value domain has decreased and guide for use has been updated.
Supported mental health housing places	Specialised mental health service—supported mental health housing places, total N(6)	Value domain has been revised and guide for use has been updated.

Short name	Technical name	Description of change
Surgical procedure for cancer	Cancer treatment—surgical procedure for cancer, procedure code (ACHI 7th edn) NNNNN-NN	Changes have been made to data element definition and guide for use has been updated.
Systemic therapy agent or protocol	Cancer treatment—systemic therapy agent or protocol, text X[(149)]	Changes made to the property and guide for use has been updated.
Time of triage	Non-admitted patient emergency department service episode—triage time, hhmm	Changes have been made to the context and guide for use has been updated.
Triage category	Non-admitted patient emergency department service episode—triage category, code N	Changes have been made to the data element definitions and collection methods.
Tumour size at diagnosis (solid tumours)	Person with cancer—solid tumour size (at diagnosis), total millimetres NNN	Guide for use has been updated.
Type of visit to emergency department	Emergency department stay—type of visit to emergency department, code N	Changes have been made to the context of the data element. Value domain has been revised as has the data element concept.
Waiting list category	Elective care waiting list episode—elective care type, code N	Revisions made to the collection methods and guide for use has been updated
Waiting time at census date	Elective surgery waiting list episode—waiting time (at census date), total days N[NNN]	Revisions have been made to the comments field.
Waiting time at removal from elective surgery waiting list	Elective surgery waiting list episode—waiting time (at removal), total days N[NNN]	Revisions have been made to the comments field.

Table 8: New classifications

Name
Australian Statistical Geography Standard 2011

Table 9: Revised classifications

Name	Description of change
Australian Standard Classification of Drugs of Concern 2011	Australian Standard Classification of Drugs of Concern 2011 replaces Australian Standard Classification of Drugs of Concern 2000.
Australian Standard Classification of Language 2011	Australian Standard Classification of Languages 2011 replaces Australian Standard Classification of Languages 2005.
Australian Standard Geographical Classification 2011	Australian Standard Geographical Classification 2011 replaces Australian Standard Geographical Classification 2010.
International Union against Cancer (UICC) TNM Classification of Malignant Tumours 7th edition.	International Union against Cancer (UICC) TNM Classification of Malignant Tumours 7th edition replaces International Union against Cancer (UICC) TNM Classification of Malignant Tumours 6th edition.
Standard Australian Classification of Countries 2011	Standard Australian Classification of Countries 2011 replaces Standard Australian Classification of Countries 2008.

Table 10: New glossary items

Name
Admitted patient mental health care service
Ambulatory mental health care service
Antenatal care visit
Chemotherapy
Class action
Course of radiotherapy treatment
Hormone therapy
Immunotherapy
Juvenile detention centre
Locality
Mental health carer workers
Mental health consumer workers
Mental health disorder
Prisoner
Radiotherapy
Reserve
Surgical procedure
Systemic therapy procedure
Transgender
Urban Centre

Table 11: Revised glossary items

Name	Description of change
Address (housing assistance)	Address (housing assistance) replaces Address, version 1, DE, NHADD, NHDAMG
Episode of residential care end	Revisions made to the glossary definition
Episode of residential care start	Revisions made to the glossary definition

Data Elements

ACCHO/AMS service provider type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service service provider type, occupation code (ANZSCO 1st edition) N[NNN]{NN}
METeOR identifier:	365480
Registration status:	Health, Standard 25/08/2011
Definition:	The type of individual service provider providing Aboriginal community controlled health organisation (ACCHO) or Aboriginal medical service (AMS) services to a prison, as represented by a code.
Data Element Concept:	Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service service provider type

Value domain attributes

Representational attributes

Classification scheme:	Australian and New Zealand Standard Classification of Occupations, First edition, 2006
Representation class:	Code
Data type:	Number
Format:	N[NNN]{NN}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	This data element should be used in conjunction with the data element: *Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service visitation frequency, code N* to gain information on the involvement of Aboriginal health services in the provision of general and mental health care to Indigenous prisoners.

Comments: The Royal Commission into Aboriginal Deaths in Custody recommended that corrective services, in conjunction with Aboriginal health services, should review and report upon the provision of health services to Aboriginal prisoners in correctional institutions and that this review should include, amongst other things, the involvement of Aboriginal health services in the provision of general and mental health care to Aboriginal prisoners (AIHW 2010).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: AIHW (Australian Institute of Health and Welfare) 2010. The health of Australia’s prisoners 2009. Cat. no. PHE 123. Canberra: AIHW

Relational attributes

Related metadata references: See also Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service visitation frequency, code N Health, Standard 25/08/2011

Implementation in Data Set Specifications: Prison establishments DSS Health, Standard 25/08/2011

Conditional obligation:
Conditional on prisons receiving visits by an Aboriginal community controlled health organisation or an Aboriginal medical service.

ACCHO/AMS visitation frequency

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service visitation frequency, code N
METeOR identifier:	403811
Registration status:	Health, Standard 25/08/2011
Definition:	The frequency of visits by an Aboriginal community controlled health organisation (ACCHO) or an Aboriginal medical service (AMS) to a prison, as represented by a code.
Data Element Concept:	Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service visitation frequency

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Every day
2	At least once a week
3	At least once every two weeks
4	At least once a month
5	Less often than once a month
6	Never

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: This data element is used in conjunction with the data element: *Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service service provider type, occupation code (ANZSCO 1st edition) N[NNN]{NN}* to provide information on the involvement of Aboriginal health services in the provision of general and mental health care to Indigenous prisoners.

Comments: The Royal Commission into Aboriginal Deaths in Custody recommended that corrective services, in conjunction with Aboriginal health services, should review and report upon the provision of health services to Aboriginal prisoners in correctional institutions and that this review should include, amongst other things, the involvement of Aboriginal health services in the provision of general and mental health care to Aboriginal prisoners (AIHW 2010).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: AIHW (Australian Institute of Health and Welfare) 2010. The health of Australia's prisoners 2009. Cat. no. PHE 123. Canberra: AIHW

Relational attributes

Related metadata references: See also Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service service provider type, occupation code (ANZSCO 1st edition) N[NNN]{NN} Health, Standard 25/08/2011

Implementation in Data Set Specifications: Prison establishments DSS Health, Standard 25/08/2011

Accrued mental health care days

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

A day is measured from midnight to 2359 hours.

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

- Admission and discharge on the same day is equal to one mental health care day.
- For a patient/resident admitted and discharged on different days all days are counted as mental health care days, except the day of discharge and any leave days.

- If the patient/resident remains in hospital or residential care facility from midnight to 2359 hours count as a mental health care day.
- The day a patient/resident goes on leave is not counted as a mental health care day, unless this was also the admission day.
- The day the patient/resident returns from leave is counted as a mental health care day, unless the patient/resident goes on leave again on the same day of return or is discharged.
- Leave days involving an overnight absence are not counted as mental health care days.
- If a patient/resident goes on leave the day they are admitted and does not return from leave until the day they are discharged, count as one mental health care day.
- If the patient/resident remains in a hospital or residential care facility from 1 July to 30 June (the whole of the reference period) count as 365 days (or 366 days in a leap year).
- If the patient/resident remains in a hospital or residential care facility after the end of the reference period (i.e. after 30 June) do not count any days after the end of the reference period.

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

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

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

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

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

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

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

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

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

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

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Activity and participation life area

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—activity and participation life area, code (ICF 2001) AN[NNN]

METeOR identifier: 320125

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Definition: The life area in which a person participates or undertakes activities, as represented by a code.

Context: Human functioning and disability

Data Element Concept: Person—activity and participation life area

Value domain attributes

Representational attributes

Classification scheme: International Classification of Functioning, Disability and Health 2001

Representation class: Code

Data type: String

Format: AN[NNN]

Maximum character length: 5

Collection and usage attributes

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

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

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

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

CODE d1	Learning and applying knowledge
CODE d2	General tasks and demands
CODE d3	Communication
CODE d4	Mobility
CODE d5	Self-care
CODE d6	Domestic life
CODE d7	Interpersonal interactions and relationships
CODE d8	Major life areas
CODE d9	Community, social and civic life

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

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

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

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

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

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

The prefix ***d*** denotes the domains within the component of

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

Source and reference attributes

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

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

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

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

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

Data element attributes

Collection and usage attributes

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

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

Source and reference attributes

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

Relational attributes

Related metadata references: See also Person—extent of participation in a life area, code

(ICF 2001) N Community Services, Standard 16/10/2006, Health, Standard 29/11/2006

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

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

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

Implementation in Data Set Specifications:

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

Activity when injured

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Injury event—activity type, code (ICD-10-AM 7th edn) ANNNN

METeOR identifier: 391320

Registration status: Health, Standard 22/12/2009

Definition: The type of activity being undertaken by the person when injured, as represented by a code.

Data Element Concept: Injury event—activity type

Value domain attributes

Representational attributes

Classification scheme: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition

Representation class: Code

Data type: String

Format: ANNNN

Maximum character length: 5

Data element attributes

Collection and usage attributes

Guide for use: Admitted patient:

External cause codes V00 to Y34 must be accompanied by an activity code.

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

Source and reference attributes

Origin: National Centre for Classification in Health

National Injury Surveillance Unit

Relational attributes

Related metadata references: Supersedes Injury event—activity type, code (ICD-10-AM 6th edn) ANNNN Health, Superseded 22/12/2009

Implementation in Data Set Specifications: Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Injury surveillance DSS Health, Standard 14/12/2009

Activity when injured (non-admitted patient)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
0	Sports activity
00	Football, rugby
01	Football, Australian
02	Football, soccer
03	Hockey
04	Squash
05	Basketball
06	Netball
07	Cricket
08	Roller blading
09	Other and unspecified sporting activity
1	Leisure activity (excluding sporting activity)
2	Working for income

3	Other types of work
4	Resting, sleeping, eating or engaging in other vital activities
5	Other specified activities
6	Unspecified activities

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Origin: National Centre for Classification in Health

National Injury Surveillance Unit

Relational attributes

Related metadata references: Supersedes Activity when injured, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.7 KB)

Implementation in Data Set Specifications: Injury surveillance DSS Health, Standard 14/12/2009

Actual place of birth

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Birth event—setting of birth (actual), code N

METeOR identifier: 269937

Registration status: Health, Standard 01/03/2005

Definition: The actual place where the birth occurred, as represented by a code.

Context: Perinatal statistics

Data Element Concept: Birth event—setting of birth

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:	Value	Meaning
	1	Hospital, excluding birth centre
	2	Birth centre, attached to hospital
	3	Birth centre, free standing
	4	Home
	8	Other
Supplementary values:	9	Not stated

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	This is to be recorded for each baby the mother delivers from this pregnancy. CODE 4 Home Should be reserved for those births that occur at the home intended. CODE 8 Other Used when birth occurs at a home other than that intended. May also include a community health centre or be used for babies ‘born before arrival’.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Actual place of birth, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.0 KB)
Implementation in Data Set Specifications:	Perinatal NMDS 2012-2013 Health, Standard 07/03/2012 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Acute coronary syndrome procedure type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—acute coronary syndrome procedure type, code NN
METeOR identifier:	356659
Registration status:	Health, Standard 01/10/2008
Definition:	The type of procedure performed, that is pertinent to the treatment of acute coronary syndrome, as represented by a code.
Data Element Concept:	Person—acute coronary syndrome procedure type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Coronary artery bypass graft (CABG)
05	Reperfusion: fibrinolytic therapy
06	Reperfusion: primary percutaneous coronary intervention (PCI)
07	Reperfusion: rescue percutaneous coronary intervention (PCI)
08	Vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities or for aortic aneurysm
09	Amputation for arterial vascular insufficiency
10	Diagnostic cardiac catheterisation/angiography
11	Blood transfusion

	12	Insertion of pacemaker
	13	Implantable cardiac defibrillator
	14	Intra-aortic balloon pump (IABP)
	15	Non-invasive ventilation (CPAP)
	16	Invasive ventilation
	17	Defibrillation
	18	Revascularisation: percutaneous coronary intervention (PCI)
	19	Pulmonary artery (Swan Ganz) catheter
	88	Other
Supplementary values:	99	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

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

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

CODE 06 Reperfusion: primary percutaneous coronary intervention (PCI)

Primary PCI relates to balloon angioplasty and/or stent implantation for reperfusion therapy of a ST-segment-elevation myocardial infarction (STEMI).

CODE 07 Reperfusion: rescue percutaneous coronary intervention (PCI)

Rescue PCI relates to a balloon angioplasty and/or stent implantation that is performed following failed fibrinolysis in people with continuing or recurrent myocardial ischaemia.

CODE 18 Revascularisation: percutaneous coronary intervention (PCI)

Revascularisation PCI relates to the restoration of blood flow through balloon angioplasty and/or stent implantation outside the setting of myocardial salvage for

STEMI. Revascularisation PCI may be performed on a person following STEMI where there is objective evidence of spontaneous or inducible ischaemia or hameodynamic instability. Revascularisation PCI may also be performed on a person with high-risk non-ST-segment-elevation acute coronary syndrome.

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

When read in conjunction with Person—acute coronary syndrome risk stratum, code N, codes 01, 05, 06, 07, 08, 09, 10 and 18 of this metadata item provide information for risk stratification.

Where codes 06, 07 and 18 have been recorded please also record Person - percutaneous coronary intervention procedure, code N.

Collection methods:

For each Person-acute coronary syndrome procedure type, code NN, the following timing data elements must also be recorded, where applicable:

- Person - clinical procedure timing, code N
- Person - intravenous fibrinolytic therapy date, DDMMYYYY
- Person - intravenous fibrinolytic therapy time, hhmm
- Person - primary percutaneous coronary intervention date, DDMMYYYY
- Person - primary percutaneous coronary intervention time, hhmm
- Person - rescue percutaneous coronary intervention date, DDMMYYYY
- Person - rescue percutaneous coronary intervention time, hhmm
- Person - revascularisation percutaneous coronary intervention date, DDMMYYYY
- Person - revascularisation percutaneous coronary intervention time, hhmm
- Person - pacemaker insertion date, DDMMYYYY
- Person - pacemaker insertion time, hhmm
- Person - implantable cardiac defibrillator procedure date, DDMMYYYY
- Person - implantable cardiac defibrillator procedure time, hhmm
- Person - intra-aortic balloon pump procedure date, DDMMYYYY

- Person - intra-aortic balloon pump procedure time, hhmm
- Person - non-invasive ventilation administration date, DDMMYYYY
- Person - non-invasive ventilation administration time, hhmm

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Person—acute coronary syndrome procedure type, code NN Health, Superseded 01/10/2008 See also Person—clinical procedure timing, code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Acute coronary syndrome related clinical event type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—type of acute coronary syndrome related clinical event experienced, code N[N]
METeOR identifier:	338314
Registration status:	Health, Standard 01/10/2008
Definition:	The type of acute coronary syndrome related clinical event, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—type of acute coronary syndrome related clinical event

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Cardiogenic shock
2	Cardiac rupture
3	Cardiac arrest
4	New or recurrent myocardial infarction
5	Stroke
6	Acute pulmonary oedema
7	Recurrent rest angina with electrocardiogram changes
8	Recurrent rest angina without electrocardiogram changes
9	New onset arrhythmia: atrial
10	New onset arrhythmia: ventricular
11	New onset arrhythmia: heart block (1,2,3)

	12	Unplanned revascularisation
	13	Acute renal failure
	14	Thrombocytopaenia
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Cardiogenic shock

Use this code when the person has experienced cardiogenic shock, including if the person was in shock at the time of presentation to the hospital.

Cardiogenic shock is defined as:

- hypotension (systolic BP <90mmHg for at least 30 minutes or the need for supportive measures to maintain blood pressure of greater than or equal to 90mmHg)

- end-organ hypoperfusion (cool extremities or a urine output of <30ml/hour, and a heart rate ≥60 beats/minute)

- a cardiac index of no more than 2.2 l/min per square meter of body-surface area and a pulmonary-capillary wedge pressure of at least 15 mmHg.

CODE 2 Cardiac rupture

Use this code when the person has a rupture of the ventricular myocardium, the ventricular septum, or a frank papillary muscle rupture. This includes if the person experienced the rupture before presentation to the hospital.

CODE 3 Cardiac arrest

Use this code when the person has experienced cardiac arrest (i.e. the lack of effective cardiac output), including if the person was under arrest at the time of presentation to the hospital.

CODE 4 New or recurrent myocardial infarction

Use this code when the person experiences a myocardial infarction during hospitalisation distinct from the index event at the time of presentation.

Recurrent myocardial infarction is defined by clinical events and cardiac marker elevations after the first 24 hours following presentation to the hospital.

For people presenting without initial evidence of myonecrosis, recurrent MI is defined by:

- A rise in troponin T or I to greater than the diagnostic threshold level (with precision of 10% coefficient of variation) as defined by the local laboratory; OR

- A CK-MB elevation of greater than twice the upper limit of normal for the laboratory (if CK-MB is not available, CK may be used).

For people presenting with evidence of myonecrosis:

- A further rise in troponin of greater than 25% or a re-elevation in CK-MB of greater than 50% (if no CK-MB is drawn, CK may be used) will define recurrent MI

- If the event occurs within 24 hours of PCI, then a level of greater than 3 times the upper limit of normal for CK-MB will be used. If the event occurs within 24 hours of CABG, then a level of greater than 5 times the upper limit of normal for CK-MB will be used.

CODE 5 Stroke

Use this code if the person experiences a loss of neurological function with residual symptoms remaining for at least 24 hours after onset and which occurred before presentation to the hospital. The occurrence of stroke should be evidenced by a record of cerebral imaging (CT or MRI).

CODE 6 Acute pulmonary oedema/congestive heart failure

Use this code when the person has experienced acute pulmonary oedema or congestive heart failure with evidence of supportive clinical signs of ventricular dysfunction. These include:

- Third heart sound (S3)

- Cardiomegaly

- Elevated jugular venous pressure (JVP)

- Chest X-ray evidence of pulmonary congestion

- Requirement for ventilatory assistance (CPAP or intubation).

This includes if acute pulmonary oedema or congestive heart failure was present at the time of presentation to the hospital.

CODE 7 Recurrent rest angina with electrocardiogram (ECG) changes

Use this code when the person has experienced recurrent ischaemic pain occurring at rest believed to be cardiac in origin with associated ECG changes.

CODE 8 Recurrent rest angina without electrocardiogram (ECG) changes

Use this code when the person has experienced recurrent ischaemic pain occurring at rest believed to be cardiac in origin without associated ECG changes.

CODE 9 New onset arrhythmia: atrial

Use this code when the person has experienced an atrial arrhythmia, that was not present before this acute coronary syndrome event, documented by one of the following:

- Atrial fibrillation/flutter

- Supraventricular tachycardia requiring treatment (i.e. requiring cardioversion, drug therapy, or is sustained for greater than one minute).

CODE 10 New onset arrhythmia: ventricular

Use this code when the person has experienced ventricular tachycardia or ventricular fibrillation requiring cardioversion and/or intravenous antiarrhythmics, that was not present before this acute coronary syndrome event.

CODE 11 New onset arrhythmia: heart block (1,2,3)

Use this code when the person has experienced first, second or third degree atrioventricular block with bradycardia with or without the requirement for pacing.

CODE 12 Unplanned revascularisation

Use this code when the person has undergone revascularisation precipitated by 20 minutes or more of recurrent chest pain with/or without objective evidence of ischaemia on the ECG.

Code 13 Acute renal failure

Use this code when the person has acute renal failure as determined by a rise in serum creatinine of x 1.5 or a decrease in GFR by 25% or urine output <0.5mL/kg/h for 6 hours.

Code 14 Thrombocytopenia

Use this code when the person has thrombocytopenia as determined by the platelet count: platelet count dropped to less than 100 x 10^9/L.

Data element attributes

Collection and usage attributes

Guide for use: Record all clinical events that the person experiences from the time of presentation to hospital until discharge from hospital.

More than one event may be recorded.

The time and date must be recorded for each clinical event that occurs.

Comments: An acute coronary syndrome (ACS) related clinical event is a clinical event which can affect the health outcomes of a person with ACS.

Information on the occurrence of these clinical events in people with ACS is required due to an emerging appreciation of their relationship with late mortality.

Source and reference attributes

Reference documents: Chew DPB et al. National data elements for the clinical management of acute coronary syndromes. Medical Journal of Australia. Volume 182 Number 9. 2 May 2005.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome clinical event cluster Health, Standard 01/10/2008

Conditional obligation:
If a clinical event has occurred, record the clinical event type.

Acute coronary syndrome related medical history

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—acute coronary syndrome related medical history, code NN
METeOR identifier:	356598
Registration status:	Health, Standard 01/10/2008
Definition:	A person's history of acute coronary syndrome related medical conditions as represented by a code.
Data Element Concept:	Person—acute coronary syndrome related medical history

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
11	Angina (excluding unstable angina): prior existing
12	Angina (excluding unstable angina): new onset
13	Unstable angina
21	Chronic lung disease
31	Heart failure
41	Hypertension
51	Ischaemic: non-haemorrhagic cerebral infarction
52	Haemorrhagic: intracerebral haemorrhage
61	Peripheral artery disease
62	Aortic aneurysm
63	Renal artery stenosis

	71	Sleep apnoea
	81	Previous myocardial infarction
	91	Atrial fibrillation
	92	Other dysrhythmia or conductive disorder
	93	Left ventricular hypertrophy
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Angina:

CODE 11 Angina (excluding unstable angina): prior existing

This code is used where there are symptoms, which can be described as chest pain or pain in either or both shoulders, the back, neck or jaw, or other equivalent discomfort (such as tightness, gripping or squeezing) suggestive of cardiac ischaemia, the onset of which occured more than two weeks ago.

CODE 12 Angina (excluding unstable angina): new onset

This code is used where there are symptoms which can be described as chest pain or pain in either or both shoulders, the back, neck or jaw, or other equivalent discomfort (such as tightness, gripping or squeezing) suggestive of cardiac ischaemia; the onset of which occured two or less weeks ago.

CODE 13 Unstable angina

This code is used where a person has experienced new onset or prior existing angina (described as chest pain or pain in either or both shoulders, the back, neck or jaw, or other equivalent discomfort (such as tightness, gripping or squeezing)), which is increasing in severity, duration or frequency.

Chronic lung disease:

CODE 21 Chronic lung disease

This code is used where there is a history or symptoms suggestive of chronic lung disease.

Heart failure:

CODE 31 Heart failure

This code is used where a person has past or current symptoms of heart failure (typically breathlessness or fatigue), either at rest or during physical activity and/or signs of pulmonary or peripheral congestion suggestive of cardiac dysfunction.

Hypertension:

CODE 41 Hypertension

This code is used where there is current use of pharmacotherapy for hypertension and/or clinical evidence of high blood pressure.

CODE 51 Ischaemic: non-haemorrhagic cerebral infarction

This code is used if there is history of stroke or cerebrovascular accident (CVA) resulting from an ischaemic event where the patient suffered a loss of neurological function with residual symptoms remaining for at least 24 hours.

CODE 52 Haemorrhagic: intracerebral haemorrhage

This code is used if there is history of stroke or cerebrovascular accident (CVA) resulting from a haemorrhagic event where the patient suffered a loss of neurological function with residual symptoms remaining for at least 24 hours.

Peripheral arterial disease:

CODE 61 Peripheral artery disease

This code is used where there is history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.

CODE 62 Aortic aneurysm

This code is used where there is a history of aneurysmal dilatation of the aorta (thoracic and or abdominal).

CODE 63 Renal artery stenosis

This code is used where there is a history of functional stenosis of one or both renal arteries.

Sleep apnoea syndrome:

CODE 71 Sleep apnoea

This code is used where there is evidence of sleep apnoea syndrome (SAS) on history.

Myocardial infarction:

CODE 81 Previous myocardial infarction

This code is used where a person has previously experienced a myocardial infarction, excluding the current event that prompted this presentation to hospital. This may be supported by clinical documentation and evidenced by ECG changes or serum cardiac biomarker changes.

Other vascular conditions:

CODE 91 Atrial fibrillation

This code is used where there is a history or symptoms suggestive of atrial fibrillation.

CODE 92 Other cardiac arrhythmias or conductive disorders

This code is used where there is a history of other cardiac arrhythmias or conductive disorders.

CODE 93 Left ventricular hypertrophy

This code is used where there is a history or symptoms suggestive of left ventricular hypertrophy.

Data element attributes

Collection and usage attributes

Guide for use: More than one medical condition may be recorded.

Record only those codes that apply.

Record all codes that apply.

Collection methods: Where codes 21, 31, 51, 52, 61, 62, 63, 71, 91, 92 and 93 are recorded Person - clinical evidence status (acute coronary syndrome related medical conditions), yes/no code N must also be recorded.

Comments: A history of the listed medical conditions is pertinent to the risk stratification and treatment of acute coronary syndrome.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Reference documents: National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Related metadata references: Supersedes Person—acute coronary syndrome concurrent clinical condition, code NN Health, Superseded 01/10/2008

Implementation in Data Set Acute coronary syndrome (clinical) DSS Health, Standard

Acute coronary syndrome stratum

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—acute coronary syndrome risk stratum, code N

METeOR identifier: 356665

Registration status: Health, Standard 01/10/2008

Definition: Risk stratum of a person presenting with clinical features consistent with an acute coronary syndrome defined by accompanying clinical, electrocardiogram (ECG) and biochemical features, as represented by a code.

Data Element Concept: Person—acute coronary syndrome risk stratum

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	ST-segment-elevation (myocardial infarction)
	2	Non-ST-segment-elevation ACS with high-risk features
	3	Non-ST-segment-elevation ACS with intermediate-risk features
	4	Non-ST-segment-elevation ACS with low-risk features
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 1 ST-segment-elevation (myocardial infarction)

This code is used where persistent ST elevation of >=1mm in two contiguous limb leads, or ST elevation of >=2mm in two contiguous chest leads, or with new left bundle -

branch block (BBB) pattern on the ECG.

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

CODE 2 Non-ST-segment-elevation ACS with high-risk features

This code is used when presentation with clinical features consistent with an acute coronary syndrome with high-risk features which include any of the following:

- repetitive or prolonged (> 10 minutes) ongoing chest pain or discomfort;
- elevated level of at least one cardiac biomarker (troponin or creatine kinase-MB isoenzyme);
- persistent or dynamic ECG changes of ST segment depression >= 0.5mm or new T wave >= 2mm;
- transient ST-segment elevation (>= 0.5 mm) in more than 2 contiguous leads;
- haemodynamic compromise: Blood pressure < 90 mmHg systolic, cool peripheries, diaphoresis, Killip Class > 1, and/or new onset mitral regurgitation;
- sustained ventricular tachycardia;
- syncope;
- left ventricular systolic dysfunction (left ventricular ejection fraction < 0.40);
- prior percutaneous coronary intervention within 6 months or prior coronary artery bypass surgery;
- presence of known diabetes (with typical symptoms of ACS);or
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with typical symptoms of ACS).

This classification is intended for identification of patients potentially eligible for aggressive medical management and coronary angiography and revascularisation.

CODE 3 Non-ST-segment-elevation ACS with intermediate-risk features

This code is used when presentation with clinical features consistent with an acute coronary syndrome and any of the following intermediate-risk features AND NOT meeting the criteria for high-risk ACS:

- chest pain or discomfort within the past 48 hours that occurred at rest, or was repetitive or prolonged (but currently resolved);

- age greater than 65yrs;
- known coronary heart disease: prior myocardial infarction with left ventricular ejection fraction >= 0.40 known coronary lesion more than 50% stenosed;
- no high-risk changes on electrocardiography (see high-risk features);
- two or more of the following risk factors: known hypertension, family history, active smoking or hyperlipidaemia;
- presence of known diabetes (with atypical symptoms of ACS);
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with atypical symptoms of ACS); or
- prior aspirin use.

This classification is intended for identification of patients potentially eligible for accelerated diagnostic evaluation and further risk stratification.

CODE 4 Non-ST-segment-elevation ACS with low-risk features

This code is used when presentation with clinical features consistent with an acute coronary syndrome without intermediate or high-risk features of non-ST-segment-elevation ACS. This includes onset of anginal symptoms within the last month, or worsening in severity or frequency of angina, or lowering of anginal threshold.

This classification is intended for identification of patients potentially eligible for outpatient investigation discharge on upgraded medical therapy and outpatient investigation.

Data element attributes

Collection and usage attributes

Guide for use:

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

Acute coronary syndrome symptoms may include:

- tightness, pressure, heaviness, fullness or squeezing in the chest which may spread to the neck and throat, jaw, shoulders, the back, upper abdomen, either or both arms and even into the wrists and hands

- dyspnoea, nausea/vomiting, cold sweat or syncope.

Collection methods: Recorded at time of presentation.

Only one code should be recorded.

Must be recorded in conjunction with Person—acute coronary syndrome procedure type, code NN and Person—clinical procedure timing, code N.

Comments: The clinical, electrocardiogram and biochemical characteristics are important to enable early risk stratification.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Origin: National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

The TIMI Risk Score for Unstable Angina/Non-ST Elevation MI JAMA. 2000; 284:835-842.

Relational attributes

Related metadata references: Supersedes Person—acute coronary syndrome risk stratum, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Additional body function or structure of patient affected

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—additional body function or structure affected, body function or structure code N[N]
METeOR identifier:	330183
Registration status:	Health, Standard 07/12/2011
Definition:	The body function or structure of the patient alleged to have been affected, in addition to the primary body function or structure affected, as represented by a code.
Data Element Concept:	Patient—additional body function or structure affected

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Mental functions or structures of the nervous system
2	Sensory functions and pain of the eye, ear and related structures
3	Voice and speech functions or structures involved in voice and speech
4	Functions or structures of the cardiovascular, haematological, immunological and respiratory systems
5	Functions or structures of the digestive, metabolic and endocrine systems
6	Genitourinary or reproductive functions and structures
7	Neuromusculoskeletal or movement-related

		functions and structures
	8	Functions and structures of the skin and related structures
	9	Death
Supplementary values:	97	Not applicable
	99	Not stated/inadequately described

Collection and usage attributes

Comments: The coding categories for this value domain are based on the chapter headings for body functions and body structures in the Body component of the World Health Organization's International Classification of Functioning, Disability and Health (ICF 2.1a) (WHO 2003).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: WHO (World Health Organization) 2003. International Classification of Functioning, Disability and Health (ICF). Geneva: WHO

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data element *Patient—primary body function or structure affected, body function or structure code N[N]* to provide a greater depth of information on the harm alleged to have resulted from the health-care incident.

Up to three codes may be selected for this data element.

Code 9 'Death' is an invalid code for this data element but is a valid response for the data element: *Patient—primary body function or structure affected, body function or structure code N[N].*

Psychological harm as an additional body function or structure affected should be coded as 1 'Mental functions or structures of the nervous system'. Where a cancer has progressed and affects major body systems, but the organ or body part where the cancer originated is known, record the appropriate code for that organ or body part as the additional body function or structure affected.

Where the patient experiences pain as a result of the incident, and this pain is an additional body function or structure affected, record Code 2 ‘Sensory functions and pain of the eye, ear and related structures’. Where the pain experienced by the patient is deemed to be more disabling than the associated physical or mental damage to the patient, record the body structure or structures with which the pain is closely associated as an additional body function or structure affected.

Code 99 ‘Not stated/Inadequately described’ should be used only when the information is not currently available, but is expected to become available as the claim progresses.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Patient—primary body function or structure affected, body function or structure code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on more than one body function or structure being affected as a result of the health-care incident.

Additional clinician specialty involved in health-care incident

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health-care incident—additional clinician specialty involved in health-care incident, clinical specialties code N[N]
METeOR identifier:	424965
Registration status:	Health, Standard 07/12/2011
Definition:	The clinical specialty of the health-care provider(s) who played a role in the health-care incident that gave rise to a medical indemnity claim, in addition to the principal clinician responsible, as represented by a code.
Data Element Concept:	Health-care incident—additional clinician specialty involved in health-care incident

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
3	Cardiology
4	Cardio-thoracic surgery
5	Chiropractics
6	Clinical genetics
7	Haematology (clinical)
8	Immunology and allergy (clinical)
9	Clinical pharmacology (excluding pharmacy)
11	Cosmetic surgery
13	Dentistry

14	Dermatology
15	Diagnostic radiology
16	Otolaryngology
17	Emergency medicine
18	Endocrinology
21	Gastroenterology and hepatology
22	General medicine
23	General practice–non-procedural
24	General practice–procedural
25	General surgery
26	Geriatric medicine
27	Gynaecology only
28	Infectious diseases
29	Intensive care medicine
30	Medical oncology
31	Midwifery
32	Neurology
33	Neurosurgery
34	Neonatal or perinatal medicine
35	Nuclear medicine
36	Nursing–general
37	Nursing–nurse practitioner
38	Nutrition or dietician
39	Obstetrics and gynaecology
40	Obstetrics only
41	Occupational and environmental medicine
42	Ophthalmology
44	Orthopaedic surgery
45	Osteopathy

46	Paediatrics
47	Paediatric surgery
48	Paramedical and ambulance staff
49	Pathology
50	Pharmacy (excluding clinical pharmacology)
51	Physiotherapy
52	Plastic and reconstructive surgery
53	Podiatry
54	Psychiatry
55	Psychology
56	Public health
57	Rehabilitation medicine
58	Nephrology
59	Respiratory and sleep medicine
60	Rheumatology
62	Sports and exercise medicine
63	Radiation oncology (therapeutic radiology)
65	Urology
66	Vascular surgery
67	Other allied health (including complementary medicine)
68	Other hospital-based medical practitioner
71	Anaesthesia
72	Maternal-fetal medicine
73	Medical administration
75	Oral and maxillofacial surgery
76	Palliative medicine
77	Urogynaecology
78	Reproductive endocrinology and infertility
79	Addiction medicine

	80	Paediatric emergency medicine
	81	Sexual health medicine
	82	Pain medicine
Supplementary values:	97	Not applicable
	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 13 Dentistry

'Dentistry' excludes oral and maxillofacial surgery.

CODE 15 Diagnostic radiology

'Diagnostic radiology' includes diagnostic ultrasound.

CODE 16 Otolaryngology

'Otolaryngology' includes ear, nose, throat, head and neck surgeons.

CODE 22 General medicine

'General medicine' includes general and internal medicine physicians and endoscopy.

CODE 25 General surgery

'General surgery' includes surgical procedures, including colorectal surgery.

CODE 27 Gynaecology only

'Gynaecology only' includes gynaecologists who only diagnose, treat and aid in the prevention of disorders of the female reproductive system (RANZCOG 2011).

CODE 31 Midwifery

'Midwifery' includes registered midwives only.

CODE 35 Nuclear medicine

'Nuclear medicine' includes radiotherapy and radiation oncology.

CODE 36 Nursing–general

'Nursing-general' includes enrolled and registered nurses.

CODE 37 Nursing–nurse practitioner

'Nursing–nurse practitioner' includes registered nurse practitioners only.

CODE 39 Obstetrics and gynaecology

'Obstetrics and gynaecology' includes specialists who carry out gynaecological examinations, diagnosis and operations on women; provide medical care before, during and after childbirth; and treat infertility by chemical or operative measures (RANZCOG 2011).

CODE 40 Obstetrics only

'Obstetrics only' includes obstetricians who only provide medical care before, during and after childbirth (RANZCOG 2011).

CODE 41 Occupational and environmental medicine

'Occupational and environmental medicine' should be used for doctors only; occupational therapists should be recorded at Code 67.

CODE 46 Paediatrics

'Paediatrics' excludes neonatal or perinatal medicine and paediatric surgery.

CODE 49 Pathology

'Pathology' includes general pathology, anatomical pathology, chemical pathology, pathological haematology, pathological immunology and clinical microbiology.

CODE 59 Respiratory and sleep medicine

'Respiratory and sleep medicine' includes thoracic medicine.

CODE 67 Other allied health (including complementary medicine)

'Other allied health (including complementary medicine)' includes: acupuncturist, allergy and asthma consultant, alternative health services, audiologist, audiometrist, Chinese medicine therapist, chiropodist, dental hygienist, dental technician, drug and alcohol counsellor, hygiene consultant, naturopath, occupational health and safety practitioner, occupational therapist, optometrist, social worker, speech pathologist, speech therapist and therapeutic masseur.

CODE 68 Other hospital-based medical practitioners

'Other hospital-based medical practitioners' includes junior doctors, resident doctors, house officers, interns, and other clinicians who do not have a specialty.

CODE 71 Anaesthesia

'Anaesthesia' includes general anaesthesia, paediatric anaesthesia and intensive care anaesthesia.

CODE 82 Pain medicine

‘Pain medicine’ includes specialists in managing severe pain problems in the areas of acute pain, cancer pain and chronic pain (Faculty of Pain Medicine 2003).

CODE 97 Not applicable

‘Not applicable’ should be used where no clinical or medical administration staff were involved in the incident.

CODE 99 Not stated/inadequately described

‘Not stated/inadequately described’ should be used when the information is not currently available. Not stated/inadequately described should not be used when a claim is closed.

Comments: The general aim of this list is to include all categories that might be of relevance to medical indemnity claims. The medical specialties included in this value domain are taken from the List of Australian Recognised Medical Specialties, a list approved by the Minister for Health and Ageing (AMC 2009) and from the lists of clinical specialties developed by various health authorities for use in their medical indemnity data collections.

The categories of medical specialists align well between the Australian Prudential Regulation Authority (2006) National Claims and Policies Database (NCPD) and the Medical Indemnity National Collection (MINC). The NCPD specifications have separate codes for several allied health and complementary fields which are subsumed within the MINC category ‘Other allied health (including complementary medicine)’. In the NCPD, ‘student practitioner or intern’ is a separate category. The MINC codes students based on the speciality they are training in, and classifies interns with ‘Other hospital-based medical practitioners’ (AIHW 2011).

Recording the specialty of the individual clinician at this data element does not imply that the individual was ‘at fault’. These individuals may or may not be defendants in the medical indemnity claim.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: AIHW (Australian Institute of Health and Welfare) 2011. Public and private sector medical indemnity claims in Australia 2008–09. Safety and quality of health care series no.10. Cat. no. HSE 112. Canberra: AIHW

AMC (Australian Medical Council) 2009. The List of Australian Recognised Medical Specialties. Canberra. Viewed 16 November 2010, <http://www.amc.org.au/images/Recognition/AMC-list-of-specialties.pdf>

APRA (Australian Prudential Regulation Authority) 2006. Data specifications National Claims and Policies Database Document Number 3.1. Canberra: APRA

Faculty of Pain Medicine 2003. Application for specialty recognition by the Faculty of Pain Medicine to the Australian Medical Council. Melbourne: Australian and New Zealand College of Anaesthetists. Viewed 25 May 2011, <http://www.anzca.edu.au/fpm/news-and-reports/FPM_AMCSub.pdf>

RANZCOG (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists) 2011. About the specialty. Viewed 20 October 2011, <http://www.ranzcog.edu.au/the-ranzcog/about-specialty.html>

Data element attributes

Collection and usage attributes

Guide for use:

This data element should be used in conjunction with the data element: *Health-care incident— principal clinician specialty involved in health-care incident, clinical specialties code N[N]* to record the specialties of the clinicians who played a prominent role in the incident that gave rise to the medical indemnity claim. That is, the individuals whose actions/omissions are directly implicated in 'what went wrong'. These individuals may or may not be defendants in the medical indemnity claim.

Up to three codes may be selected for this data element.

For a particular clinician, the specialty recorded should be the main clinical area in which that clinician has formal qualifications (or, in the case of a specialist-in training, is working towards gaining formal qualifications), and/or in which that clinician primarily practices. The specialty recorded may not be the area in which the clinician was working at the time of the incident. For example, if a clinician involved in the incident was a general surgeon, but was working in the Emergency department when the incident occurred, Code 25 'General surgery' should be recorded.

Where a private doctor was closely involved in the incident, the specialty of the private doctor should be recorded.

This data element should be completed on the basis of available information about the specialty of clinicians closely involved in the incident; specialty should not be assumed based on other information. For example, if the incident occurred in the course of repair to an aortic abdominal aneurysm, Code 66 'Vascular surgery' should only be recorded where there is information to confirm that a vascular surgeon was among the clinicians involved.

Where a registrar was closely involved in the incident, the specialty for which the registrar was training at the time of the incident should be recorded.

Where no clinical staff were involved in the incident (for example, where the claim relates to actions of hospital administrative staff) Code 97 'Not applicable' should be recorded.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Health-care incident—principal clinician specialty involved in health-care incident, clinical specialties code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on more than one clinician specialty being involved in the health-care incident that gave rise to a medical indemnity claim.

Additional diagnosis

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of care—additional diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]}

METeOR identifier: 391322

Registration status: Health, Standard 22/12/2009

Definition: A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment, as represented by a code.

Data Element Concept: Episode of care—additional diagnosis

Value domain attributes

Representational attributes

Classification scheme: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition

Representation class: Code

Data type: String

Format: ANN{.N[N]}

Maximum character length: 6

Data element attributes

Collection and usage attributes

Guide for use: Record each additional diagnosis relevant to the episode of care in accordance with the ICD-10-AM Australian Coding Standards. Generally, external cause, place of occurrence and activity codes will be included in the string of additional diagnosis codes. In some data collections these codes may also be copied into specific fields.

The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.

Additional diagnoses give information on the conditions that are significant in terms of treatment required, investigations needed and resources used during the episode of care. They are used for casemix analyses relating to severity of illness and for correct classification of patients into Australian Refined Diagnosis Related Groups (AR-DRGs).

Collection methods: An additional diagnosis should be recorded and coded where appropriate upon separation of an episode of admitted patient care or the end of an episode of residential care or attendance at a health care establishment. The additional diagnosis is derived from and must be substantiated by clinical documentation.

Comments: Additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:

- Commencement, alteration or adjustment of therapeutic treatment
- Diagnostic procedures
- Increased clinical care and/or monitoring

In accordance with the Australian Coding Standards, certain conditions that do not meet the above criteria may also be recorded as additional diagnoses.

Additional diagnoses are significant for the allocation of Australian Refined Diagnosis Related Groups. The allocation of patient to major problem or complication and co-morbidity Diagnosis Related Groups is made on the basis of the presence of certain specified additional diagnoses. Additional diagnoses should be recorded when relevant to the patient's episode of care and not restricted by the number of fields on the morbidity form or computer screen.

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

Source and reference attributes

Origin: National Centre for Classification in Health

Relational attributes

Related metadata references: Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009, Tasmanian Health, Proposed

28/09/2011

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Supersedes Episode of care—additional diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Additional incident or allegation type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim—additional incident or allegation type, health-care code NN[N]
METeOR identifier:	329728
Registration status:	Health, Standard 07/12/2011
Definition:	The high level category describing the type of health-care incident that was of importance in giving rise to a medical indemnity claim, as alleged or documented as part of a medical indemnity claim, in addition to the primary incident or allegation type, as represented by a code.
Data Element Concept:	Medical indemnity claim—additional incident or allegation type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
10	Diagnosis
20	Medication-related: type and dosage
21	Medication-related: method of administration
22	Medication-related: other or not further defined
30	Anaesthetic
40	Blood or blood product-related (includes blood transfusions)
50	Procedure—failure to perform
51	Procedure—wrong procedure

	52	Procedure—wrong body site
	53	Procedure—post-operative complications
	54	Procedure—failure of procedure
	56	Procedure—post-operative infection
	57	Procedure—intra-operative complications
	59	Procedure—other or not further defined
	60	Treatment—delayed
	61	Treatment—not provided
	62	Treatment—complications
	63	Treatment—failure of treatment
	64	Treatment—other or not further defined
	70	Consent (includes failure to warn)
	80	Infection control (includes instrument sterilisation)
	90	Device failure (includes problems with implanted devices)
	100	Other general duty of care issues
	888	Other
Supplementary values:	999	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 10 Diagnosis

'Diagnosis' includes missed, delayed or incorrect diagnosis.

'Medication-related' is defined to cover the use of drugs and other medicines in the delivery of health services, including immunisations; excludes 'anaesthetic' and 'blood or blood product-related'.

CODE 20 Medication-related: type and dosage

'Medication-related: type and dosage' includes issues related to type of medication or its dosage.

CODE 21 Medication-related: method of administration

'Medication-related: method of administration' includes issues related to method of administration of medication.

CODE 22 Medication-related: other or not further defined

‘Medication-related: other or not further defined’ includes any medication-related issues other than type, dosage or method of administration. Examples include medication not provided and a patient’s reaction to a correctly prescribed and administered medication.

CODE 30 Anaesthetic

‘Anaesthetic’ includes all issues related to epidural, anaesthetic substances, equipment, monitoring or resuscitation and patient awareness.

‘Procedure’ is defined as an invasive clinical intervention, where there is an incision and/or the body cavity is entered; procedures may be therapeutic or diagnostic. A vaginal delivery is also considered a procedure for the purposes of this metadata item.

CODE 51 Procedure—wrong procedure

‘Procedure—wrong procedure’ includes unnecessary procedures, for example, removal of a healthy appendix.

CODE 53 Procedure—post-operative complications

‘Procedure—post-operative complications’ includes incidents involving unintentionally retained objects following a procedure.

CODE 56 Procedure—post-operative infection

‘Procedure—post-operative infection’ includes wound infection due to a procedure; excludes hospital-acquired infections, for example, post-operative sepsis, needlestick injuries and claims involving failure to properly sterilise equipment.

CODE 57 Procedure—intra-operative complications

‘Procedure—intra-operative complications’ includes complications that arise during the course of a procedure, for example unintended perforations of adjacent organs.

CODE 59 Procedure—other or not further defined

‘Procedure—other or not further defined’ includes alleged negligent procedure (where no further information is available).

‘Treatment’ refers to health-care acts other than ‘medication-related’, ‘anaesthetic’, ‘blood or blood product-related (includes blood transfusions)’ or ‘procedure’. Examples of treatment include applying a dressing to a wound, setting a broken bone, physiotherapy services and psychiatric counselling for mental health patients.

CODE 61 Treatment—not provided

‘Treatment—not provided’ includes, for example, where an ambulance is called to attend but does not arrive, where a patient’s condition deteriorates after the patient elects to leave or is turned away from a medical facility, or where a patient is not provided with the diet required by the patient’s condition.

CODE 62 Treatment—complications

‘Treatment—complications’ includes, for example, developing ulcers under a plaster or dressing or a bone fractured during physiotherapy treatment, or where the failure to clean a wound sustained from an injury results in infection.

CODE 63 Treatment—failure of treatment

‘Treatment—failure of treatment’ includes incorrectly setting a broken bone.

CODE 64 Treatment—other or not further defined

‘Treatment—other or not further defined’ includes any incident or allegation of treatment as defined here, which does not fall under the treatment subcategories listed above.

CODE 70 Consent (includes failure to warn)

‘Consent (includes failure to warn)’ includes no valid consent and failure to warn, cessation or continuation of treatment without consent or against patient’s stated wishes, and disposing of a fetus without the consent of the parents.

CODE 80 Infection control (includes instrument sterilisation)

‘Infection control (includes instrument sterilisation)’ includes hospital-acquired infections, for example, post-operative sepsis, needlestick injuries and claims involving failure to properly sterilise equipment, but excluding post-operative infection.

CODE 90 Device failure (includes problems with implanted devices)

‘Device failure (includes problems with implanted devices)’ includes device failure during insertion and the insertion procedure is consequently aborted. Excludes problems due to the surgical implantation procedure.

CODE 100 Other general duty of care issues

‘Other general duty of care issues’ includes falls, administrative errors, for example, placing a ‘nil by mouth’ sign on the bed of the wrong patient, and patient monitoring and follow-up issues.

CODE 888 Other

'Other' includes medico-legal reports, disciplinary enquiries and other legal issues, breach of confidentiality, record keeping or loss of documents, and harassment and discrimination.

CODE 999 Not stated/inadequately described

'Not stated/inadequately described' should be used when the information is not currently available.

Comments: The definition of 'Procedure' used in the Medical indemnity data set specification was agreed to by the MIDWG during the data development phase of the MINC. This definition is narrower than the definition of 'Procedure' used in the National Health Data Dictionary METeOR identifier 391349.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: National Centre for Classification in Health (NCCH) 2010. The Australian Classification of Health Interventions (ACHI) – Seventh Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data element: *Health-care incident—primary incident or allegation type, health-care code NN[N]* to enable the identification of all medical indemnity claims involving a certain type of incident or allegation.

Up to three codes may be selected.

The Code 999 'Not stated/inadequately described' is not a valid code for this data element as it is valid only for the data element: *Health-care incident—primary incident or allegation type, health-care code NN[N].*

Comments: The coding categories for this data element have been developed with reference to a range of classifications currently in use, among which there is a high degree of commonality in terms of the categories identified. At the time of developing this data element a list of 46 categories of 'clinical incident category alleged in claim' was used in New South Wales to record this information. This list was also adopted for use in Tasmania. In Western Australia eight broad 'incident type' categories were used to collect this information on clincial incident notification forms. Two studies of the epidemiology of adverse events (one Australian and one from the United States of America) used similar, broad categories of the nature of adverse events to analyse data (Thomas et al. 2000; Wilson et al. 1995).

There is concordance between the Australian Prudential Regulation Authority (2006) National Claims and Policies Database claims data item 15 'Cause of loss' and the Medical Indemnity National Collection data item (AIHW 2011).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents:

AIHW (Australian Institute of Health and Welfare) 2011. Public and private sector medical indemnity claims in Australia 2008-09. Safety and quality of health care series no. 10. Cat. no. HSE 112. Canberra: AIHW

APRA (Australian Prudential Regulation Authority) 2006. Data Specifications National Claims and Policies Database document number 3.1. Canberra: APRA

Thomas EJ, Studdert DM, Burstin HR, Orav EJ, Zeena T, Williams EJ et al. 2000. Incidence and types of adverse events and negligent care in Utah and Colorado. Medical Care 38: 261–71

Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L & Hamilton JD 1995. The quality in Australian health care study. Medical Journal of Australia 163: 458–471

Relational attributes

Related metadata references: See also Medical indemnity claim—primary incident or allegation type, health-care code NN[N] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on more than one health-care incident or allegation type being involved in a medical indemnity

claim.

Address line (person)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

- Suburb, town or locality

- Postcode—Australian or international

- State, Territory, local government area, electorate, statistical local area

- Postal delivery point identifier

- Countries, provinces, etc other than in Australia

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

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

- Building/complex sub-unit type

- Building/complex sub-unit number

- Building/property name

- Floor/level number

- Floor/level type

- House/property number

- Lot/section number

- Street name

- Street type code

- Street suffix code

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

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

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

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

Multiple Address lines may be recorded as required.

Collection methods:

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

- Building/complex sub-unit type is to be collected in conjunction with Building/complex sub-unit number and vice versa.

- Floor/level type is to be collected in conjunction with Floor/level number and vice versa.

- Street name is to be used in conjunction with Street type code and Street suffix code.

- Street type code is to be used in conjunction with Street name and Street suffix code.

- Street suffix code is to be used in conjunction with Street name and Street type code.

- House/property number is to be used in conjunction with Street name.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: Health Data Standards Committee

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

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

AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references: Is formed using Person (address)—building/complex sub-unit identifier, [X(7)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Is formed using Person (address)—building/complex sub-unit type, code A[AAA] Community Services, Superseded 06/02/2012, Health, Standard 01/03/2005

Is formed using Person (address)—building/property name, text [X(30)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Is formed using Person (address)—floor/level identifier, [NNNA] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Is formed using Person (address)—floor/level type, code A[A] Community Services, Superseded 06/02/2012, Health, Standard 01/03/2005

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

Is formed using Person (address)—house/property identifier, text [X(12)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Is formed using Person (address)—lot/section identifier, N[X(14)] Community Services, Superseded 06/02/2012, Health, Standard 01/03/2005

Is formed using Person (address)—street name, text [A(30)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Is formed using Person (address)—street suffix, code A[A] Community Services, Superseded 06/02/2012, Health, Standard 01/03/2005

Is formed using Person (address)—street type, code A[AAA] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Standard 07/12/2011

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Address line (service provider organisation)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Service provider organisation (address)—address line, text [X(180)]

METeOR identifier: 290315

Registration status:

Community Services, Standard 30/09/2005
Housing assistance, Recorded 13/10/2011
Health, Standard 04/05/2005
Early Childhood, Standard 21/05/2010

Definition: A composite of one or more standard **address** components, as represented by text.

Data Element Concept: Service provider organisation (address)—address line

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: [X(180)]

Maximum character length: 180

Data element attributes

Collection and usage attributes

Guide for use:

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

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

These components of a complete address do not form part of the Address line.
When addressing an Australian location, following are the standard address data elements that may be concatenated in the Address line:

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

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

Collection methods:

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

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

Source and reference attributes

Submitting organisation: Standards Australia

Origin: Health Data Standards Committee

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

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

Relational attributes

Related metadata references:

Is formed using Service provider organisation (address)—building/complex sub-unit identifier, [X(7)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Is formed using Service provider organisation (address)—building/complex sub-unit type, code A[AAA] Community Services, Superseded 06/02/2012, Health, Standard 04/05/2005

Is formed using Service provider organisation (address)—building/property name, text [X(30)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Is formed using Service provider organisation (address)—floor/level identifier, [NNNA] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Is formed using Service provider organisation (address)—floor/level type, code A[A] Community Services, Superseded 06/02/2012, Health, Standard 04/05/2005

Is formed using Service provider organisation (address)—house/property identifier, text [X(12)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Is formed using Service provider organisation (address)—lot/section identifier, N[X(14)] Community Services, Superseded 06/02/2012, Health, Standard 04/05/2005

Is formed using Service provider organisation (address)—street name, text [A(30)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Is formed using Service provider organisation (address)—street suffix, code A[A] Community Services, Superseded 06/02/2012, Health, Standard 04/05/2005

Is formed using Service provider organisation (address)—street type, code A[AAA] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Implementation in Data Set Specifications:

Health care provider identification DSS Health, Standard 03/12/2008

Indigenous primary health care DSS Health, Standard 07/12/2011

Address site name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Address—address site name, text X[50]
Synonymous names:	Building property name; Primary complex name
METeOR identifier:	429252
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	The official place name or culturally accepted common usage name for an address site, as represented by text.
Data Element Concept:	Address—address site name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[50]
Maximum character length:	50

Data element attributes

Collection and usage attributes

Guide for use:

This data element represents the name given to an entire building or address site.

Names of persons, associations or businesses should not be used as address site names.

Usage Examples:

Parliament House (Name of the building)

University of Melbourne (Site name of university campus – a complex)

Happy Valley Retirement Village (Site name of gated property – a complex)

Darwin Town Hall (Name of the building)

Blue Hills Farm (Name of the property)

This data element is one of a number of items that can be used to create a primary address, as recommended by the AS 4590-2006 *Interchange of client information* standard. Components of the primary address are:

- Address site (or Primary complex) name
- Address number or number range
- Road name (name/type/suffix)
- Locality
- State/Territory
- Postcode (optional)
- Country (if applicable).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references: Supersedes Person (address)—building/property name, text [X(30)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Supersedes Service provider organisation (address)—building/property name, text [X(30)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Public hospital establishment address details DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on this component being part of the address of the Public hospital establishment.

Address type (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—address type, code N
METeOR identifier:	286728
Registration status:	Community Services, Superseded 06/02/2012 Health, Standard 04/05/2005
Definition:	A code set representing a type of address, as represented by a code.
Data Element Concept:	Person (address)—address type

Value domain attributes

Representational attributes

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

	Value	Meaning
Permissible values:	1	Business
	2	Mailing or postal
	3	Residential
	4	Temporary residential
Supplementary values:	9	Unknown/Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Business

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

CODE 2 Mailing or postal

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

CODE 3 Residential

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

CODE 4 Temporary residential

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

CODE 9 Unknown/Not stated/inadequately described

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

Data element attributes

Collection and usage attributes

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

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

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

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Person (address)—address type, code A Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008

Address type (service provider organisation)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Service provider organisation (address)—address type, code N

METeOR identifier: 286792

Registration status: Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Definition: The type of geographical/physical location where an organisation can be located, as represented by a code.

Data Element Concept: Service provider organisation (address)—address type

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Business
	2	Mailing or postal
Supplementary values:	9	Unknown/Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 1 Business

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

CODE 2 Mailing or postal

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

CODE 9 Unknown/Not stated/inadequately described

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

Data element attributes

Collection and usage attributes

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

Collection methods: At least one address must be recorded (this may be an unknown Address type). When recording the address for a health care provider or organisation, the business address should always be collected. In addition, other addresses may also need to be recorded for individuals and organisations.

Source and reference attributes

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

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

Relational attributes

Implementation in Data Set Specifications: Health care provider identification DSS Health, Standard 03/12/2008

Administrative health region name

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Administrative health region—region name, text [A(80)]

METeOR identifier: 297639

Registration status: Health, Standard 05/12/2007

Definition: Textual description of the full name of an administrative health region.

Data Element Concept: Administrative health region—region name

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: [A(80)]

Maximum character length: 80

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

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

Administrative health region palliative care strategic plan indicator

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

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

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

- timeframe (the beginning and end-date in years), with a minimum time period of two years to demonstrate a strategic focus

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

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

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

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

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

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

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

Admission date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission date, DDMMYYYY
METeOR identifier:	269967
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	Date on which an admitted patient commences an episode of care.
Data Element Concept:	Episode of admitted patient care—admission date

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Admission date, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Superseded 13/12/2011

Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 13/12/2011

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

Is used in the formation of Episode of admitted patient

care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

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

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

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

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

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

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

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admission time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission time, hhmm
METeOR identifier:	269972
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	Time at which an admitted patient commences an episode of care.
Data Element Concept:	Episode of admitted patient care—admission time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Comments:	Required to identify the time of commencement of the

episode or hospital stay, for calculation of waiting times and length of stay.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Admission time, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB)

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

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient election status

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of admitted patient care—patient election status, code N

METeOR identifier: 326619

Registration status: Health, Standard 23/10/2006

Definition: Accommodation chargeable status elected by a patient on **admission**, as represented by a code.

Data Element Concept: Episode of admitted patient care—patient election status

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Public
2	Private

Collection and usage attributes

Guide for use: Public patient:

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

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

Private patient:

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

Clause 49 states that:

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

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

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

- a public patient or
- a private patient

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

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

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

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

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

purchased by a private hospital then it will be assumed that they elected to be treated as a private patient.

Source and reference attributes

Submitting organisation: Admitted patient care NMDS Technical Reference Group

Relational attributes

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

Implementation in Data Set Specifications: Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient service unit identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—admitted patient service unit identifier, XXXXXX
METeOR identifier:	404390
Registration status:	Health, Standard 07/12/2011
Definition:	A unique identifier for a specialised mental health admitted patient service unit, as represented by a combination of numeric and/or alphabetic characters.
Data Element Concept:	Specialised mental health service—admitted patient service unit identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	XXXXXX
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:

Admitted patient service units should be differentiated by target population and program type. For example, if a hospital had separate wards for child and adolescent and general adult populations, these should be reported as separate service units. Similarly, if the hospital provided separate wards for older persons acute and older persons other program types, such as rehabilitation or extended care, this would require separate service units to be identified (that is, defined by the *Specialised mental health service—admitted patient care program type, code N* data element as well as the *Specialised mental health service—target population group, code N* data element). Where a hospital has, for example, two older persons acute admitted patient service units, these only need to be reported as one combined older persons acute admitted patient service unit to satisfy the minimum reporting requirements for NMDS purposes, but could be reported as two separate service units if desired. For additional information, please refer to the glossary item **Admitted patient mental health care service.**The complete identifier string, including State/Territory identifier, Region identifier, Organisation identifier, Hospital identifier and Admitted patient service unit identifier, should be a unique code for the service unit in that state/territory. Where applicable, service unit reporting structures should be identical between all mental health collections (e.g., Mental Health National Minimum Data Sets and the Mental Health National Outcomes and Casemix Collection (NOCC)).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Specialised mental health service—admitted patient care program type, code N Health, Standard 08/12/2004

See also Specialised mental health service—target population group, code N Health, Standard 07/12/2011

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient service unit name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—admitted patient service unit name, text XXX[X(97)]
METeOR identifier:	407462
Registration status:	Health, Standard 07/12/2011
Definition:	The appellation by which a specialised mental health admitted patient service unit is known or called, as represented by text.
Data Element Concept:	Specialised mental health service—admitted patient service unit name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	XXX[X(97)]
Maximum character length:	100

Data element attributes

Collection and usage attributes

Guide for use:

Admitted patient service units should be differentiated by target population and program type. For example, if a hospital had separate wards for child and adolescent and general adult populations, these should be reported as separate service units. Similarly, if the hospital provided separate wards for older persons acute and older persons other program types, such as rehabilitation or extended care, this would require separate service units to be identified (that is, defined by the *Specialised mental health service—admitted patient care program type, code N* data element as well as the *Specialised mental health service—target population group, code N* data element). Where a hospital has, for example, two older persons acute admitted patient service units, these only need to be reported as one combined older persons acute admitted patient service unit to satisfy the minimum reporting requirements for NMDS purposes, but could be reported as two separate service units if desired. For additional information, please refer to the glossary item **Admitted patient mental health care service.**The Admitted patient service unit name should be unique for the service unit in that state/territory. Where applicable, service unit reporting structures should be identical between all mental health collections (e.g., Mental Health National Minimum Data Sets and the Mental Health National Outcomes and Casemix Collection (NOCC)).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Specialised mental health service—target population group, code N Health, Standard 07/12/2011

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Age

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—age, total years N[NN]
METeOR identifier:	303794
Registration status:	Community Services, Standard 29/04/2006 Housing assistance, Standard 10/02/2006 Health, Standard 08/02/2006 Early Childhood, Standard 21/05/2010 Tasmanian Health, Proposed 28/09/2011
Definition:	The age of the person in (completed) years at a specific point in time.
Context:	Age is a core data element in a wide range of social, labour and demographic statistics. It is used in the analyses of service utilisation by age group and can be used as an assistance eligibility criterion.
Data Element Concept:	Person—age

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
999	Unknown/not stated

Unit of measure:	Year

Data element attributes

Collection and usage attributes

Guide for use:

Age in single years (if aged under one year, record as zero).

If age (or date of birth) is unknown or not stated, and cannot be estimated, use Code 999.

National community services and housing assistance data dictionary specific:

If year of birth is known (but date of birth is not) use the date, 0101YYYY of the birth year to estimate age (where YYYY is the year of birth).

National housing assistance data dictionary specific:

In the housing assistance data collections age is calculated at 30 June for the corresponding year.

Collection methods:

Although collection of date of birth allows more precise calculation of age, this may not be feasible in some data collections, and alternative questions are: Age last birthday?

What was .... age last birthday?

What is .... age in complete years?

Comments:

National community services data dictionary specific:

Different rules for reporting data may apply when estimating the Date of birth of children aged under 2 years since the rapid growth and development of children within this age group means that a child’s development can vary considerably over the course of a year. Thus, more specific reporting of estimated age is recommended.

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

Source and reference attributes

Submitting organisation: National Public Health Information Working Group

Origin:

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

http://www.abs.gov.au/AUSSTATS/abs@.nsf/DirClassManualsbyCatalogue/76CD93AA32E74B29CA25713E0005A2EA?OpenDocument

Relational attributes

Related metadata references:

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

See also Person—date of birth, MMYYYY Health, Standard

	10/12/2009
Implementation in Data Set Specifications:	Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008 Indigenous primary health care DSS Health, Standard 07/12/2011 Prison entrants DSS Health, Standard 25/08/2011 *Conditional obligation:* Age in years should be completed/estimated when date of birth is unknown.

Age at first pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—age at first pregnancy, total years N[N]
METeOR identifier:	399602
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	The age, in total years, of a female at the time of her first pregnancy.
Data Element Concept:	Female—age at first pregnancy

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

Guide for use: Pregnancy includes babies carried full term, abortions and miscarriages.

Collection methods: Responses must be in whole years only.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Female—ever been pregnant indicator, yes/no/not stated/inadequately described code N Health, Standard 25/08/2011

Implementation in Data Set Specifications: Pregnancy status cluster Health, Standard 25/08/2011

Conditional obligation:
Conditional on person having been pregnant.

Age range

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—age range, code NN

METeOR identifier: 290540

Registration status: Health, Standard 04/05/2005

Definition: The age range that best accommodates a person's completed age in years, at the time of data collection, as represented by a code.

Data Element Concept: Person—age range

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: NN

Maximum character length: 2

Permissible values:

Value	Meaning
01	0-4

	02	5-14
	03	15-24
	04	25-34
	05	35-44
	06	45-54
	07	55-64
	08	65-74
	09	75 years or older
Supplementary values:	99	Not stated

Data element attributes

Collection and usage attributes

Guide for use: Used in computer assisted telephone interview (CATI) surveys in cases where the specific age is not available.

Depending on the collection a different starting age may be used, but should map back to the standard output.

Information at a finer level can be collected as long as it maps back to the proposed data domain, e.g. 75+ age group can be split into 75-84 and 85 years or older.

Collection methods: Although collection of date of birth allows more precise calculation of age, as does the collection of a single age, this may not always be feasible. Age range should be derived from a question on date of birth or age at last birthday.

Comments: In cases where an exact age is not known or not stated, age may be reported as an age range. The age ranges are consistent with the standard 10 year ranges recommended by the ABS.

Source and reference attributes

Submitting organisation: National Public Health Information Working Group

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

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

Relational attributes

Implementation in Data Set Specifications: Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Alcohol consumption frequency

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—alcohol consumption frequency, AUDIT alcohol consumption frequency code N

METeOR identifier: 403077

Registration status: Health, Standard 25/08/2011

Definition: The self-reported frequency of a person's alcohol consumption, as measured by the Alcohol Use Disorders Identification Test (AUDIT).

Data Element Concept: Person—alcohol consumption frequency

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
0	Never
1	Monthly or less
2	2-4 times a month
3	2-3 times a week
4	4 or more times a week

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Babor T, Higgins-Biddle JC, Saunders JB, Monteiro MG 2001.The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care. 2nd edn. Switzerland: World Health Organization.

Data element attributes

Collection and usage attributes

Guide for use: This data element when used in conjunction with the data elements: *Person—consumption of 6 or more standard drinks on one occasion, AUDIT consumption of 6 or more standard drinks code N* and *Person—alcohol consumption amount (self-reported), total standard drinks NN* provides a score on the AUDIT, and a risk of alcohol-related harm.

Comments: The AUDIT is an alcohol screen that can help identify patients who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Babor T, Higgins-Biddle JC, Saunders JB, Monteiro MG 2001.The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care. 2nd edn. Switzerland: World Health Organization.

Relational attributes

Related metadata references: See also Person—alcohol consumption amount (self-reported), total standard drinks NN Health, Standard 01/03/2005

See also Person—consumption of 6 or more standard drinks on one occasion, AUDIT consumption of 6 or more standard drinks code N Health, Standard 25/08/2011

Implementation in Data Set Specifications: AUDIT score of risky alcohol consumption cluster Health, Standard 25/08/2011

Alcohol consumption frequency (self reported)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:	99	Not reported

Data element attributes

Collection and usage attributes

Collection methods:

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

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

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

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

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

Relational attributes

Related metadata references: Supersedes Alcohol consumption frequency- self report, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (24.3 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Alcohol consumption in standard drinks per day (self reported)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—alcohol consumption amount (self-reported), total standard drinks NN

METeOR identifier: 270249

Registration status: Health, Standard 01/03/2005

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

Data Element Concept: Person—alcohol consumption amount

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: NN

Maximum character length: 2

Supplementary values:

Value	Meaning
99	Consumption not reported

Unit of measure: Standard drink

Collection and usage attributes

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

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

Data element attributes

Collection and usage attributes

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

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

- Light beer (2.7%):

- 1 can or stubbie = 0.8 a standard drink

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

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

Collection methods:

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

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

Origin:

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

Relational attributes

Related metadata references:

Supersedes Alcohol consumption in standard drinks per day - self report, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.6 KB)

See also Person—alcohol consumption frequency, AUDIT alcohol consumption frequency code N Health, Standard 25/08/2011

See also Person—consumption of 6 or more standard drinks on one occasion, AUDIT consumption of 6 or more standard drinks code N Health, Standard 25/08/2011

Implementation in Data Set

AUDIT score of risky alcohol consumption cluster Health,

Specifications:

Standard 25/08/2011

Conditional obligation:
Conditional on the person having had an alcoholic drink in the last 12 months.

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Alcohol consumption status recorded indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—alcohol consumption status recorded indicator, yes/no code N

METeOR identifier: 441441

Registration status: Health, Standard 07/12/2011

Definition: An indicator of whether a person's alcohol consumption status has been recorded, as represented by a code.

Data Element Concept: Person—alcohol consumption status recorded indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes

A person has had their alcohol consumption status recorded.

CODE 2 No

A person has not had their alcohol consumption status recorded.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Indigenous primary health care DSS Health, Standard

Specifications: 07/12/2011

Conditional obligation:
This item is only collected for persons aged 15 years and older.

Ambulatory service unit identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—ambulatory service unit identifier, XXXXXX
METeOR identifier:	404829
Registration status:	Health, Standard 07/12/2011
Definition:	A unique identifier for a specialised mental health ambulatory service unit, as represented by a combination of numeric and/or alphabetic characters.
Data Element Concept:	Specialised mental health service—ambulatory service unit identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	XXXXXX
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:

For the ambulatory service setting, the service unit is equivalent to an organisation's ambulatory services as a whole. However, ambulatory service units should be differentiated by target population. Where an organisation provides multiple teams serving the same target population, these may be grouped and reported as a single service unit, or identified as individual service units in their own right. Ambulatory services would be separately identifiable as service units using the *Specialised mental health service – target population group, code N* data element. For additional information, please refer to the glossary item **Ambulatory mental health care service**.The complete identifier string, including State/Territory identifier, Region identifier, Organisation identifier, Service unit cluster identifier and Ambulatory service unit identifier, should be a unique code for the service unit in that state/territory. Service unit reporting structures should be identical between all mental health collections (e.g., Mental Health National Minimum Data Sets and the Mental Health National Outcomes and Casemix Collection (NOCC)).

Relational attributes

Related metadata references: See also Specialised mental health service—target population group, code N Health, Standard 07/12/2011

Implementation in Data Set Specifications: Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Ambulatory service unit name

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service—ambulatory service unit name, text XXX[X(97)]

METeOR identifier: 409038

Registration status: Health, Standard 07/12/2011

Definition: The appellation by which a specialised mental health ambulatory service unit is known or called, as represented by text.

Data Element Concept: Specialised mental health service—ambulatory service unit name

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: XXX[X(97)]

Maximum character length: 100

Data element attributes

Collection and usage attributes

Guide for use: For the ambulatory service setting, the service unit is equivalent to an organisation's ambulatory services as a whole. However, ambulatory service units should be differentiated by target population. Where an organisation provides multiple teams serving the same target population, these may be grouped and reported as a single service unit, or identified as individual service units in their own right. Ambulatory services would be separately identifiable as service units using the *Specialised mental health service – target population group, code N* data element. For additional information, please refer to the glossary item **Ambulatory mental health care service.**The Ambulatory service unit name should be unique for the service unit in that state/territory. Service unit reporting structures should be identical between all mental health collections (e.g., Mental Health National Minimum Data Sets and the

Mental Health National Outcomes and Casemix Collection (NOCC)).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Specialised mental health service—target population group, code N Health, Standard 07/12/2011

Implementation in Data Set Specifications: Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Anaesthesia administered for operative delivery of the baby

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	None
	2	Local anaesthetic to perineum
	3	Pudendal
	4	Epidural or caudal
	5	Spinal
	6	General anaesthetic
	7	Combined spinal-epidural
	8	Other
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: Operative delivery includes caesarean section, forceps and vacuum extraction.

Code 7: this code is used when this technique has been selected for the administration of anaesthesia for the operative delivery of the baby.

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

This item should only be recorded for the operative delivery of the baby and not third stage labour e.g. removal of placenta.

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

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

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

Analgesia administered for labour

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Birth event—analgesia administered, code N

METeOR identifier: 292546

Registration status: Health, Standard 07/12/2005

Definition: Analgesia administered to the woman to relieve pain for labour, as represented by a code.

Data Element Concept: Birth event—analgesia administered

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

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

Collection and usage attributes

Guide for use:

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

Data element attributes

Collection and usage attributes

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

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

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

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

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

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

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

Angina status

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—angina status, Canadian Cardiovascular Society code N

METeOR identifier: 338335

Registration status: Health, Standard 01/10/2008

Definition: The limitation of physical activity experienced by a person with the onset of angina, as represented by the Canadian Cardiovascular Society code.

Data Element Concept: Person—angina status

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	No angina with ordinary physical activity
	2	Slight limitation of ordinary physical activity
	3	Marked limitation of ordinary physical activity
	4	Inability for any physical activity without anginal symptoms
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: Code 1 No angina with ordinary physical activity

Use this code for patients who have no angina on ordinary physical activity such as walking or stair climbing. Angina occurs with strenuous, rapid or prolonged exertion at work or recreation.

Code 2 Slight limitation of ordinary physical activity

Use this code for patients for whom angina occurs on walking or climbing stairs rapidly, walking uphill, walking or climbing stairs after a meal, or under emotional stress, or in the cold, or only during the first few hours after waking.

Code 3 Marked limitation or ordinary physical activity

Use this code for patients where angina occurs walking one or two blocks on the level and climbing one or more flights of stairs in normal conditions and at a normal pace.

Code 4 Inability for any physical activity without anginal symptoms

Use this code for patients who are unable to carry on any physical activity without discomfort - anginal symptoms may be present at rest.

Collection methods: Angina status is self-reported by the person but is interpreted, coded and recorded by the health professional.

Data element attributes

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Angiotensin converting enzyme (ACE) inhibitors therapy status

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

	29	Not given - other
Supplementary values:	90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 21 - 29 Not given

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

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

Relational attributes

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

Antenatal care visits

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of antenatal care visits, total N[N]
Synonymous names:	Number of antenatal care visits
METeOR identifier:	423828
Registration status:	Health, Standard 12/10/2011
Definition:	The total number of **antenatal care** visits attended by a pregnant female.
Data Element Concept:	Female—number of antenatal care visits

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Antenatal care visits are attributed to the pregnant woman.

In **rural and remote locations** where a midwife or doctor is not employed, registered Aboriginal health workers and **registered nurses** may perform this role within the scope of their training and skill licence.

Include all pregnancy-related appointments with medical doctors where the medical officer has entered documentation related to that visit on the antenatal record.

An antenatal care visit does not include a visit where the sole purpose of contact is to confirm the pregnancy only, or those contacts that occurred during the pregnancy that related to other non-pregnancy related issues.

An antenatal care visit does not include a visit where the sole purpose of contact is to perform image screening, diagnostic testing or the collection of bloods or tissue for pathology testing. Exception to this rule is made when the health professional performing the procedure or test is a doctor or midwife and the appointment directly relates to this pregnancy and the health and wellbeing of the fetus.

Collection methods: Collect the total number of antenatal care visits for which there is documentation included in the health record of pregnancy and/or birth. To be collected once, after the onset of labour. Include all medical specialist appointments or medical specialist clinic appointments where the provider of the service event has documented the visit on the health record.

Multiple visits on the same day should be recorded as one visit.

Comments: The scope and definition of antenatal care visits was developed through consultation with stakeholders from midwifery, obstetric, perinatal data managers and other interested parties in 2010.

Source and reference attributes

Submitting organisation: National Perinatal Epidemiology and Statistics Unit

Reference documents: Clinical Practice Improvement Unit (CPIU) 2006, 3Centre consensus guidelines on antenatal care. Melbourne: 3Centres Collaboration.

Relational attributes

Implementation in Data Set Specifications: Perinatal DSS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Anticipated patient election status

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Public
2	Private

Collection and usage attributes

Guide for use:

CODE 1 Public patient:

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

CODE 2 Private patient:

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

Data element attributes

Collection and usage attributes

Guide for use:

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

- a public patient; or
- a private patient

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

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

Comments:

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

Relational attributes

Related metadata references:

Supersedes Anticipated patient election status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (15.2 KB)

Apgar score at 1 minute

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Collection and usage attributes

Guide for use:

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

Data element attributes

Collection and usage attributes

Comments:

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

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

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

Apgar score at 5 minutes

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Birth—Apgar score (at 5 minutes), code NN

METeOR identifier: 289360

Registration status: Health, Standard 07/12/2005

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

Data Element Concept: Birth—Apgar score

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: NN

Maximum character length: 2

	Value	Meaning
Permissible values:	00-10	Apgar score
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Birth—Apgar score (at 5 minutes), code NN Health, Superseded 07/12/2005

Implementation in Data Set Specifications: Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Area of practice - dental

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—principal area of practice, dental code NN
METeOR identifier:	377981
Registration status:	Health, Standard 10/12/2009
Definition:	The area of dental practice in which a dentist spent the most hours in their main job in the week prior to registration, as represented by a code.
Data Element Concept:	Registered health professional—principal area of practice

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	General dental practice
02	Dento-maxillofacial radiology
03	Endodontics
04	Oral and maxillofacial surgery
05	Oral surgery
06	Oral medicine
07	Oral pathology
08	Orthodontics
09	Paedodontics
10	Periodontics
11	Prosthodontics
12	Public health dentistry

	13	Special needs dentistry
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 01 GENERAL DENTAL PRACTICE

That part of dental practice that deals with a range of general dental care.

CODE 02 DENTO-MAXILLOFACIAL RADIOLOGY

That part of dental practice that deals with diagnostic imaging procedures applicable to the hard and soft tissues of the oral and maxillofacial region and to other structures which are relevant for the proper assessment of oral conditions.

CODE 03 ENDODONTICS

That part of dental practice that deals with the morphology, physiology, and pathology of the human tooth and, in particular, the dental pulp, root and peri-radicular tissues. It includes the biology of the normal pulp, crown, root and peri-radicular tissues and the aetiology, prevention, diagnosis and treatment of diseases and injuries that affect these tissues.

CODE 04 ORAL AND MAXILLOFACIAL SURGERY

That part of dental practice that deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the human jaws and associated structures.

CODE 05 ORAL SURGERY

That part of dental practice that deals with the diagnosis, surgical and adjunctive treatment of diseases and injuries limited to the dento-alveolar complex.

CODE 06 ORAL MEDICINE

That part of dental practice that deals with the clinical diagnosis, assessment and principally non-surgical, pharmacological management of anatomical variants, pathological conditions, diseases and pain of the dental, oral and adjacent anatomical structures and the dental/oral manifestations and complications of systemic diseases, pathology and conditions and their treatment.

CODE 07 ORAL PATHOLOGY

That part of dental practice that deals with diseases of the teeth, jaws, oral soft tissues and associated structures, studies their causes, pathogenesis and effects, and by use of clinical, radiographic, microscopic and other laboratory procedures establishes differential diagnoses and provides forensic evaluations.

CODE 08 ORTHODONTICS

That part of dental practice that deals with the study and supervision of the growth and development of the dentition and its related anatomical structures, including preventive and corrective procedures of dentofacial irregularities requiring the re-positioning of teeth, jaws, and/or soft tissues by functional or mechanical means.

CODE 09 PAEDIATRIC
DENTISTRY (PAEDODONTICS)

That part of dental practice that deals with the prevention and the treatment of dental diseases and abnormalities in children and their associated developmental and behavioural problems.

CODE 10 PERIODONTICS

That part of dental practice that deals with the prevention, recognition, diagnosis and treatment of the diseases and disorders of the investing and supporting tissues of natural teeth or their substitutes.

CODE 11 PROSTHODONTICS

That part of dental practice that deals with the restoration and maintenance of oral health, function and appearance by coronal alteration or reconstruction of natural teeth, or the replacement of missing teeth and contiguous oral and maxillofacial tissues with substitutes.

CODE 12 PUBLIC HEALTH DENTISTRY

That part of dental practice that deals with the community as the patient rather than the individual, being concerned with oral health education of the public, applied dental research and administration of dental care programmes including prevention and control of oral diseases on a community basis.

CODE 13 SPECIAL NEEDS DENTISTRY

That part of dental practice that deals with patients where intellectual disability, medical, physical or psychiatric conditions require special methods or techniques to prevent or treat oral health problems, or where such conditions necessitate special dental treatment plans.

Registered health professionals on leave at the time of registration are asked to report their usual principle area of practice worked.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Australian Dental Association
Reference documents:	Australian Dental Association Policy Statement 2.4, November 2008 *Specialisation in Dentistry*

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Health professional—area of clinical practice (principal), code ANN Health, Superseded 10/12/2009
Implementation in Data Set Specifications:	Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009 Second job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Area of practice - midwifery

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—principal area of practice, midwifery code NN
METeOR identifier:	382168
Registration status:	Health, Standard 10/12/2009
Definition:	The area of midwifery practice in which a midwife spent the most hours in their main job in the week prior to registration, as represented by a code.
Data Element Concept:	Registered health professional—principal area of practice

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	NN	
Maximum character length:	2	
Permissible values:	Value	Meaning
	01	Antenatal care
	02	Care during labour and birth
	03	Continuum of midwifery care
	04	Maternal and child health
	05	Midwifery education
	06	Midwifery management
	07	Midwifery research
	08	Neonatal care
	09	Postnatal care
	10	Other
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

The midwifery care during the woman's pregnancy, labour and birth and the postnatal period as well as the care of the well, normal baby is undertaken in partnership with the woman, consulting and referring to other health professionals as required. This care also includes preventative measures, the promotion of normal birth, the detection of complication in mother and child, accessing medical care or other appropriate assistance and the carrying out of emergency measures.

CODE 01 ANTENATAL CARE

Care, including counselling and education of the woman, and care of her unborn baby from the time the woman's pregnancy is diagnosed until the onset of labour.

CODE 02 CARE DURING LABOUR AND BIRTH

Care, including advocacy and support of the woman and her baby during all stages of labour and during the baby's birth.

CODE 03 CONTINUUM OF MIDWIFERY CARE

Care across the continuum of the woman's pregnancy, labour, the baby's birth and the post natal period.

CODE 04 MATERNAL AND CHILD HEALTH

Care of the mother and child following the postnatal period of 6 weeks focussing on parenting and the child's growth and development, up until at least the age of 5 years and in some cases beyond that age.

CODE 05 MIDWIFERY EDUCATION

The design, planning, implementation, delivery and evaluation of midwifery education and/or staff development programs and management of educational resources.

CODE 06 MIDWIFERY MANAGEMENT

The management of a health unit or sub-unit of a service, hospital or community health care facility providing midwifery services and care, supervising midwives and the financial resources to enable the provision safe, cost effective midwifery care within the service and monitors quality, clinical standards and the professional development of midwives.

CODE 07 MIDWIFERY RESEARCH

The design, planning, implementation and evaluation of midwifery research programs and projects and management of research resources.

CODE 08 NEONATAL CARE

Care and close observation of the normal well newborn baby ensuring the baby's continued well being, growth and development in the first 6 weeks of life.

CODE 09 POSTNATAL CARE

Care, including counselling and education of the woman and care of her baby from the baby's birth until the baby is 6 weeks old.

CODE 10 OTHER

All other areas of midwifery not covered above.

Registered health professionals on leave at the time of registration are asked to report their usual principle area of practice worked.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Health professional—area of clinical practice (principal), code ANN Health, Superseded 10/12/2009

Implementation in Data Set Specifications: Main job of registered midwife cluster Health, Standard 10/12/2009

Second job of registered midwife cluster Health, Standard 10/12/2009

Area of practice - nursing

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—principal area of practice, nursing code NN
METeOR identifier:	377983
Registration status:	Health, Standard 10/12/2009
Definition:	The area of nursing practice in which a nurse spent the most hours in their main job in the week prior to registration, as represented by a code.
Data Element Concept:	Registered health professional—principal area of practice

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Aged care
02	Child and family health
03	Community health
04	Critical care and emergency
05	Education
06	Management
07	Medical
08	General practice/Medical practice
09	Mental health
10	Midwifery
11	Paediatrics
12	Peri-operative

	13	Rehabilitation and disability
	14	Research
	15	Surgical
	16	Other
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 01 AGED CARE

Nursing care to the elderly in community settings, residential aged care facilities, retirement villages and health care facilities.

CODE 02 CHILD AND FAMILY HEALTH

Nursing care to children from birth to school age and their families with an emphasis on the prevention, early detection of, and early intervention in, physical, emotional and social problems affecting children and their families such as assistance with parentcraft, immunisation and developmental milestones.

CODE 03 COMMUNITY HEALTH

Nursing care, health counselling, screening and education to individuals, families and groups in the wider community with a focus on patient independence and health promotion.

CODE 04 CRITICAL CARE AND EMERGENCY

Provides nursing care to critically ill patients and patients with unstable health following injury, surgery or during the acute phase of diseases, integrating new technological equipment into care in settings such as high dependency units, intensive care units, emergency departments or retrieval services.

CODE 05 EDUCATION

Design, planning, implementation, evaluation and delivery of nursing education and staff development programs, and management of educational resources.

CODE 06 MANAGEMENT

Management of a health service unit or sub-unit of a hospital, aged care or community health care facility, supervision of nursing staff and financial resources to enable the provision of safe, cost effective nursing care within a specified field or for a particular unit, and monitoring of quality, clinical standards and professional development of nurses.

CODE 07 MEDICAL

Nursing care to patients with conditions, such as infections, metabolic disorders and degenerative conditions, which require medical intervention in a range of health, aged care and community settings.

CODE 08 GENERAL PRACTICE/MEDICAL PRACTICE

Clinical care to patients, clinical organisation and practice administration, and the facilitation of communication within a general practice environment and between the practice and outside organisations and individuals.

CODE 09 MENTAL HEALTH

Nursing care to patients with mental health illness, disorder and dysfunction, and those experiencing emotional difficulties, distress and crisis in health, welfare and aged care facilities, correctional services and the community.

CODE 10 MIDWIFERY

Nursing care and advice to women during pregnancy, labour and childbirth, and postnatal care for women and babies in a range of settings such as the home, community, hospitals, clinics and health units.

CODE 11 PAEDIATRICS

Providing nursing care and advice regarding internal diseases and disorders in children from birth up to, and including, adolescence.

CODE 12 PERI-OPERATIVE

Nursing care to patients before, during and immediately after surgery, assessment of patients' condition, planning of nursing care for surgical intervention, maintenance of a safe and comfortable environment, assistance to Surgeons and Anaesthetists during surgery, and monitoring of patients' recovery from anaesthetic, prior to return to, or discharge from, ward.

CODE 13 REHABILITATION AND DISABILITY

Nursing care to patients recovering from injury and illness, and assistance and facilitation for patients with disabilities to live more independently.

CODE 14 RESEARCH

The design, conduct and evaluation of nursing and interdisciplinary research projects, and promotion of the implementation of research findings into clinical nursing practice.

CODE 15 SURGICAL

Nursing care to patients with injuries and illness that require surgical intervention.

CODE 16 OTHER

All other areas of nursing practice not covered above.

Registered health professionals on leave at the time of registration are asked to report their usual principle area of practice worked.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: These definitions are based on occupational definitions as described in the Australian and New Zealand Standard Classification of Occupations, First Edition (ABS cat. no. 1220.0)

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Health professional—area of clinical practice (principal), code ANN Health, Superseded 10/12/2009

Implementation in Data Set Specifications: Main job of registered nursing professional cluster Health, Standard 10/12/2009

Second job of registered nursing professional cluster Health, Standard 10/12/2009

Area of practice - psychology

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—principal area of practice, psychology code NN
METeOR identifier:	377985
Registration status:	Health, Standard 10/12/2009
Definition:	The area of psychology practice in which a psychologist spent the most hours in their main job in the week prior to registration, as represented by a code.
Data Element Concept:	Registered health professional—principal area of practice

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	NN	
Maximum character length:	2	
Permissible values:	Value	Meaning
	01	Assessment
	02	Psychological intervention
	03	Community psychology
	04	Management/Administration
	05	Organisational psychology
	06	Research
	07	Teaching/supervision
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 01 ASSESSMENT

Includes behavioural, neuropsychological, cognitive, medico-legal, and educational.

CODE 02 PSYCHOLOGICAL INTERVENTION

Includes counselling, mental health intervention, personal development/coaching, physical health and lifestyle intervention, intervention for drug and/or alcohol misuse and/or other addiction.

CODE 03 COMMUNITY PSYCHOLOGY

Includes mental health promotion, community engagement/education, health promotion.

CODE 04 MANAGEMENT/ADMINISTRATION

Includes planning and coordination of psychology programs and services, maintaining standards of care, provision of leadership to ensure an appropriately skilled workforce, and contribution to health service planning.

CODE 05 ORGANISATIONAL PSYCHOLOGY

Includes organisational practices, consulting/advising for work purposes, recruitment and vocational assessment.

CODE 06 RESEARCH

Includes research design and implementation, statistical analysis, project/program development and evaluation.

CODE 07 TEACHING/SUPERVISION

Includes teaching, supervision and assessment of the psychological work of a student, provisional/probationary psychologist or a colleague.

CODE 08 OTHER

Includes all other areas of psychology practice not defined above.

Registered health professionals on leave at the time of registration are asked to report their usual principle area of practice worked.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Categories and definitions are based on advice from the Australian Psychological Society Ltd - www.psychology.org.au

Reference documents:

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Health professional—area of clinical practice (principal), code ANN Health, Superseded 10/12/2009
Implementation in Data Set Specifications:	Main job of registered psychologist cluster Health, Standard 10/12/2009 Second job of registered psychologist cluster Health, Standard 10/12/2009

Area of usual residence

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—area of usual residence, geographical location code (ASGC 2011) NNNNN

METeOR identifier: 455536

Registration status: Community Services, Standard 21/02/2012
Health, Standard 22/11/2011
Early Childhood, Standard 09/03/2012

Definition: Geographical location of usual residence of the person, as represented by a code.

Data Element Concept: Person—area of usual residence

Value domain attributes

Representational attributes

Classification scheme: Australian Standard Geographical Classification 2011

Representation class: Code

Data type: Number

Format: NNNNN

Maximum character length: 5

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: The geographical location is reported using a five digit numerical code to indicate the Statistical Local Area (SLA) within the reporting state or territory, as defined in the Australian Standard Geographical Classification (ASGC) (Australian Bureau of Statistics (ABS), catalogue number 1216.0). It is a composite of state/territory identifier and SLA (first digit = state/territory identifier, next four digits = SLA).

The Australian Standard Geographical Classification (ASGC) is updated by the ABS on an annual basis, with a date of effect of 1 July each year.

Up until 2007, the ABS's National Localities Index (NLI) (catalogue number 1252.0.55.001) was available as a coding tool designed to assist users assign the ASGC Main Structure codes to street address information. However, the NLI is no longer produced by the ABS. To replace the Localities file of the NLI, the ABS has created a Locality to SLA correspondence file for 2011. This file is available on request by contacting ABS Geography at geography@abs.gov.au.

Collection methods:

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

Comments:

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

- comparison of the use of services by persons residing in different geographical areas;
- characterisation of catchment areas and populations for establishments for planning purposes; and
- documentation of the provision of services to residents of states or territories other than the state or territory of the provider.

Source and reference attributes

Origin:

Australian Standard Geographical Classification (Australian Bureau of Statistics catalogue number 1216.0)

Relational attributes

Related metadata references:

Supersedes Person—area of usual residence, geographical location code (ASGC 2010) NNNNN Health, Superseded

22/11/2011

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Perinatal DSS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Area of usual residence (SA2)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—area of usual residence, statistical area level 2 (SA2) code (ASGS 2011) N(9)
METeOR identifier:	469909
Registration status:	Health, Standard 07/12/2011
Definition:	The geographical region in which a person or group of people usually reside, as represented by a code.
Data Element Concept:	Person—area of usual residence

Value domain attributes

Representational attributes

Classification scheme:	Australian Statistical Geography Standard 2011
Representation class:	Code
Data type:	String
Format:	N(9)
Maximum character length:	9

Collection and usage attributes

Guide for use:

SA2 coding structure:

An SA2 is identifiable by a 9-digit fully hierarchical code. The SA2 identifier is a 4-digit code, assigned in alphabetical order within an SA3. An SA2 code is only unique within a state/territory if it is preceded by the state/territory identifier.

For example:

State/territory	SA4	SA3	SA2
N	NN	NN	NNNN

Comments:

There are 2,196 SA2 spatial units. In aggregate, they cover the whole of Australia without gaps or overlaps. Jervis Bay Territory, the Territory of the Cocos (Keeling) Islands and the Territory of Christmas Island are each represented by an SA2.

Source and reference attributes

Origin: 1270.0.55.001 - Australian Statistical Geography Standard (ASGS): Volume 1 - Main Structure and Greater Capital City Statistical Areas, July 2011
http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1270.0.55.001July%202011?OpenDocument

Data element attributes

Collection and usage attributes

Guide for use: The geographical location is reported using a nine digit numerical code to indicate the Statistical Area (SA) within the reporting state or territory, as defined in the Australian Statistical Geography Standard (ASGS) (Australian Bureau of Statistics (ABS), catalogue number 1270.0.55.001).

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

Comments: Geographical location is reported using Statistical Area to enable accurate aggregation of information to larger areas within the ASGS as well as detailed analysis at the SA2 level. The use of SA2 also allows analysis relating the data to information compiled by the ABS on the demographic and other characteristics of the population of each SA2. Analyses facilitated by the inclusion of SA2 information include:

- comparison of the use of services by persons residing in different geographical areas;
- characterisation of catchment areas and populations for establishments for planning purposes; and
- documentation of the provision of services to residents of states or territories other than the state or territory of the provider.

Relational attributes

Related metadata references: Supersedes Person—area of usual residence, geographical location code (ASGC 2010) NNNNN Health, Superseded 22/11/2011

Implementation in Data Set Admitted patient care NMDS 2012-2013 Health, Standard

Specifications:

11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Aspirin therapy status

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	NN	
Maximum character length:	2	
Permissible values:	Value	Meaning
	10	Given
	21	Not given - patient refusal
	22	Not given - true allergy to aspirin
	23	Not given - active bleeding
	24	Not given - bleeding risk
	29	Not given - other
Supplementary values:	90	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODES 21 - 29 Not given

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

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

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

Relational attributes

Related metadata references: Supersedes Aspirin therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.2 KB)

Assistance with activities

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001	
Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	0	Does not need help/supervision
	1	Sometimes needs help/supervision
	2	Always needs help/supervision
	3	Unable to do this task or action, even with assistance
Supplementary values:	8	Not specified
	9	Not applicable

Collection and usage attributes

Guide for use:

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

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

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

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

Where a life area includes a range of examples, (e.g. domestic life includes cooking, cleaning and shopping), if a person requires assistance in any of the areas then the highest level of assistance should be recorded.

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

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

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

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

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

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

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

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

Source and reference attributes

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

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

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

Reference documents:

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

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

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

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

At risk of suicide or self-harm indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Prison entrant—at risk of suicide or self-harm indicator, yes/no code N
METeOR identifier:	412490
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether a prison entrant has been identified as being at risk of suicide or self-harm, as represented by a code.
Data Element Concept:	Prison entrant—at risk of suicide or self-harm indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: Self-harm is when a person deliberately inflicts physical harm to themself, often in secret and without anyone else knowing about it. Self-harm is not necessarily a suicide attempt, although it may include suicidal behaviour.

Comments: Entry to prison can be a time of increased vulnerability and risk of suicide or self-harming behaviours. All prisoners upon reception into prison are assessed to identify those at current risk of suicide or self-harm. These prisoners are then provided with closer observation and monitoring.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Kirchner T, Forns M & Mohino S 2008. Identifying the risk of deliberate self-harm among young prisoners by means of coping typologies. Suicide and Life-Threatening Behavior 38(4):442-48.

Relational attributes

Implementation in Data Set Specifications: Prison entrants DSS Health, Standard 25/08/2011

Australian postcode (address)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Address—Australian postcode, code (Postcode datafile) {NNNN}

METeOR identifier: 429894

Registration status: Community Services, Standard 06/02/2012
Health, Standard 07/12/2011
Early Childhood, Standard 09/03/2012

Definition: The Australian numeric descriptor for a postal delivery area for an address.

Data Element Concept: Address—Australian postcode

Value domain attributes

Representational attributes

Classification scheme: Postcode datafile

Representation class: Code

Data type: Number

Format: {NNNN}

Maximum character length: 4

Data element attributes

Collection and usage attributes

Guide for use: Australian postal addresses should include a valid postcode. Refer to the Australia Post Address Presentation Standard for rules on presentation and positioning of postcodes on mail.

For a full list of Australian postcodes visit the Australia Post website: www.auspost.com.au

This data element may be used in the analysis of data on a geographical basis which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information as postcodes do not have a geographic definition and boundaries are not well defined. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g.

Statistical areas - SA) is not always possible.

When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Statistical Geography Standard (ASGS) codes using an ABS concordance, for example to determine SA2s. For a more advanced concordance, locality, postcode and state, which are all part of an address, used in conjunction can effectively code data to the SA1 level and above in the ASGS.

This data element is one of a number of items that can be used to create a primary address, as recommended by the AS 4590-2006 *Interchange of client information* standard. Components of the primary address are:

- Address site (or Primary complex) name
- Address number or number range
- Road name (name/type/suffix)
- Locality
- State/Territory
- Postcode (optional)
- Country (if applicable).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references: See also Address—statistical area, level 2 (SA2) code (ASGS 2011) N(9) Community Services, Standard 06/12/2011, Health, Standard 07/12/2011

Supersedes Person (address)—Australian postcode, code (Postcode datafile) {NNNN} Community Services, Superseded 06/02/2012, Housing assistance, Standard 10/02/2006, Health, Superseded 07/12/2011, Early Childhood, Superseded 09/03/2012, Homelessness, Standard 23/08/2010, Tasmanian Health, Proposed 28/09/2011

Supersedes Service provider organisation (address)—Australian postcode, code (Postcode datafile) {NNNN} Community Services, Superseded 06/02/2012, Housing assistance, Recorded 13/10/2011, Health, Superseded 07/12/2011, Early Childhood, Superseded 09/03/2012

Supersedes Workplace (address)—Australian postcode, code (Postcode datafile) {NNNN} Health, Superseded 07/12/2011, Tasmanian Health, Proposed 30/09/2011

Implementation in Data Set Specifications:	Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013 Public hospital establishment address details DSS Health, Standard 07/12/2011

Australian state of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—Australian state/territory of birth, code N
METeOR identifier:	375455
Registration status:	Health, Standard 10/12/2009
Definition:	The Australian state/territory in which a person was born, as represented by a code.
Data Element Concept:	Person—state/territory of birth

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

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

Source and reference attributes

Reference documents: Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered medical professional labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered midwifery labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered optometry labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered podiatry labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered psychology labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Australian state/territory identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—Australian state/territory identifier, code N
METeOR identifier:	286919
Registration status:	Community Services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006 Health, Standard 04/05/2005 Early Childhood, Standard 21/05/2010 Tasmanian Health, Proposed 30/09/2011
Definition:	The Australian state or territory where a person can be located, as represented by a code.
Data Element Concept:	Person—Australian state/territory identifier

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

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

Source and reference attributes

Reference documents: Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

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

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

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

Relational attributes

Related metadata references: See also Person (address)—Australian postcode, code (Postcode datafile) {NNNN} Community Services, Superseded 06/02/2012, Housing assistance, Standard 10/02/2006, Health, Superseded 07/12/2011, Early Childhood, Superseded 09/03/2012, Homelessness, Standard 23/08/2010, Tasmanian Health, Proposed 28/09/2011

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Australian state/territory identifier (establishment)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

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

Source and reference attributes

Reference documents: Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Health Data Committee

National Community Services Data Committee

Relational attributes

Related metadata references: Supersedes Australian State/Territory identifier, version 4, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (18.8 KB)

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

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

Is used in the formation of Establishment—geographical location, code (ASGC 2007) NNNNN Health, Superseded 04/02/2009

Is used in the formation of Establishment—geographical location, code (ASGC 2008) NNNNN Health, Superseded 02/10/2009

Is used in the formation of Establishment—geographical location, code (ASGC 2009) NNNNN Health, Superseded 17/12/2010

Is used in the formation of Establishment—geographical location, code (ASGC 2010) NNNNN Health, Superseded

07/12/2011

Is used in the formation of Establishment—geographical location, code (ASGC 2011) NNNNN Health, Standard 07/12/2011

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

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

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

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

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2007) NNNNN Health, Superseded 04/02/2009

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2008) NNNNN Health, Superseded 02/10/2009

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2009) NNNNN Health, Superseded 17/12/2010

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2010) NNNNN Health, Superseded 07/12/2011

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2011) NNNNN Health, Standard 07/12/2011

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Mental health establishments NMDS 2012-2013 Health,

Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Prison entrants DSS Health, Standard 25/08/2011

Prison establishments DSS Health, Standard 25/08/2011

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Australian state/territory identifier (jurisdiction)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

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

Source and reference attributes

Reference documents: Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.

Data element attributes

Source and reference attributes

Submitting organisation: Health expenditure advisory committee

Relational attributes

Implementation in Data Set Specifications: Government health expenditure NMDS 2009-2010 Health, Standard 01/04/2009

Implementation start date: 01/07/2009

Australian state/territory identifier (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—Australian state/territory identifier, code N
METeOR identifier:	289083
Registration status:	Community Services, Standard 07/12/2005 Housing assistance, Proposed 01/11/2011 Health, Standard 04/05/2005 Early Childhood, Standard 21/05/2010 Tasmanian Health, Proposed 30/09/2011
Definition:	An identifier of the Australian state or territory where an organisation or agency can be located, as represented by a code.
Data Element Concept:	Service provider organisation—Australian state/territory identifier

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	New South Wales
2	Victoria
3	Queensland
4	South Australia
5	Western Australia
6	Tasmania
7	Northern Territory
8	Australian Capital Territory

9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)

Collection and usage attributes

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

Source and reference attributes

Reference documents: Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Health Data Standard Committee

National Community Services Data Committee

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

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

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

Relational attributes

Implementation in Data Set Specifications: Health care provider identification DSS Health, Standard 03/12/2008

Indigenous primary health care DSS Health, Standard 07/12/2011

Australian state/territory identifier of address

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Address—Australian state/territory identifier, code AA[A]
Synonymous names:	State/territory code
METeOR identifier:	430134
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011 Early Childhood, Standard 09/03/2012
Definition:	An identifier of the state or territory of an address, as represented by a code.
Data Element Concept:	Address—Australian state/territory identifier

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AA[A]
Maximum character length:	3

Permissible values:

Value	Meaning
NSW	New South Wales
VIC	Victoria
QLD	Queensland
SA	South Australia
WA	Western Australia
TAS	Tasmania
NT	Northern Territory
ACT	Australian Capital Territory
AAT	Australian Antarctic Territory

Collection and usage attributes

Guide for use: These Australian state/territory codes are used for addressing purposes only. The codes are listed in the order commonly used for statistical reporting by ABS and used in the National Standard for Australian state/territory identifier.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Data element attributes

Collection and usage attributes

Guide for use: This data element is one of a number of items that can be used to create a primary address, as recommended by the AS 4590-2006 *Interchange of client information* standard. Components of the primary address are:

- Address site (or Primary complex) name
- Address number or number range
- Road name (name/type/suffix)
- Locality
- State/Territory
- Postcode (optional)
- Country (if applicable).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Implementation in Data Set Specifications: Public hospital establishment address details DSS Health, Standard 07/12/2011

Average available beds for hospital-in-the-home patients

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Occupied bed—hospital in the home care, average number of beds N[NNN.N]
METeOR identifier:	373955
Registration status:	Health, Standard 24/03/2009
Definition:	The number of beds used to care for hospital admitted patients in their place of residence as a substitute for hospital accommodation, calculated by dividing the number of days of **hospital-in-the-home care** reported for the period by the number of days in the period. Place of residence may be permanent or temporary.
Data Element Concept:	Occupied bed—hospital in the home care

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN.N]
Maximum character length:	5
Unit of measure:	Bed

Collection and usage attributes

Guide for use:	Average available beds, rounded to the nearest decimal or whole number.

Data element attributes

Collection and usage attributes

Guide for use:	Calculated by dividing the total hospital-in-the-home patient days by the number of days in the period, e.g. in a normal year, a hospital records 4000 hospital-in-the-home patient days – the average hospital-in-the-home beds would be 4000/365 = 11.0.
Collection methods:	Beds exclusively or predominantly for overnight-stay admitted

care, beds exclusively or predominantly for same-day admitted care, and non-special-care neonatal cots are collected and reported in separate categories.

Hospitals should establish clear recording and reporting practices. Criteria should exist to ensure that each available bed is counted and that no available bed is counted more than once. A bed should first be assessed as available and then categorised according to its predominant use. For large hospitals a reconciliation of the sum of the counts for the four available bed types and an unduplicated establishment bed count is advisable.

Comments: This data element is necessary to provide an indicator of the availability and type of service for an establishment.

Source and reference attributes

Submitting organisation: Victorian Department of Human Services

Average available beds for overnight-stay patients

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Available bed—overnight-stay admitted care, average number of beds N[NNN.N]
METeOR identifier:	374151
Registration status:	Health, Standard 03/12/2008
Definition:	The number of beds available to provide overnight accommodation for patients (other than neonatal cots (non-special-care) and beds occupied by **hospital-in-the-home patients**), **averaged over the counting period**.
Context:	Public hospital establishments
Data Element Concept:	Available bed—overnight-stay admitted care

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN.N]
Maximum character length:	5
Unit of measure:	Bed

Collection and usage attributes

Guide for use:	Average available beds, rounded to the nearest decimal or whole number.

Data element attributes

Collection and usage attributes

Guide for use:

The number of available beds should be collected at least monthly at the same time on the same day. To improve accuracy data could be collected more frequently (e.g. daily). If so it should be collected at the same time on each day. More frequent data collection is preferable if a single monthly count is likely to be significantly different from the monthly average.

Inclusions: Both occupied and unoccupied beds are included in the count as they are deemed as available beds.

The number of beds available to provide overnight accommodation is recorded, e.g. maternity ward beds are counted but beds in the delivery suite are not. However, if in a delivery suite patients are admitted, deliver and are discharged from the same bed, such beds should be included because these beds are available for use for overnight-stay patients.

Exclusions: surgical tables, recovery trolleys, delivery beds, discharge lounges for patients who have been formally discharged, medi-hotel beds, beds exclusively or predominantly for same-day admitted care, neonatal cots (non-special-care), hospital-in-the home beds, and beds exclusively or predominantly for non-admitted patients (e.g. emergency trolleys) or residential care. No adjustment should be made for contracted services, either provided by, or to this hospital.

Collection methods:

Beds exclusively or predominantly for overnight-stay admitted care, beds exclusively or predominantly for same-day admitted care and, if required, non-special care neonatal cots are to be collected and reported in separate categories. Hospitals should establish clear recording and reporting practices. Criteria should exist to ensure that each available bed is counted once and only once. A bed should first be assessed as available and then categorised to its predominant use. For large hospitals, a reconciliation of the sum of the bed types and an unduplicated establishment bed count is advisable.
The assessment of availability must reflect the ability of the hospital to provide the necessary resources. This can be significantly impacted by seasonal demand or events such as a strike, clinical staff shortage, fire or renovation. This is illustrated by the following examples.

Example 1: A large hospital, which conducts a daily bed count, has a ward containing 20 beds suitably equipped for overnight admitted patient care. The funding for this ward would allow an average of 15 beds to be staffed over the year. Provided demand is constant and there are no circumstances which prevent these beds from being available for patients, such as a strike, clinical staff shortage, fire or renovation, the hospital would report 15 available beds for this ward.

Example 2: A small hospital, which conducts a monthly bed count, is located in a summer holiday area and has 30 beds suitably equipped for overnight admitted patient care. It manages its resources in such a way that 30 beds are fully staffed during the four months from December to March, but only 15 beds are staffed during the remaining eight months from April to November. The annual average number of available beds is the average of the twelve counts – i.e. ((30 beds x 4 months) + (15 beds x 8 months) divided by 12 counting periods) = 20 beds.

Example 3: A hospital conducts a monthly bed count. Ward A containing 20 beds is closed for six months for a planned renovation. During this period a temporary 10 bed ward (B) is established and the necessary resources are provided. The annual average number of available beds for Ward A is the average of the twelve counts i.e. (20 beds X 6 months) + (0 beds X 6 months) divided by 12 counting periods = 10 beds. The annual average number of available beds for Ward B is (0 beds X 6 months) + (10 beds X 6 months) divided by 12 counting periods = 5 beds.

Example 4: A hospital conducts a daily bed count. A 20 bed ward is closed during the first week of June because of a strike, but for the remainder of June it is fully staffed so that all 20 beds are available. So the average number of beds available for this ward in June is ((0 beds X 7 days) + (20 beds X 23 days) = 460/30 = 15.3.

Comments: This data element is necessary to provide an indicator of the availability and type of service for an establishment.

Source and reference attributes

Submitting organisation: Victorian Department of Human Services

Relational attributes

Related metadata references: Supersedes Establishment—number of available beds for admitted patients/residents, average N[NNN] Health, Superseded 03/12/2008

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Average available beds for residential mental health patients

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Available bed—residential mental health care, average number of beds N[NNN.N]

METeOR identifier: 373650

Registration status: Health, Standard 03/12/2008

Definition: The number of beds available in the **specialised residential mental health services** for overnight accommodation, **averaged over the counting period.**

Data Element Concept: Available bed—residential mental health care

Value domain attributes

Representational attributes

Representation class: Average

Data type: Number

Format: N[NNN.N]

Maximum character length: 5

Unit of measure: Bed

Collection and usage attributes

Guide for use: Average available beds, rounded to the nearest decimal or whole number.

Data element attributes

Collection and usage attributes

Guide for use: Residential mental health beds are available only if they are suitably located and equipped to provide residential mental health care and the necessary financial and human resources can be provided. Average available residential mental health beds are the average bed counts conducted during the year as required.

Inclusions: Both occupied and unoccupied residential mental health beds are included.

Collection methods:

Specialised residential mental health care services should establish clear recording and reporting practices and criteria that ensure that each available residential mental health bed is counted and that no available residential mental health bed is counted more than once.

The assessment of availability must reflect the ability of the specialised residential mental health care service to provide the necessary resources, and this can be significantly impacted by events such as a strike, clinical staff shortage, fire or renovation. This is illustrated by the following examples.

Example 1: A specialised residential mental health care service containing 20 residential mental health beds (A) is closed for several months, either for a planned renovation or in response to an unplanned event such as a fire. During this period a temporary 10 specialised residential mental health bed facility (B) is established and the necessary resources are provided. The specialised residential mental health care service would not report the residential mental health beds in facility A, but it would report the 10 residential mental health beds in facility B.

Example 2: A 20 bed specialised residential mental health service is closed during the first week of February because of a strike, but for the remaining three weeks of February it is fully staffed so that all 20 residential mental health beds can be occupied during those three weeks. So the average number of residential mental health beds available for this service in February is 15.

Comments:

This data element is necessary to provide an indicator of the capacity of the residential service.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Average available beds for same-day patients

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Available bed—same-day admitted care, average number of beds N[NNN.N]

METeOR identifier: 373966

Registration status: Health, Standard 03/12/2008

Definition: The number of beds, chairs or trolleys available to provide accommodation for same-day patients, **averaged over the counting period**.

Data Element Concept: Available bed—same-day admitted care

Value domain attributes

Representational attributes

Representation class: Average

Data type: Number

Format: N[NNN.N]

Maximum character length: 5

Unit of measure: Bed

Collection and usage attributes

Guide for use: Average available beds, rounded to the nearest decimal or whole number.

Data element attributes

Collection and usage attributes

Guide for use: The number of beds, chairs or trolleys available to provide accommodation for same-day patients is recorded. Same-day patients are accommodated in the following ways:

1. Patients occupy a single bed or chair in a single location throughout their stay, e.g. dialysis or chemotherapy chair. In this situation the bed or chair is counted as a bed available for same-day patients.
2. Patients occupy a trolley which is moved to different locations throughout their stay – e.g. endoscopy suite, where patients move from the same-day ward to a

procedure room, onto a recovery room and back to the same-day ward. In this situation the trolley is counted as a bed available for same-day patients.

3. Same-day patients are accommodated in a general ward after being transferred from another area of the hospital (e.g. Emergency, another ward, etc). In this situation the beds may be counted as either overnight-stay or same-day according to their predominant use.

The number of available same day beds should be collected at least monthly at the same time on the same day. To improve accuracy data could be collected more frequently (e.g. daily) at the same time on each day. More frequent data collection is preferable if a single monthly count is likely to be significantly different from the monthly average.

Inclusions: Both occupied and unoccupied beds are included. Beds, chairs or trolleys available, exclusively or predominantly intended to accommodate same-day admitted care or treatment. This includes day surgery beds, dialysis, chemotherapy, electro-convulsive therapy (ECT) and dental chairs for admitted patients.

Exclusions: Exclude beds, chairs or trolleys designated exclusively for same-day non-admitted patient care or predominantly used by non-admitted patients (e.g. emergency trolleys), medical ambulatory care, discharge lounges for patients who have been formally discharged, medi-hotel beds, hospital-in-the-home, neonatal cots (non-special-care), and beds for overnight-stay patients (even where overnight beds are used for unplanned same-day episodes e.g. patients who die or abscond on the day of admission). No adjustment should be made for contracted services, either provided by, or to this hospital.

Collection methods:

Beds exclusively or predominantly for overnight-stay admitted care, beds exclusively or predominantly for same-day admitted care and, if required, non-special-care neonatal cots are to be collected and reported in separate categories. Hospitals should establish clear recording and reporting practices. Criteria should exist to ensure that each available bed is counted once and only once. A bed should first be assessed as available and then categorised to the most appropriate accommodation category. For large hospitals, a reconciliation of the sum of the bed types and an unduplicated establishment bed count is advisable.

The assessment of availability must reflect the ability of the hospital to provide the necessary resources, and this can be significantly impacted by seasonal demand or events such as a strike, clinical staff shortage, fire or renovation. This is illustrated by the following examples:

Example 1: A large hospital, which conducts a daily bed count, has a ward containing 20 beds suitably equipped for same-day admitted patient care. The funding for this ward would allow an average of 15 beds to be staffed over the year. Provided demand is constant and there are no circumstances which prevent these beds from being available for patients, such as a strike, clinical staff shortage, fire or renovation, the hospital would report 15 available beds for this ward.

Example 2: A hospital located in a summer holiday area, which conducts monthly bed counts, has 12 beds suitably equipped for same-day admitted patient care. It manages its resources in such a way that 12 beds are fully staffed during the four months from December to March, but only 9 beds are staffed during the remaining eight months from April to November. The annual average number of available beds is the average of the twelve monthly averages, i.e. ((12 beds x 4 months) + (9 beds x 8 months) divided by 12 counting periods) = 120/12 = 10 beds.

Example 3: A hospital conducts a monthly bed count. Ward A containing 20 beds is closed for six months, for a planned renovation. During this period a temporary 10 bed ward (B) is established and the necessary resources are provided. The annual average number of available beds for Ward A is the average of the twelve counts, i.e. (20 beds X 6 months) + (0 beds X 6 months) divided by 12 counting periods = 120/12 = 10 beds. The annual average number of available beds for Ward B is (0 beds X 6 months) + (10 beds X 6 months) divided by 12 counting periods = 60/12 = 5 beds.

Example 4: A 20 bed ward is closed during the first week of June because of a strike, but for the remainder of June it is fully staffed so that all 20 beds are available. So the average number of beds available for this ward in June is ((0 beds X 7 days) + (20 beds X 23 days) divided by 30 counting periods) = 460/30 = 15.3.

Comments: This data element is necessary to provide an indicator of the availability and type of service for an establishment.

Source and reference attributes

Origin: Victorian Department of Human Services

Relational attributes

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Average available neonatal cots (non-special-care)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Available bed—neonatal admitted care (Non-special-care), average number of beds N[NNN.N]
METeOR identifier:	373640
Registration status:	Health, Standard 03/12/2008
Definition:	The number of cots available to provide neonatal accommodation, other than special care accommodation, **averaged over the counting period**.
Data Element Concept:	Available bed—neonatal admitted care (Non-special-care)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN.N]
Maximum character length:	5
Unit of measure:	Bed

Collection and usage attributes

Guide for use: Average available beds, rounded to the nearest decimal or whole number.

Data element attributes

Collection and usage attributes

Guide for use: Average available cots are the average of 12 monthly (or more frequent) counts of these available cots.

The number of available cots should be collected at least monthly at the same time on the same day. To improve accuracy data could be collected more frequently (e.g. daily). If so, it should be collected at the same time on each day. More frequent data collection is preferable if a single monthly count is likely to be significantly different from the monthly average.

Inclusions: neonatal cots which are not in an intensive care facility approved by the Commonwealth Health Minister for the purpose of the provision of special care. They accommodate unqualified newborns and may also accommodate qualified newborns who do not need to be treated in such a facility (e.g. healthy second twin).

Exclusions: cots in intensive care facilities approved by the Commonwealth Health Minister for the purpose of the provision of special care. Also exclude cots intended to accommodate older (not newborn) babies when they are admitted to hospital. (These cots are reported as available overnight beds.)

Collection methods:

Beds exclusively or predominantly for overnight stay admitted care, beds exclusively or predominantly for same-day admitted care and, if required, non-special care neonatal cots are to be collected and reported in separate categories. Hospitals should establish clear recording and reporting practices. Criteria should exist to ensure that each available bed is counted once and only once. A bed should first be assessed as available and then categorised to its predominant use. For large hospitals, a reconciliation of the sum of the bed types and an unduplicated establishment bed count is advisable.

The assessment of availability must reflect the ability of the hospital to provide the necessary resources. This can be significantly impacted by seasonal demand or events such as a strike, clinical staff shortage, fire or renovation. This is illustrated by the following examples.

Example 1: A large maternity hospital, which conducts a daily bed count, has a ward (not an approved intensive care facility) containing 20 cots used to accommodate newborns. The funding for this ward would allow an average of 15 cots to be staffed over the year. Provided demand is constant and there are no circumstances which prevent these cots from being available for patients, such as a strike, clinical staff shortage, fire or renovation, the hospital would report 15 available cots for this ward.

Example 2: A maternity hospital, which conducts a monthly bed count, has a ward (not an approved intensive care facility) containing 30 cots used to accommodate newborns. It manages its resources in such a way that it is staffed for 30 cots for four months of the year and staffed for 24 cots during the remaining eight months. The annual average number of available cots is the average of the twelve counts – i.e. (30 cots x 4 months) + (24 cots x 8 months) divided by 12 counting periods = (120 + 192)/12 = 26 cots.

Example 3: A hospital conducts a monthly bed count. Ward A containing 20 cots is closed for six months, for a planned renovation. During this period a temporary ward (B) containing 10 cots is established and the necessary resources are provided. The annual average number of available cots in Ward A is the average of the twelve counts, i.e. (20 cots X 6 months) + (0 cots X 6 months) divided by 12 counting periods = 10 cots. The annual average number of available cots for Ward B is (0 cots X 6 months) + (10 cots X 6 months) divided by 12 counting periods = 5 cots.

Example 4: A hospital conducts a daily bed count. A ward containing 20 cots is closed during the first week of June because of a strike, but for the remainder of June it is fully staffed so that all 20 cots are available. So the average number of cots available for this ward in June is ((0 cots X 7 days) + (20 cots X 23 days) = 460/30 = 15.3.

Comments: This data element is necessary to provide an indicator of the availability and type of service for an establishment.

Source and reference attributes

Origin: Victorian Department of Human Services

Behaviour-related risk factor intervention

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

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

Collection and usage attributes

Guide for use:

CODE 01 No intervention

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

CODE 02 Information and education (not including written regimen)

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

CODE 03 Counselling

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

CODE 04 Pharmacotherapy

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

CODE 05 Referral provided to a health professional

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

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

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

CODE 07 Written regimen provided

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

CODE 08 Surgery

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references: Supersedes Behaviour-related risk factor intervention, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.6 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Behaviour-related risk factor intervention - purpose

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of care—behaviour-related risk factor intervention purpose, code N

METeOR identifier: 270338

Registration status: Health, Standard 01/03/2005

Definition: The behaviour-related risk factor(s) associated with an intervention(s), as represented by a code.

Data Element Concept: Episode of care—behaviour-related risk factor intervention purpose

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Smoking
2	Nutrition
3	Alcohol misuse

	4	Physical inactivity
	8	Other
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

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

Relational attributes

Related metadata references: Supersedes Behaviour-related risk factor intervention - purpose, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.5 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Beta-blocker therapy status

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:	90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 15 - 29 Not given

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

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

Relational attributes

Related metadata references: Supersedes Beta-blocker therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Birth order

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Singleton or first of a multiple birth
	2	Second of a multiple birth
	3	Third of a multiple birth
	4	Fourth of a multiple birth
	5	Fifth of a multiple birth
	6	Sixth of a multiple birth
	8	Other
Supplementary values:	9	Not stated

Data element attributes

Collection and usage attributes

Guide for use:

CODE 2 Second of a multiple birth

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

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

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Standards Australia

Relational attributes

Related metadata references: Supersedes Birth order, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.9 KB)

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Birth plurality

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

	Value	Meaning
Permissible values:	1	Singleton
	2	Twins
	3	Triplets
	4	Quadruplets
	5	Quintuplets
	6	Sextuplets
	8	Other
Supplementary values:	9	Not stated

Data element attributes

Collection and usage attributes

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

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

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Birth plurality, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.6 KB)

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Birth weight

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Birth—birth weight, code N

METeOR identifier: 459938

Registration status: Health, Standard 07/12/2011

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, as represented by a code.

Data Element Concept: Birth—birth weight

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Low birth weight (less than 2,500 grams)
	2	Normal birth weight (2,500 grams to less than 4,500 grams)
	3	High birth weight (4,500 grams and over)
Supplementary values:	8	Unknown birth weight

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Data element attributes

Collection and usage attributes

Guide for use: For **live births**, **birthweight** should preferably be measured within the first hour of life before significant postnatal weight loss has occurred.

In perinatal collections the birthweight is to be provided for liveborn and stillborn babies.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Birth weight recorded indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—birth weight recorded indicator, yes/no code N
METeOR identifier:	441701
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a person's **birth weight** has been recorded, as represented by a code.
Data Element Concept:	Person—birth weight recorded indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A person's birth weight has been recorded.

CODE 2 No

A person's birth weight has not been recorded.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Conditional obligation:
This item is only collected for infants born during the preceding 12 months.

Bleeding episode using TIMI criteria (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—bleeding episode status, Thrombolysis in Myocardial Infarction (TIMI) code N
METeOR identifier:	356725
Registration status:	Health, Standard 01/10/2008
Definition:	A person's episode of bleeding as described by the Thrombolysis In Myocardial Infarction (TIMI) criteria, as represented by a code.
Data Element Concept:	Person—bleeding episode status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Major
	2	Minor
	3	Non TIMI bleeding
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

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

CODE 1 Major

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

CODE 2 Minor

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

CODE 3 Non TIMI Bleeding

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

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

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

Relational attributes

Related metadata references: See also Person with acute coronary syndrome—bleeding location, instrumented code N(N) Health, Standard 01/10/2008

Supersedes Person—bleeding episode status, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Blindness (diabetes complication)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—blindness, code N

METeOR identifier: 270065

Registration status: Health, Standard 01/03/2005

Definition: Whether the individual has become legally blind in either or both eyes, as represented by a code.

Data Element Concept: Person—blindness

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Blindness - (
	2	Blindness - (
	3	Blindness - (
	4	No blindness
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 3 Blindness - (< 6/60) occurred in one eye within 12 months and in the other eye prior to the last 12 months

Blindness can be diagnosed in one eye within 12 months even though it has been previously diagnosed on the other eye.

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

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

Data element attributes

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

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

Relational attributes

Related metadata references: Supersedes Blindness - diabetes complication, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (19.7 KB)

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

Blood pressure measurement result less than or equal to 130/80 mmHg indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—blood pressure measurement result less than or equal to 130/80 mmHg indicator, yes/no code N
METeOR identifier:	443234
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a person's **blood pressure** measurement result was less than or equal to 130/80mmHg, as represented by a code.
Data Element Concept:	Person—blood pressure measurement result less than or equal to 130/80 mmHg indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A person's blood pressure measurement result was less than or equal to 130/80 mmHg.

CODE 2 No

A person's blood pressure measurement result was greater than 130/80 mmHg.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Conditional obligation:

This data element is conditional on a person having both:

a) Type II diabetes, and

b) a blood pressure measurement result recorded within the previous 6 months.

Blood pressure measurement result recorded indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—blood pressure measurement result recorded indicator, yes/no code N
METeOR identifier:	441407
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a person's **blood pressure** measurement result has been recorded, as represented by a code.
Data Element Concept:	Person—blood pressure measurement result recorded indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A person has had their blood pressure measurement result recorded.

CODE 2 No

A person has not had their blood pressure measurement result recorded.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Conditional obligation:
This item is only collected for persons who have Type II diabetes.

Blood pressure—diastolic (measured)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—blood pressure (diastolic) (measured), millimetres of mercury NN[N]

METeOR identifier: 270072

Registration status: Health, Standard 01/03/2005

Definition: The person's diastolic **blood pressure,** measured in millimetres of mercury (mmHg).

Data Element Concept: Person—blood pressure (diastolic)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: NN[N]

Maximum character length: 3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure: Millimetre of mercury (mmHg)

Data element attributes

Collection and usage attributes

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

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

Collection methods:

Measurement protocol for resting blood pressure:

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

- The patient should be relaxed and seated, preferably for several minutes, (at least 5 minutes). Ideally, patients should not take caffeine-containing beverages or smoke for two hours before blood pressure is measured.
- Ideally, patients should not exercise within half an hour of the measurement being taken (National Nutrition Survey User's Guide).
- Use a mercury sphygmomanometer. All other sphygmomanometers should be calibrated regularly against mercury sphygmomanometers to ensure accuracy.
- Bladder length should be at least 80%, and width at least 40% of the circumference of the mid-upper arm. If the velcro on the cuff is not totally attached, the cuff is probably too small.
- Wrap cuff snugly around upper arm, with the centre of the bladder of the cuff positioned over the brachial artery and the lower border of the cuff about 2 cm above the bend of the elbow.
- Ensure cuff is at heart level, whatever the position of the patient.
- Palpate the radial pulse of the arm in which the blood pressure is being measured.
- Inflate cuff to the pressure at which the radial pulse disappears and note this value. Deflate cuff, wait 30 seconds, and then inflate cuff to 30 mm Hg above the pressure at which the radial pulse disappeared.
- Deflate the cuff at a rate of 2-3 mm Hg/beat (2-3 mm Hg/sec) or less.
- Recording the diastolic pressure use phase V Korotkoff (disappearance of sound). Use phase IV Korotkoff (muffling of sound) only if sound continues towards zero but does not cease. Wait 30 seconds before repeating the procedure in the same arm. Average the readings.
- If the first two readings differ by more than 4 mmHg

diastolic or if initial readings are high, take several readings after five minutes of quiet rest.

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

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

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

National Diabetes Data Working Group

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

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

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

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

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

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

Relational attributes

Related metadata references: Supersedes Blood pressure - diastolic measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (26.3 KB)

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

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

Blood pressure—systolic (measured)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure: Millimetre of mercury (mmHg)

Data element attributes

Collection and usage attributes

Guide for use:

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

Collection methods:

Measurement protocol for resting blood pressure:

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

- The patient should be relaxed and seated, preferably for several minutes, (at least 5 minutes). Ideally, patients should not take caffeine-containing beverages or smoke for two hours before blood pressure is measured.

- Ideally, patients should not exercise within half an hour of the measurement being taken (National Nutrition Survey User's Guide).
- Use a mercury sphygmomanometer. All other sphygmomanometers should be calibrated regularly against mercury sphygmomanometers to ensure accuracy.
- Bladder length should be at least 80%, and width at least 40% of the circumference of the mid-upper arm. If the Velcro on the cuff is not totally attached, the cuff is probably too small.
- Wrap cuff snugly around upper arm, with the centre of the bladder of the cuff positioned over the brachial artery and the lower border of the cuff about 2 cm above the bend of the elbow.
- Ensure cuff is at heart level, whatever the position of the patient.
- Palpate the radial pulse of the arm in which the blood pressure is being measured.
- Inflate cuff to the pressure at which the radial pulse disappears and note this value. Deflate cuff, wait 30 seconds, and then inflate cuff to 30 mm Hg above the pressure at which the radial pulse disappeared.
- Deflate the cuff at a rate of 2-3 mm Hg/beat (2-3 mm Hg/sec) or less.
- For recording the systolic reading, use phase I Korotkoff (the first appearance of sound). Wait 30 seconds before repeating the procedure in the same arm. Average the readings. If the first two readings differ by more than 6 mm Hg systolic or if initial readings are high, take several readings after five minutes of quiet rest.

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

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

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

National Diabetes Data Working Group

Origin:

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

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

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

Reference documents:

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

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

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

Relational attributes

Related metadata references:

Supersedes Blood pressure - systolic measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (25.9 KB)

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

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

Blow to the head indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—blow to the head indicator, yes/no/not stated/inadequately described code N
METeOR identifier:	358833
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	An indicator of whether a person has ever received a blow to the head resulting in a loss of consciousness, as represented by a code.
Data Element Concept:	Person—blow to the head indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Collection methods: This information is based on self-reporting. Only record blows to the head which resulted in a loss of consciousness.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Prison entrants DSS Health, Standard 25/08/2011

Bodily location of main injury

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—bodily location of main injury, code NN

METeOR identifier: 268943

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: The bodily location of the injury chiefly responsible for the attendance of the person at the health care facility, as represented by a code.

Data Element Concept: Person—bodily location of main injury

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: NN

Maximum character length: 2

Permissible values:

Value	Meaning
01	Head (excludes face)
02	Face (excludes eye)
03	Neck
04	Thorax
05	Abdomen
06	Lower back (includes loin)
07	Pelvis (includes perineum, anogenital area

	and buttocks)
08	Shoulder
09	Upper arm
10	Elbow
11	Forearm
12	Wrist
13	Hand (include fingers)
14	Hip
15	Thigh
16	Knee
17	Lower leg
18	Ankle
19	Foot (include toes)
20	Unspecified bodily location
21	Multiple injuries (involving more than one bodily location)
22	Bodily location not required

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

Comments:

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

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

Source and reference attributes

Submitting organisation:

National Injury Surveillance Unit, Flinders University, Adelaide

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references:

Supersedes Bodily location of main injury, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.5 KB)

See also Injury event—nature of main injury, non-admitted patient code NN{.N} Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Implementation in Data Set Specifications:

Injury surveillance DSS Health, Standard 14/12/2009

Body function

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Collection and usage attributes

Guide for use:

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

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

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

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

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

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

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

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

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

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

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

Source and reference attributes

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

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

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

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

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

Data element attributes

Collection and usage attributes

Guide for use: This data element can be used to record positive or neutral body function, as well as impairment of body function when used in conjunction with the metadata item Person—extent of impairment of body function, code (ICF 2001)N.

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

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

Source and reference attributes

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

Relational attributes

Related metadata references: See also Person—extent of impairment of body function, code (ICF 2001) N Community Services, Standard

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

Body mass index recorded indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—body mass index recorded indicator, yes/no code N
METeOR identifier:	443083
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a person's body mass index (BMI) has been recorded, as represented by a code.
Data Element Concept:	Person—body mass index recorded indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A person has had their BMI recorded.

CODE 2 No

A person has not had their BMI recorded.

Comments:

Body mass index (BMI): A measure of an adult's weight (body mass) relative to height, used to assess the extent of weight deficit or excess where height and weight have been measured. Body mass index is the weight in kilograms divided by the square of the height in metres (WHO 2000).

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)
Origin:	WHO (World Health Organisation) 2000. Obesity: Preventing and Managing the Global Epidemic, report of a WHO Consultation. World Health Organization, Geneva.

Relational attributes

Implementation in Data Set Specifications:	Indigenous primary health care DSS Health, Standard 07/12/2011

Conditional obligation:
This item is only collected for persons aged 25 years and older.

Body mass index—adult (measured)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Adult—body mass index (measured), ratio NN[N].N[N]

METeOR identifier: 270084

Registration status: Health, Standard 01/03/2005

Definition: A measure of an adult's weight (body mass) relative to height used to assess the extent of weight deficit or excess where height and weight have been measured.

Data Element Concept: Adult—body mass index

Value domain attributes

Representational attributes

Representation class: Ratio

Data type: Number

Format: NN[N].N[N]

Maximum character length: 5

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Guide for use: Formula: BMI = weight (kg) divided by height (m) squared.

Body mass index is a continuous variable.

Code body mass index to one or two decimal places (i.e. 99.99 or 99.9). If any component necessary for its calculation (i.e. weight or height for adults) is unknown or has not been collected, code to 888.8, 999.9.

Collection methods: NN.NN for BMI calculated from measured height and weight.

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

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

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

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

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

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

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

Presentation of data:

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

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

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

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

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

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

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

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

Source and reference attributes

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

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

Relational attributes

Related metadata references: Supersedes Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.7 KB)

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

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

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

Body mass index—adult (self-reported)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Collection methods:

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

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

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

Comments:

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

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

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

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

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

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

Presentation of data:

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

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

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

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

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

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

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

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

Source and reference attributes

Submitting organisation: The Commonwealth Department of Health and Ageing based on the work of the consortium to develop an

Australian standard definition of child/adolescent overweight and obesity; based at the Children Hospital at Westmead.

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

Relational attributes

Related metadata references: Supersedes Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.7 KB)

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

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

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

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

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

Body mass index—child (measured)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Collection methods:

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

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

Comments:

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

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

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

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

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

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

Presentation of data:

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

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

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

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

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

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

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

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

Source and reference attributes

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

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

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

Relational attributes

Related metadata references:

Supersedes Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.7 KB)

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

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

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

Body mass index—child (self-reported)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

Representation class: Ratio

Data type: Number

Format: NN[N].N[N]

Maximum character length: 5

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Collection methods:

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

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

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

Comments:

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

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

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

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

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

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

Presentation of data:

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

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

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

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

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

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

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

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

Source and reference attributes

Submitting organisation: The Commonwealth Department of Health and Ageing based on the work of the consortium to develop an

Australian standard definition of child/adolescent overweight and obesity; based at the Children Hospital at Westmead.

Origin:

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

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

Relational attributes

Related metadata references:

Supersedes Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.7 KB)

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

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

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

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

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

Body mass index—classification

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—body mass index (classification), code N[.N]
METeOR identifier:	270474
Registration status:	Health, Standard 01/03/2005
Definition:	The category of weight deficit or excess in adults and weight excess only in children and adolescents as measured by a code.
Data Element Concept:	Person—body mass index (classification)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N[.N]	
Maximum character length:	2	
Permissible values:	Value	Meaning
	1	Not overweight or obese
	1.1	Underweight
	1.2	Normal range 18.50 - 24.99 Average
	2	Overweight >= 25.00 Average
	2.1	Overweight >= 25.0 Average
	2.2	Pre Obese 25.00 - 29.99 Increased
	3	Obese >= 30 Increased
	3.1	Obese class 1 30.00 - 34.99 Moderate
	3.2	Obese class 2 35.00 - 39.99 Severe
	3.3	Obese class 3 >= 40.00 Very severe
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Adults:

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

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

Children/adolescents:

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

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

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

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

Collection methods:

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

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

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

Data element attributes

Collection and usage attributes

Guide for use:

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

Age(years)	BMI equivalent to 25 kg/m2		BMI equivalent to 30 kg/m2	
	Males	Females	Males	Females
2	18.41	18.02	20.09	19.81
2.5	18.13	17.76	19.80	19.55
3	17.89	17.56	19.57	19.36
3.5	17.69	17.40	19.39	19.23
4	17.55	17.28	19.29	19.15
4.5	17.47	17.19	19.26	19.12
5	17.42	17.15	19.30	19.17
5.5	17.45	17.20	19.47	19.34
6	17.55	17.34	19.78	19.65
6.5	17.71	17.53	20.23	20.08
7	17.92	17.75	20.63	20.51
7.5	18.16	18.03	21.09	21.01
8	18.44	18.35	21.60	21.57
8.5	18.76	18.69	22.17	22.18
9	19.10	19.07	22.77	22.81
9.5	19.46	19.45	23.39	23.46
10	19.84	19.86	24.00	24.11
10.5	20.20	20.29	24.57	24.77
11	20.55	20.74	25.10	25.42
11.5	20.89	21.20	25.58	26.05
12	21.22	21.68	26.02	26.67
12.5	21.56	22.14	26.43	27.24
13	21.91	22.58	26.84	27.76
13.5	22.27	22.98	27.25	28.20

14	22.62	23.34	27.63	28.57
14.5	22.96	23.66	27.98	28.87
15	23.29	23.94	28.30	29.11
15.5	23.60	24.17	28.60	29.29
16	23.90	24.37	28.88	29.43
16.5	24.19	24.54	29.14	29.56
17	24.46	24.70	29.41	26.69
17.5	24.73	24.85	29.70	29.84
18	25.00	25.00	30.00	30.00

Comments:

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

BMI can be considered to provide the most useful, albeit crude, population-level measure of obesity. The robust nature of the measurements and the widespread routine inclusion of weights and heights in clinical and population health surveys mean that a more selective measure of adiposity, such as skinfold thickness measurements, provides additional rather than primary information. BMI can be used to estimate the prevalence of obesity within a population and the risks associated with it, but does not, however, account for the wide variation in the nature of obesity between different individuals and populations (WHO 2000).

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

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

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

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

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

Presentation of data:

Methods used to establish cut-off points for overweight have been arbitrary and, as a result, cut-off points vary between countries. The data are derived mainly from studies of mortality and morbidity risk performed in people living in western Europe or the United States of America, and cut-off points for BMI as an indicator of adiposity and risk in populations who differ in body build and genetic disposition are likely to vary.

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

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

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

Source and reference attributes

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

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

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

Relational attributes

Related metadata references: See also Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Supersedes Body mass index - classification, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (79.5 KB)

See also Child—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Conditional obligation:
This item is only collected for persons aged 25 years and older.

Body structure

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—body structure, code (ICF 2001) AN[NNNN]

Synonymous names: Body structure code

METeOR identifier: 320147

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Definition: An anatomical part of a person's body such as organs, limbs or their components, as represented by a code.

Data Element Concept: Person—body structure

Value domain attributes

Representational attributes

Classification scheme: International Classification of Functioning, Disability and Health 2001

Representation class: Code

Data type: String

Format: AN[NNNN]

Maximum character length: 6

Collection and usage attributes

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

Data can be collected at the three digit level in one chapter and at the chapter level in another. However it is only possible to collect data at a single level of the hierarchy in a single chapter to maintain mutual exclusivity. For example, it is not permitted to collect both ‘Skin and related structures’ (chapter level) and ‘Structure of nails’ (3 digit level) as the former includes the latter.

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

CODE s1	Structures of the nervous system
CODE s2	The eye, ear and related structures
CODE s3	Structures involved in voice and speech
CODE s4	Structures of the cardiovascular, immunological and respiratory systems
CODE s5	Structures related to the digestive, metabolic and endocrine systems
CODE s6	Structures related to the genitourinary and reproductive systems
CODE s7	Structures related to movement
CODE s8	Skin and related structures

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

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

An example of a value domain at the 3 digit level from the Structures of the nervous system chapter may include:

CODE s110	Structure of the brain
CODE s120	Spinal cord and related structures
CODE s130	Structure of the meninges
CODE s140	Structure of sympathetic nervous system
CODE s150	Structure of parasympathetic nervous system
CODE s198	Structure of the nervous system, other specified
CODE s199	Structure of the nervous system, unspecified

An example of a value domain at the 4 digit level from the Structures related to movement chapter may include:

CODE s7300	Structure of upper arm
CODE s7301	Structure of forearm
CODE s7302	Structure of hand
CODE s7500	Structure of thigh
CODE s7501	Structure of lower leg
CODE s7502	Structure of ankle and foot
CODE s7600	Structure of vertebral column

The prefix *s* denotes the domains within the component of *Body Structures*.

Source and reference attributes

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

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

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

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

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

Data element attributes

Collection and usage attributes

Guide for use:

This data element consists of a single, neutral list of body structures that can be used to record positive or neutral body function. In conjunction with *Impairment extent code N*, it enables the provision of information about the presence and extent of impairment for any given body structures; with *Impairment nature code N*, the provision of information about the nature of the impairment for given body functions; and *Impairment location code N*, the location of the impairment for given body functions.

Where multiple body structures or **impairments of body structures** are recorded, the following prioritising system should be useful:

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

Source and reference attributes

Submitting organisation:

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

Relational attributes

Implementation in Data Set Specifications:

Body structures cluster Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Building/complex sub-unit type—abbreviation (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—building/complex sub-unit type, code A[AAA]
Synonymous names:	Australian unit type
METeOR identifier:	270023
Registration status:	Community Services, Superseded 06/02/2012 Health, Standard 01/03/2005
Definition:	The type of building/complex where a person can be located, as represented by a code.
Data Element Concept:	Person (address)—building/complex sub-unit type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[AAA]
Maximum character length:	4

Permissible values:

Value	Meaning
APT	Apartment
CTGE	Cottage
DUP	Duplex
FY	Factory
F	Flat
HSE	House
KSK	Kiosk
MSNT	Maisonette
MB	Marine Berth
OFF	Office

PTHS	Penthouse
RM	Room
SHED	Shed
SHOP	Shop
SITE	Site
SL	Stall
STU	Studio
SE	Suite
TNHS	Townhouse
U	Unit
VLLA	Villa
WARD	Ward
WE	Warehouse

Collection and usage attributes

Guide for use: Addresses may contain multiple instances of building/complex type. Record each instance of building/complex type with its corresponding building/complex number when appropriate.

Examples:

APT 6

SHOP 3A

U 6

PTHS

Data element attributes

Collection and usage attributes

Collection methods: To be collected in conjunction with building/complex sub unit number.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Health Data Standards Committee

Relational attributes

Related metadata references:

Supersedes Building/complex sub-unit type - abbreviation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.8 KB)

Is used in the formation of Person (address)—address line, text [X(180)] Community Services, Standard 30/09/2005, Health, Standard 04/05/2005

Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Building/complex sub-unit type—abbreviation (service provider organisation)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Service provider organisation (address)—building/complex sub-unit type, code A[AAA]

METeOR identifier: 290278

Registration status: Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Definition: The type of building/complex where an organisation can be located, as represented by a code.

Data Element Concept: Service provider organisation (address)—building/complex sub-unit type

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: A[AAA]

Maximum character length: 4

Permissible values:

Value	Meaning
APT	Apartment

CTGE	Cottage
DUP	Duplex
FY	Factory
F	Flat
HSE	House
KSK	Kiosk
MSNT	Maisonette
MB	Marine Berth
OFF	Office
PTHS	Penthouse
RM	Room
SHED	Shed
SHOP	Shop
SITE	Site
SL	Stall
STU	Studio
SE	Suite
TNHS	Townhouse
U	Unit
VLLA	Villa
WARD	Ward
WE	Warehouse

Collection and usage attributes

Guide for use: Addresses may contain multiple instances of building/complex type. Record each instance of building/complex type with its corresponding building/complex number when appropriate.

Examples:

APT 6

SHOP 3A

U 6

PTHS

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Health Data Standards Committee

Relational attributes

Related metadata references: Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Community Services, Standard 30/09/2005, Housing assistance, Recorded 13/10/2011, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010

Implementation in Data Set Specifications: Health care provider identification DSS Health, Standard 03/12/2008

Bundle-branch block status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram—bundle-branch block status, code N
METeOR identifier:	343866
Registration status:	Health, Standard 01/10/2008
Definition:	The bundle-branch block status identified on a person's electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—bundle-branch block status

Value domain attributes

Representational attributes

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

	Value	Meaning
Permissible values:	Value	Meaning
	1	New
	2	Pre-existing
	3	Uncertain timing
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

To determine the bundle-branch block status, compare the current ECG to the preceding or most recently available ECG.

Collection methods:

Record for each ECG that indicates a bundle-branch block is present.

Only one bundle-branch block status can be recorded for each ECG performed.

Only one bundle-branch block can occur at any one time, but in any given person, a left bundle-branch block may occur at one time point and a right bundle-branch block at another time point. Therefore, there can only be one bundle-branch block per ECG, but they may differ temporally.

Relational attributes

Implementation in Data Set Specifications:

Electrocardiogram cluster Health, Standard 01/10/2008

Conditional obligation:
Record if a bundle-branch block has been detected on an electrocardiogram.

C-reactive protein level (measured)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—C-reactive protein level (measured), total milligrams per litre N[NN].N

Synonymous names: CRP measured

METeOR identifier: 338256

Registration status: Health, Standard 01/10/2008

Definition: A person's serum C-reactive protein (CRP) level, measured in milligrams per litre.

Data Element Concept: Person—C-reactive protein level (measured)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NN].N

Maximum character length: 4

Supplementary values:

Value	Meaning
999.9	Not stated/inadequately described

Unit of measure: Milligram per litre (mg/L)

Unit of measure precision: 1

Data element attributes

Collection and usage attributes

Comments: The value should be recorded on a high sensitivity assay.

CRP is used in the assessment of acute phase reaction in inflammatory, infective and neoplastic disorders.

Source and reference attributes

Reference documents: The Royal College of Pathologists of Australia Version 4.0 12th March 2004 (last accessed 12May 2006).
http://www.rcpamanual.edu.au/sections/pathologytest.asp?s=33&i=468

Relational attributes

Related metadata references: See also Person—C-reactive protein level measured date, DDMMYYYY Health, Standard 01/10/2008

See also Person—C-reactive protein level measured time, hhmm Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Caesarean section indicator, last previous birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—caesarean section indicator (last previous birth) code N
METeOR identifier:	301993
Registration status:	Health, Standard 29/11/2006
Definition:	Whether a caesarean section was performed for the woman's last previous birth, as represented by a code.
Data Element Concept:	Female—caesarean section indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: This item should be completed if there has been a previous birth. In the case of no previous births, the item should be left blank.

Comments: Previous caesarean sections are associated with a higher risk of obstetric complications, and when used with other indicators provides important information on the quality of obstetric care.

This item can be used to determine vaginal births occurring after a caesarean section delivery (VBAC).

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Cancer initial treatment completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—non-surgical cancer treatment completion date, DDMMYYYY
METeOR identifier:	288136
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which the initial non-surgical treatment for cancer was completed.
Data Element Concept:	Cancer treatment—non-surgical cancer treatment completion date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Collected for radiation therapy and systemic therapy.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Cancer initial treatment - completion date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.6 KB)

Cancer initial treatment starting date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—non-surgical cancer treatment start date, DDMMYYYY
METeOR identifier:	288103
Registration status:	Health, Standard 04/06/2004
Definition:	The start date of the initial course of non-surgical treatment for cancer.
Data Element Concept:	Cancer treatment—non-surgical cancer treatment start date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

The start date of the treatment is recorded regardless of whether treatment is completed as intended or not. Treatment subsequent to a recurrence will not be recorded.

Collected for radiation therapy and systemic therapy.

Date of surgical treatment is collected as a separate item.

Source and reference attributes

Submitting organisation:	National Cancer Control Institute
Origin:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references:

Supersedes Cancer initial treatment - starting date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1

KB)

Cancer staging scheme source edition number

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Cancer staging—cancer staging scheme source edition number, code N[N]

METeOR identifier: 393398

Registration status: Health, Standard 07/12/2011

Definition: The edition number of the cancer staging scheme used to determine the extent or stage of the cancer, as represented by a code.

Data Element Concept: Cancer staging—cancer staging scheme source edition number

Value domain attributes

Representational attributes

Representation class: Text

Data type: Number

Format: N[N]

Maximum character length: 2

Supplementary values:

Value	Meaning
97	Not applicable
98	Unknown
99	Not stated/inadequately described

Collection and usage attributes

Guide for use: Record the edition number, valid entries are from 1 to 96.

CODE 97 Not applicable

To be used for cases that do not have a recommended staging scheme or when the staging scheme source does not have edition number.

Source and reference attributes

Submitting organisation: Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use: Record for any staging classification system that has an edition number. For example, record the edition number when the TNM Classification of Malignant Tumours (International Union Against Cancer (UICC)) or the American Joint Committee on Cancer (AJCC) Cancer Staging Manual is used for the purpose of staging the cancer.

Comments: Collected to identify the edition number of the staging scheme source. Cancer stage is an important determinant of treatment and prognosis, and is used to evaluate new treatments and analyse outcomes. Survival analysis is adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references: Supersedes Cancer staging—cancer staging scheme source edition number, code N[N] Health, Superseded 07/12/2011

See also Cancer staging—cancer staging scheme source, code N[N] Health, Standard 07/12/2011

See also Person with cancer—extent of primary cancer, stage grouping other, code X[XXXXX] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Cancer staging—M stage code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX]
METeOR identifier:	403720
Registration status:	Health, Standard 07/12/2011
Definition:	The absence or presence of distant metastasis in a person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—distant metastasis status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer (UICC) TNM Classification of Malignant Tumours 7th edition
Representation class:	Code
Data type:	String
Format:	X[XX]
Maximum character length:	3

Supplementary values:

Value	Meaning
997	Not applicable
998	Unknown
999	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Valid M codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Refer to the TNM Supplement: A commentary on uniform use, 3rd Edition for coding rules.

Source and reference attributes

Reference documents:

Wittekind C et al (Editors) 2003. International Union Against Cancer (UICC): TNM supplement: A commentary on uniform use, 3rd edition. Wiley-Blackwell.

Data element attributes

Collection and usage attributes

Guide for use:

Record the absence or presence of distant metastasis at the time of diagnosis of the cancer.

TNM staging applies to solid tumours excluding brain tumours.

Choose the lower (less advanced) M category when there is any uncertainty.

The current edition of the AJCC Cancer Staging Manual provides an equivalent and alternative source of M stage codes.

Staging classification systems other than the TNM classification system are recorded separately.

Collection methods:

This information should be obtained from the patient's medical record.

Comments:

Cancer stage is an important determinant of treatment and prognosis, and is used to evaluate new treatments and analyse outcomes. Survival analysis is adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Source and reference attributes

Submitting organisation:

Cancer Australia

Origin:

International Union Against Cancer (UICC)

Commission on Cancer, American College of Surgeons

Reference documents:

Sobin LH, Gospodarowicz MK, Wittekind C (Editors) 2009. International Union Against Cancer (UICC): TNM Classification of Malignant Tumours, 7th edition. Wiley-Blackwell

American Joint Committee on Cancer 2010. AJCC Cancer Staging Manual, 7th edition. New York: Springer

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Relational attributes

Related metadata references:

See also Cancer staging—staging basis of cancer, code A Health, Superseded 07/12/2011

See also Cancer staging—staging basis of cancer, code A

Health, Standard 07/12/2011

Supersedes Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours, 6th edn) code XX Health, Superseded 07/12/2011

See also Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011

See also Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XXX] Health, Standard 07/12/2011

See also Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Cancer staging—N stage code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX]
METeOR identifier:	403661
Registration status:	Health, Standard 07/12/2011
Definition:	The absence or presence and extent of regional lymph node metastasis in a person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—regional lymph node metastasis status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer (UICC) TNM Classification of Malignant Tumours 7th edition
Representation class:	Code
Data type:	String
Format:	X[XX]
Maximum character length:	3

Supplementary values:

Value	Meaning
997	Not applicable
998	Unknown
999	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Valid N codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Record the stage in Arabic numerals and the appropriate upper or lower case alphabetic character omitting the prefix "N". For example, record stage N1b for malignant melanoma of the skin as "1b".

Record if the N stage value has a prefix of “c” or “p”. For example, record retinoblastoma N stage pN1 as “p1”.

Refer to the TNM Supplement: A Commentary on Uniform Use, 3rd Edition for coding rules.

Source and reference attributes

Reference documents: Wittekind C et al (Editors) 2003. International Union Against Cancer (UICC): TNM supplement: A commentary on uniform use, 3rd edition. Wiley-Blackwell.

Data element attributes

Collection and usage attributes

Guide for use: Record the absence or presence and extent of regional lymph node metastasis at the time of diagnosis of the cancer.

TNM staging applies to solid tumours excluding brain tumours.

Choose the lower (less advanced) N category when there is any uncertainty.

The current edition of the AJCC (American Joint Committee on Cancer) Cancer Staging Manual provides an equivalent and alternative source of N stage codes.

Staging classification systems other than the TNM classification system are recorded separately.

Collection methods: This information should be obtained from the patient's medical record.

Comments: Cancer stage is an important determinant of treatment and prognosis, and is used to evaluate new treatments and analyse outcomes. Survival analysis is adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Sobin LH, Gospodarowicz MK, Wittekind C (Editors) 2009. International Union Against Cancer (UICC): TNM Classification of Malignant Tumours, 7th edition. Wiley-Blackwell

American Joint Committee on Cancer 2010. AJCC Cancer Staging Manual, 7th edition. New York: Springer

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Relational attributes

Related metadata references:	See also Cancer staging—staging basis of cancer, code A Health, Standard 07/12/2011 See also Cancer staging—staging basis of cancer, code A Health, Superseded 07/12/2011 See also Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011 See also Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011 See also Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XXX] Health, Standard 07/12/2011 Supersedes Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX Health, Superseded 07/12/2011
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Standard 07/12/2011

Cancer staging—stage grouping other

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—extent of primary cancer, stage grouping other, code X[XXXXX]
METeOR identifier:	393377
Registration status:	Health, Standard 07/12/2011
Definition:	The anatomical extent of disease in a person with cancer based on stage categories of a staging classification other than the standard TNM classification, as represented by a code.
Data Element Concept:	Person with cancer—extent of primary cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	X[XXXXX]
Maximum character length:	6

Supplementary values:

Value	Meaning
999997	Not applicable
999998	Unknown
999999	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Record valid stage grouping codes from the current edition of the appropriate staging source for the particular cancer.

Convert all Roman numerals in the stage grouping to Arabic numbers. For example, stage IIIA would convert to 3A.

Data element attributes

Collection and usage attributes

Guide for use: Record the extent of the primary cancer at the time of diagnosis of the cancer.

Applies to all cancer stage groupings where a staging classification other than the standard TNM classification is used.

Choose the lower (less advanced) stage category when there is any uncertainty.

The relevant cancer stage grouping source will be indicated in the data element *Cancer staging-cancer staging scheme source, code N[N]* and if applicable, the related edition number will be recorded in data element *Cancer staging-cancer staging scheme source edition number, code N[N].*

A separate data element captures the extent of the primary cancer based on the TNM stage classification.

Collection methods: This information should be obtained from the patient's medical record.

Comments: Cancer stage is an important determinant of treatment and prognosis, and is used to evaluate new treatments and analyse outcomes. Survival analysis is adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Source and reference attributes

Submitting organisation: Cancer Australia

Relational attributes

Related metadata references: See also Cancer staging—cancer staging scheme source edition number, code N[N] Health, Standard 07/12/2011

See also Cancer staging—cancer staging scheme source, code N[N] Health, Standard 07/12/2011

See also Cancer staging—staging basis of cancer, code A Health, Standard 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Cancer staging—T stage code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XXX]
METeOR identifier:	403564
Registration status:	Health, Standard 07/12/2011
Definition:	The size and extent of the primary tumour in a person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—primary tumour status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer (UICC) TNM Classification of Malignant Tumours 7th edition
Representation class:	Code
Data type:	String
Format:	X[XXX]
Maximum character length:	4

Supplementary values:

Value	Meaning
9997	Not applicable
9998	Unknown
9999	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Valid T codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Record the stage in Arabic numerals and the appropriate upper or lower case alphabetic character omitting the prefix "T". For example, record stage T2a for lung cancer as "2a".

Record if the T stage value has a prefix of “c” or “p”; for example, record retinoblastoma T stage pT2b as “p2b”.

Refer to the TNM Supplement: A Commentary on Uniform Use, 3rd Edition for coding rules.

Source and reference attributes

Reference documents: Wittekind C et al (Editors) 2003. International Union Against Cancer (UICC): TNM supplement: A commentary on uniform use, 3rd edition. Wiley-Blackwell.

Data element attributes

Collection and usage attributes

Guide for use: Record the size and extent of the primary tumour at the time of diagnosis of the cancer.

TNM staging applies to solid tumours excluding brain tumours.

Choose the lower (less advanced) T category when there is any uncertainty.

The T stage value is derived from the size of the tumour and its relationship (extension) to other structures. The size is reflected in the value of data element *Person with cancer—solid tumour size (at diagnosis), total millimetres NNN*; the usage attributes provide additional detail.

The extent of the primary cancer at diagnosis is usually recorded. An exception is malignant melanoma of the skin; by convention T stage is recorded after tumour excision and is based on tumour thickness with T subcategories based on ulceration and the number of mitoses seen. Ovarian cancer is also surgically/pathologically staged.

The current edition of the American Joint Committee on Cancer (AJCC) Cancer Staging Manual provides an equivalent and alternative source of T stage codes.

Staging classification systems other than the TNM classification system are recorded separately.

Collection methods: This information should be obtained from the patient's medical record.

Comments: Cancer stage is an important determinant of treatment and prognosis, and is used to evaluate new treatments and analyse outcomes. Survival analysis is adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Sobin LH, Gospodarowicz MK, Wittekind C (Editors) 2009. International Union Against Cancer (UICC): TNM

Classification of Malignant Tumours, 7th edition. Wiley-Blackwell

American Joint Committee on Cancer 2010. AJCC Cancer Staging Manual, 7th edition. New York: Springer

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Relational attributes

Related metadata references:

See also Cancer staging—staging basis of cancer, code A Health, Superseded 07/12/2011

See also Cancer staging—staging basis of cancer, code A Health, Standard 07/12/2011

See also Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011

See also Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011

Supersedes Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX[X] Health, Superseded 07/12/2011

See also Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011

See also Person with cancer—solid tumour size (at diagnosis), total millimetres NNN Health, Superseded 07/12/2011

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Standard 07/12/2011

Cancer staging—TNM stage grouping code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX]
METeOR identifier:	403726
Registration status:	Health, Standard 07/12/2011
Definition:	The anatomical extent of disease in a person with cancer based on the previously coded T, N and M stage categories, as represented by a code.
Data Element Concept:	Person with cancer—extent of primary cancer

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer (UICC) TNM Classification of Malignant Tumours 7th edition
Representation class:	Code
Data type:	String
Format:	X[XX]
Maximum character length:	3

Supplementary values:

Value	Meaning
997	Not applicable
998	Unknown
999	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Record the stage in Arabic numerals and the appropriate upper or lower case alphabetic character omitting the prefix "stage". For example, record Stage IIA2 for cancer of the cervix uteri as "2A2".

Valid stage grouping codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Refer to the TNM Supplement: A Commentary on Uniform Use, 3rd Edition for coding rules.

Source and reference attributes

Reference documents: Wittekind C et al (Editors) 2003. International Union Against Cancer (UICC): TNM supplement: A commentary on uniform use, 3rd edition. Wiley-Blackwell.

Data element attributes

Collection and usage attributes

Guide for use: Record the extent of the primary cancer at the time of diagnosis of the cancer.

TNM staging applies to solid tumours excluding brain tumours.

The current edition of the American Joint Committee on Cancer (AJCC) Cancer Staging Manual provides an equivalent and alternative source of TNM stage grouping codes.

Stage groupings using classification systems other than the TNM classification system are recorded separately.

Collection methods: This information should be obtained from the patient's medical record.

Comments: Cancer stage is an important determinant of treatment and prognosis, and is used to evaluate new treatments and analyse outcomes. Survival analysis is adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Sobin LH, Gospodarowicz MK, Wittekind C (Editors) 2009. International Union Against Cancer (UICC): TNM Classification of Malignant Tumours, 7th edition. Wiley-Blackwell

American Joint Committee on Cancer 2010. AJCC Cancer Staging Manual, 7th edition. New York: Springer

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Relational attributes

Related metadata references: See also Cancer staging—staging basis of cancer, code A Health, Superseded 07/12/2011

	See also Cancer staging—staging basis of cancer, code A Health, Standard 07/12/2011
	See also Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011
	Supersedes Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XXXX{[X]XX} Health, Superseded 07/12/2011
	See also Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XXX] Health, Standard 07/12/2011
	See also Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Standard 07/12/2011

Cancer status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—cancer status, code N
METeOR identifier:	394071
Registration status:	Health, Standard 07/12/2011
Definition:	The absence or presence of clinical evidence of cancer in the patient, as represented by a code.
Data Element Concept:	Patient—cancer status

Value domain attributes

Representational attributes

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

Permissible values:	Value	Meaning
	1	No evidence of cancer
	2	Evidence of cancer
Supplementary values:	8	Unknown whether there is evidence of cancer
	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Record whether or not there is clinical evidence of cancer in the patient at the date of last contact or death.

Cancer status changes if the patient has a recurrence or relapse and the record should be updated.

The patient's cancer status should be changed only if new information is received from an official source. If information is obtained from the patient, a family member or other non-physician, then cancer status is not updated.

If the patient has multiple primary cancers, each primary should have the appropriate cancer status recorded.

For patients with hematopoietic disease who are in remission, code as 1-no evidence of this cancer.

Collection methods: This information should be collected from the patient's medical record.

Comments: This information is used for patient follow-up and outcome studies.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Relational attributes

Related metadata references: See also Patient—date of last contact, DDMMYYY Health, Standard 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Cancer treatment type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—cancer treatment type, code N[N]
METeOR identifier:	399629
Registration status:	Health, Standard 07/12/2011
Definition:	The type of treatment administered during the initial course of treatment for cancer, as represented by a code.
Data Element Concept:	Cancer treatment—cancer treatment type

Value domain attributes

Representational attributes

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

	Value	Meaning
Permissible values:	Value	Meaning
	1	Surgery only
	2	Radiotherapy only
	3	Systemic agent therapy only
	4	Surgery and radiotherapy
	5	Surgery and systemic agent therapy
	6	Radiotherapy and systemic agent therapy
	7	Surgery, radiotherapy and systemic agent therapy
Supplementary values:	97	Not applicable—treatment was not administered
	98	Unknown whether treatment was administered
	99	Treatment was administered but the type was not stated/inadequately described

Collection and usage attributes

Guide for use:

More than one treatment type may be administered during the initial course of treatment; select the appropriate code value.

Systemic agent therapy includes:

- chemotherapy
- hormone therapy
- immunotherapy

Surgery includes:

- surgical procedure for cancer
- systemic therapy procedure involving surgery

A systemic therapy procedure is a medical, surgical or radiation procedure that has an effect on the hormonal or immunologic balance of the patient.

Treatments other than surgery, radiotherapy or systemic agent therapy administered as part of the initial course of treatment are recorded separately.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents:

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009
revision. Commission on Cancer, 28E

Data element attributes

Collection and usage attributes

Guide for use:

All treatments administered to the patient during the initial course of cancer treatment should be recorded. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

When the patient has received treatment for cancer and codes 1 to 7 are recorded, the relevant treatment information for each treatment modality should also be collected.

Cancer-directed treatments administered to the patient during the initial course of treatment that cannot be characterised as surgery, radiotherapy or systemic therapy according to the definitions in this data set specification, are recorded separately in the data element *Cancer treatment—other cancer treatment, text [X(150)].*

Collection methods: This information should be obtained from the patient's medical record.

Comments: The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Origin: Commission on Cancer, American College of Surgeons

New South Wales Health Department

Reference documents: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Public Health Division 2001. NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1. Sydney: NSW Health Department

Relational attributes

Related metadata references: Supersedes Cancer treatment—cancer treatment type, code N Health, Superseded 07/12/2011

See also Cancer treatment—other cancer treatment, text [X(150)] Health, Standard 07/12/2011

See also Chemotherapy for cancer cluster Health, Standard 07/12/2011

See also Hormone therapy for cancer cluster Health, Standard 07/12/2011

See also Immunotherapy for cancer cluster Health, Standard 07/12/2011

See also Radiotherapy for cancer cluster Health, Standard 07/12/2011

See also Surgery for cancer cluster Health, Standard 07/12/2011

See also Systemic therapy procedure for cancer cluster Health, Standard 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Cancer treatment—target site (ICD-10-AM)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—target site for cancer treatment, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391324
Registration status:	Health, Standard 22/12/2009
Definition:	The site or region which is the target of particular surgical or radiotherapy treatment, as represented by an ICD-10-AM code.
Data Element Concept:	Cancer treatment—target site for cancer treatment

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:

This information is collected for surgical and radiotherapy treatments.

Current edition of International Classification of Diseases (ICD-10-AM), Australian Modification, National Centre for Classification in Health, Sydney is used.

Relational attributes

Related metadata references:

Supersedes Cancer treatment—target site for cancer treatment, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Cancer treatment—target site (ICDO-3)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—target site for cancer treatment, code (ICDO-3) ANN
METeOR identifier:	293161
Registration status:	Health, Standard 13/06/2004
Definition:	The site or region of cancer which is the target of a particular surgical or radiotherapy treatment, as represented by an ICDO-3 code.
Data Element Concept:	Cancer treatment—target site for cancer treatment

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:

This information is collected for surgical and radiotherapy treatments.

Current edition of International Classification of Diseases for Oncology (ICD-O), World Health Organisation is used.

Major organ only - first 3 characters.

Relational attributes

Related metadata references:

Supersedes Cancer treatment - target site, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.2 KB)

Capital consumption expenses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—capital consumption expenses, total Australian currency NNNNN.N
METeOR identifier:	376399
Registration status:	Health, Standard 01/04/2009
Definition:	Expenses of an organisation consisting of consumption of fixed capital (depreciation), in Australian currency.
Data Element Concept:	Organisation—capital consumption expenses

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	NNNNN.N
Maximum character length:	6
Unit of measure:	Australian currency (AU$)

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use:

Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.

Depreciation expenses are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).

Depreciation represents the expensing of a long-term asset over its useful life and is related to the basic accounting principle of matching revenue and expenses for the financial period. Depreciation charges for the current financial year only should be shown as expenditure. Where intangible assets are amortised (such as with some private hospitals) this should also be included in recurrent expenditure.

Collection methods: Depreciation expenses are to be reported for the *Health industry relevant organisation type* and *Type of health and health related functions* data elements.

Health industry relevant organisation type

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments: In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Origin: Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.aasb.com.au>

Relational attributes

Related metadata references: Supersedes Organisation—depreciation expenses, total Australian currency NNNNN.N Health, Superseded 01/04/2009

Is used in the formation of Organisation—expenses, total Australian currency NNNNN.N Health, Standard

05/12/2007

Implementation in Data Set Specifications:

Government health expenditure organisation expenditure capital consumption data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure data element cluster Health, Standard 01/04/2009

Cardiovascular disease recorded indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cardiovascular disease recorded indicator, yes/no code N
Synonymous names:	CVD recorded indicator
METeOR identifier:	465948
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a person has a cardiovascular disease recorded on their clinical record, as represented by a code.
Data Element Concept:	Person—cardiovascular disease recorded indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A person has a cardiovascular disease recorded on their clinical record.

CODE 2 No

A person does not have a cardiovascular disease recorded on their clinical record.

Heart disease encompasses a range of diseases that affect the heart, and individual diseases are classified as heart disease or not by Patient Information Retrieval (PIRS) systems.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Cardiovascular medication (current)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—cardiovascular medication taken (current), code N

METeOR identifier: 270237

Registration status: Health, Standard 01/03/2005

Definition: Whether the individual is currently taking cardiovascular medication, as represented by a code.

Data Element Concept: Person—cardiovascular medication taken

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Angiotensin converting enzyme (ACE) inhibitors
	2	Angiotensin II (A2) receptor blockers
	3	Beta blockers
	4	Calcium antagonists
	8	None of the above
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 1 Angiotensin converting enzyme (ACE) inhibitors

Use this code for ACE inhibitors (captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril and trandolapril).

CODE 2 Angiotensin II (A2) receptor blockers

Use this code for Angiotensin II receptor blockers (candesartan, eprosartan, irbesartan and telmisartan).

CODE 3 Beta blockers

Use this code for Beta blockers (atenolol, carvedilol, labetalol, metoprolol, oxprenolol, pindolol, propranolol and sotalol).

CODE 4 Calcium antagonists

Use this code for Calcium antagonists (amlodipine, diltiazem, felodipine, lercanidipine, nifedipine and verapamil).

CODE 8 None of the above

This code is used when none of the listed medications is being taken by the person.

CODE 9 Not stated/inadequately described

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

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

Are you currently taking any medication for a cardiovascular condition?

___Yes ___No

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

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

Ace Inhibitors ___Yes ___No

Angiotensin II receptor blockers ___Yes ___No

Beta blockers ___Yes ___No

Calcium antagonists ___Yes ___No

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

Data element attributes

Collection and usage attributes

Collection methods: A person may be taking one or more of the following medications for a cardiovascular condition. Therefore more than one code may be reported.

Source and reference attributes

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary. Australian Medicines Handbook: last modified by February 2001 Contents of Cardiovascular, Version 3, 1999 Therapeutic Guidelines Limited (05.04.2002)].

Relational attributes

Related metadata references: Supersedes Cardiovascular medication - Superseded 01/03/2005, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.1 KB)

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

Care type

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Hospital service—care type, code N[N].N

METeOR identifier: 270174

Registration status: Health, Standard 01/03/2005

Definition: The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or **posthumous organ procurement** (other care), as represented by a code.

Data Element Concept: Hospital service—care type

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N[N].N

Maximum character length: 3

Permissible values:

Value	Meaning
1.0	Acute care (Admitted care)
2.0	Rehabilitation care (Admitted care)

2.1	Rehabilitation care delivered in a designated unit (optional)
2.2	Rehabilitation care according to a designated program (optional)
2.3	Rehabilitation care is the principal clinical intent (optional)
3.0	Palliative care
3.1	Palliative care delivered in a designated unit (optional)
3.2	Palliative care according to a designated program (optional)
3.3	Palliative care is the principal clinical intent (optional)
4.0	Geriatric evaluation and management
5.0	Psychogeriatric care
6.0	Maintenance care
7.0	Newborn care
8.0	Other admitted patient care
9.0	Organ procurement - posthumous (Other care)
10.0	Hospital boarder (Other care)

Collection and usage attributes

Guide for use:

Persons with mental illness may receive any one of the care types (except newborn and organ procurement). Classification depends on the principal clinical intent of the care received.

Admitted care can be one of the following:

CODE 1.0 Acute care (Admitted care)

Acute care is care in which the clinical intent or treatment goal is to:

- manage labour (obstetric)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury (excluding palliative care)
- reduce severity of an illness or injury

- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function
- perform diagnostic or therapeutic procedures.

CODE 2.0 Rehabilitation care (Admitted care)

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

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

Optional:

CODE 2.1 Rehabilitation care delivered in a designated unit (optional)

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

CODE 2.2 Rehabilitation care according to a designated program (optional)

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

CODE 2.3 Rehabilitation care is the principal clinical intent (optional)

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

Code 3.0 Palliative care

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

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

Optional:

CODE 3.1 Palliative care delivered in a designated unit (optional)

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

CODE 3.2 Palliative care according to a designated program (optional)

In a designated palliative care program, care is delivered by a specialised team of staff who provide palliative care to patients in beds that may or may not be dedicated to palliative care. The program may, or may not be funded through identified palliative care funding. Code 3.1 should be used instead of code 3.2 if care is being delivered in a designated palliative care program and a designated palliative care unit.

CODE 3.3 Palliative care is the principal clinical intent (optional)

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

CODE 4.0 Geriatric evaluation and management

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

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

CODE 5.0 Psychogeriatric care

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

- in a psychogeriatic care unit;
- in a designated psychogeriatic care program; or

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

CODE 6.0 Maintenance care

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

CODE 7.0 Newborn care

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

- patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders
- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated
- patients aged less than 10 days and not admitted at birth (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.

CODE 8.0 Other admitted patient care

Other admitted patient care is care where the principal clinical intent does meet the criteria for any of the above.

Other care can be one of the following:

CODE 9.0 Organ procurement - posthumous (Other care)

Organ procurement - posthumous is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.

Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant ICD-10-AM Australian Coding Standards. These patients are not admitted to the hospital but are registered by the hospital.

CODE 10.0 Hospital boarder (Other care)

Hospital boarder is a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.
Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days of less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

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

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Care type, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (33.1 KB)

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

Implementation in Data Set Specifications: Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013

Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Care type, derived subacute

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—care type, subacute (derived) code N
Synonymous names:	Care type
METeOR identifier:	400649
Registration status:	Health, Standard 06/10/2010
Definition:	A descriptor of the overall nature of subacute care delivered during a non-admitted patient service event, derived from other service characteristics, as represented by a code.
Data Element Concept:	Non-admitted patient service event—care type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Rehabilitation care
2	Palliative care
3	Geriatric evaluation and management
4	Psychogeriatric care
8	Other care

Collection and usage attributes

Guide for use:

Subacute care is defined as rehabilitation, palliative care, geriatric evaluation and management, and psychogeriatric care.

CODE 1 Rehabilitation care

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

CODE 2 Palliative care

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

CODE 3 Geriatric evaluation and management (GEM)

Geriatric evaluation and management is care in which the clinical intent or treatment goal is to maximise the 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 interdisciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames.

CODE 4 Psychogeriatric care

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

CODE 8 Other care

Any care provided that does not fall within the categories above. e.g. maintenance care, and acute care.

NOTE: Interdisciplinary care is care provided by a multidisciplinary team.

Data element attributes

Collection and usage attributes

Guide for use: In addition to the definitions within the value domain, further clarifying information is provided below.

Rehabilitation care includes care provided:

- in a designated rehabilitation unit (i.e. a dedicated unit that receives identified funding for rehabilitation care and/or primarily delivers rehabilitation care); or
- according to a designated rehabilitation program (i.e. care is delivered by a specialised team of staff who are dedicated to rehabilitation care); or
- under the principal clinical management of a rehabilitation physician or related healthcare worker; or
- where the care requested is rehabilitation care.

Palliative care includes care provided:

- in a designated palliative care unit (i.e. a dedicated unit that receives identified funding for palliative care and/or primarily delivers palliative care); or
- according to a designated palliative care program (i.e. care is delivered by a specialised team of staff who are dedicated to palliative care); or
- under the principal clinical management of a palliative care physician or related healthcare worker; or
- where the care requested is palliative care.

Geriatric evaluation and management (GEM) includes care provided:

- in a geriatric evaluation and management unit (i.e. a dedicated unit that receives identified funding for GEM and/or primarily delivers GEM); or
- in a designated geriatric evaluation and management program (i.e. care is delivered by a specialised team of staff who are dedicated to GEM); or
- under the principal clinical management of a geriatric evaluation and management physician or related healthcare worker; or
- where the care requested is geriatric evaluation and management.

Psychogeriatric care includes care provided:

- in a psychogeriatric care unit (i.e. a dedicated unit that receives identified funding for psychogeriatric care and/or primarily delivers psychogeriatric care); or
- in a designated psychogeriatric care program (i.e. care is delivered by a specialised team of staff who are dedicated to psychogeriatric care); or
- under the principal clinical management of a psychogeriatric physician or related healthcare worker; or
- where the care requested is psychogeriatric care.

Collection methods: Classification depends on an assessment of the overall nature of care provided, based on other service event characteristics collected at the jurisdiction level such as clinic type, provider type and/or referral details. The method used to derive the care type should be submitted with the dataset.

Relational attributes

Implementation in Data Set Specifications: Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Carer participation arrangements—carer consultants employed

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N

METeOR identifier: 288833

Registration status: Health, Standard 08/12/2004

Definition: Whether a specialised mental health service organisation has carer consultants employed on a paid basis to represent the interests of carers and advocate for their needs, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.

Data Element Concept: Specialised mental health service organisation—carer participation arrangements status (carer consultants employed)

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Carer participation arrangements—carer satisfaction surveys

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N
METeOR identifier:	290367
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a specialised mental health service organisation periodically conducts carer satisfaction surveys, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Carer participation arrangements—formal complaints mechanism

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N

METeOR identifier: 290370

Registration status: Health, Standard 08/12/2004

Definition: Whether a specialised mental health service organisation has a formal internal complaints mechanism in which complaints made by carers are regularly reviewed by a committee that includes carers, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.

Data Element Concept: Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism)

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Carer participation arrangements—formal participation policy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N
METeOR identifier:	290365
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a specialised mental health service organisation has developed a formal and documented policy on participation by carers, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (formal participation policy)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Carer participation arrangements—regular discussion groups

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N
METeOR identifier:	290359
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service holds regular discussion groups to seek the views of carers about the service, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (regular discussion groups)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Carer responsibility indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—carer responsibility indicator, yes/no/not stated/inadequately described code N
METeOR identifier:	378324
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of responsibilities of a person in relation to ongoing day-to-day care of a dependent child or other person who is in need of care and support, e.g. an ageing parent, as represented by a code.
Data Element Concept:	Person—carer responsibility indicator

Value domain attributes

Representational attributes

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

	Value	Meaning
Permissible values:	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

A person is considered to have carer responsibility if the person is:

- the main provider of ongoing help and supervision in the core activities of daily living for the individual in need of care, and

- has ongoing responsibilities for safeguarding the health and welfare of the individual needing care.

Carer responsibility can be split or shared between several parties. This may include custodians, foster carers, guardians and other relations such as spouses and kin.

A person with carer responsibility does not necessarily live with the person in need of care.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Cataract - history

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cataract status, code N
METeOR identifier:	270252
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has a cataract present in either or both eyes or has had a cataract previously removed from either or both eyes, as represented by a code.
Data Element Concept:	Person—cataract status

Value domain attributes

Representational attributes

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

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

Data element attributes

Collection and usage attributes

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

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

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

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

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

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

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

Relational attributes

Related metadata references: Supersedes Cataract - history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.4 KB)

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

Category reassignment date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective care waiting list episode—category reassignment date, DDMMYYYY
METeOR identifier:	270010
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a patient awaiting elective hospital care is assigned to a different urgency category as a result of **clinical review** for the awaited procedure, or is assigned to a different patient listing status category.
Data Element Concept:	Elective care waiting list episode—category reassignment date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	The date needs to be recorded each time a patient's urgency classification or listing status changes.
Comments:	This date is necessary for the calculation of the waiting time at admission and the waiting time at a census date.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Category reassignment date, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.2 KB) Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days

N[NNN] Health, Standard 22/12/2011

Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Superseded 13/12/2011

Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 13/12/2011

Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Superseded 13/12/2011

Census date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital census (of elective surgery waitlist patients)—census date, DDMMYYYY
METeOR identifier:	270153
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which the hospital takes a point in time (census) count of and characterisation of patients on the waiting list.
Data Element Concept:	Hospital census (of elective surgery waitlist patients)—census date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

This date is recorded when a census is done of the patients on a waiting list.

Source and reference attributes

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Census date, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.4 KB)

Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Superseded 13/12/2011

Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days

	N[NNN] Health, Standard 22/12/2011
Implementation in Data Set Specifications:	Elective surgery waiting times (census data) NMDS 2012-2013 Health, Standard 13/12/2011
	Implementation start date: 30/09/2012

Centrelink customer reference number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—government funding identifier, Centrelink customer reference number {N(9)A}
Synonymous names:	CRN; Centrelink reference number
METeOR identifier:	270098
Registration status:	Health, Standard 01/03/2005
Definition:	A personal identifier assigned by Centrelink for the purposes of identifying people (and organisations) eligible for specific services, including some public health care services, such as oral health services.
Data Element Concept:	Person—government funding identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	{N(9)A}
Maximum character length:	10

Data element attributes

Collection and usage attributes

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

authorised by law.

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

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

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS5017 Health Care Client Identification

Relational attributes

Related metadata references: Supersedes Centrelink customer reference number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (14.5 KB)

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Cerebral stroke due to vascular disease (history)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cerebral stroke due to vascular disease (history), code N
METeOR identifier:	270355
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has had a cerebral stroke due to vascular disease, as represented by a code.
Data Element Concept:	Person—cerebral stroke due to vascular disease

Value domain attributes

Representational attributes

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

	Value	Meaning
Permissible values:		
	1	Cerebral stroke - occurred in the last 12 months
	2	Cerebral stroke - occurred prior to the last 12 months
	3	Cerebral stroke - occurred both in and prior to the last 12 months
	4	No history of cerebral stroke due to vascular disease
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references: Supersedes Cerebral stroke due to vascular disease - history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

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

Cervical screening indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—cervical screening indicator, yes/no/not stated/inadequately described code N
Synonymous names:	Pap smear indicator
METeOR identifier:	358921
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether a female person has had a cervical screening, as represented by a code.
Data Element Concept:	Female—cervical screening indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Comments:

Currently, the screening test for cervical cancer is the Pap test (the terms Pap test and Pap smear are often used interchangeably), which is carried out by a general practitioner, nurse, or gynaecologist. During a Pap test, cells are collected from the surface of the cervix, transferred onto a slide or into a special liquid, and sent to a pathology laboratory for assessment. Details of the woman, the Pap test results, and any follow-up that may be recommended are then stored on a cervical cytology register (AIHW 2009).

Early detection and treatment of cervical cancer leads to a reduction of morbidity and mortality due to the disease. It is recommended that women aged 18-69 years, who have ever had sex, have a cervical screening every two years (DOHA 2006).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: AIHW (Australian Institute of Health and Welfare) 2009. Cervical screening in Australia 2006–2007. Cancer series no. 47. Cat. no. CAN 43. Canberra: AIHW.

DOHA (Department of Health and Ageing) 2006. National cervical screening program. Canberra: Department of Health and Ageing.

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Prison entrants DSS Health, Standard 25/08/2011

Conditional obligation:

This data element is conditional on the respondent being female.

Change to body structure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—nature of impairment of body structure, code (ICF 2001) N
METeOR identifier:	320171
Registration status:	Community Services, Standard 16/10/2006 Health, Standard 29/11/2006
Definition:	The qualitative or quantitative change of a person's impairment in a specified body structure, as represented by a code.
Data Element Concept:	Person—nature of impairment of body structure

Value domain attributes

Representational attributes

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

	Value	Meaning
Permissible values:		
	0	No change in structure
	1	Total absence
	2	Partial absence
	3	Additional part
	4	Aberrant dimensions
	5	Discontinuity
	6	Deviating position
	7	Qualitative changes in structure
Supplementary values:	8	Not specified
	9	Not applicable

Collection and usage attributes

Guide for use:

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

Impairments of body structure are problems in body structure such as a loss or significant departure from population standards or averages.

CODE 0 No change in structure

Used when the structure of the body part is within the range of the population standard.

CODE 1 Total absence

Used when the body structure is not present. For example total absence of the structures of the lower leg following a thorough knee amputation.

CODE 2 Partial absence

Used when only part of a body structure is present. For example partial absence of the bones of the lower leg following below knee amputation.

CODE 3 Additional part

Used when a structure, not usually present in the population is present, for example a sixth lumbar vertebra or an sixth digit on one hand.

CODE 4 Aberrant dimensions

Used when the shape and size of a body structure is significantly different from the population standard. For example radial aplasia where the shape and size of the radial bone does not develop.

CODE 5 Discontinuity

Used when parts of a body structure are separated, for example cleft palate or fracture.

CODE 6 Deviating position

Used when the location of a structure is not according to population standard; for example, transposition of the great vessels, where the aorta arises from the right ventricle and the pulmonary vessels from the left ventricle.

CODE 7 Qualitative changes in structure

Used when the structure of a body part is altered from the population standard. This includes accumulation of fluid, changes in bone structure as a result of osteoporosis or Paget's disease.

CODE 8 Not specified

Used when there is a change to a body structure, but the nature of the change is not described.

CODE 9 Not applicable

Used when it is not appropriate to code the nature of the change to a body structure.

Source and reference attributes

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

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

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

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

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

Data element attributes

Collection and usage attributes

Guide for use: This data element is used in conjunction with specified body structures, for example 'partial absence of structures related to movement'. This data element may also be used in conjunction with Person—extent of impairment of body structure, code (ICF 2001) N and Person—location of impairment of body structure, code (ICF 2001) N.

Source and reference attributes

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

Relational attributes

Related metadata references: See also Person—extent of impairment of body structure, code (ICF 2001) N Community Services, Standard

16/10/2006, Health, Standard 29/11/2006

See also Person—location of impairment of body structure, code (ICF 2001) N Community Services, Standard 16/10/2006, Health, Standard 29/11/2006

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

Chemotherapy completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—chemotherapy completion date, DDMMYYYY
METeOR identifier:	393552
Registration status:	Health, Standard 07/12/2011
Definition:	The completion date of **chemotherapy** administered during the initial course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—chemotherapy completion date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Chemotherapy is cancer treatment that achieves its antitumour effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

The completion date of chemotherapy is the date the last dose was administered during the initial course of treatment. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The completion date of chemotherapy is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of the chemotherapy.

Multiple entries are not permitted.

Dates relating to targeted therapies using a chemotherapy agent are included. Targeted therapies are treatments that use drugs or other substances to identify and attack specific cancer cells.

Dates of surgery, radiotherapy and other systemic treatments are collected as separate items. However, if a patient receives treatment with a protocol that includes different types of systemic therapy agents, for example, a chemotherapy agent and a hormone therapy agent, record the completion date of treatment in both relevant data items.

Collection methods: The information should be obtained from the patient's medical record.

Comments: Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references: See also Cancer treatment—chemotherapy cycles administered, number of cycles N[NN] Health, Standard 07/12/2011

See also Cancer treatment—chemotherapy start date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—systemic therapy agent or protocol, text X[(149)] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Chemotherapy for cancer cluster Health, Standard 07/12/2011

Chemotherapy cycles administered

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—chemotherapy cycles administered, number of cycles N[NN]
METeOR identifier:	393814
Registration status:	Health, Standard 07/12/2011
Definition:	The total number of cycles of **chemotherapy** administered during the initial course of treatment for cancer.
Data Element Concept:	Cancer treatment—chemotherapy cycles administered

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
997	Not applicable-no chemotherapy was administered
998	Unknown whether chemotherapy was administered
999	Chemotherapy was administered but the number of cycles was not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Chemotherapy is a type of cancer treatment that achieves its antitumour effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Chemotherapy may be administered as single-agent treatment or as a combination of drugs administered according to a prespecified regimen or protocol.

The number of cycles of each course of single agent chemotherapy, regimen or protocol administered to the patient during the initial treatment of cancer should be recorded separately. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The number of cycles of chemotherapy received is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of the chemotherapy.

If any part of a cycle is administered but the cycle is not completed, record as one cycle.

Oral chemotherapy normally given on an outpatient basis should also be included.

The number of cycles of targeted therapies using a chemotherapy agent is included. Targeted therapies are treatments that use drugs or other substances to identify and attack specific cancer cells.

If a patient receives treatment with a protocol including both a chemotherapy agent and another systemic agent such as an immunotherapy or hormone therapy agent, record the number of cycles here.

Collection methods: This information should be collected from the patient's medical record.

Comments: The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Cancer Institute NSW 2006. NSW Clinical Cancer Registration: Minimum Data Set Data Dictionary, version 1.9 draft

Relational attributes

Related metadata references: See also Cancer treatment—chemotherapy completion date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—chemotherapy start date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—systemic therapy agent or protocol, text X[(149)] Health, Standard 07/12/2011

Implementation in Data Set Specifications:	Chemotherapy for cancer cluster Health, Standard 07/12/2011

Chemotherapy start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—chemotherapy start date, DDMMYYYY
METeOR identifier:	393514
Registration status:	Health, Standard 07/12/2011
Definition:	The start date of **chemotherapy** administered during the initial course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—chemotherapy start date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Chemotherapy is cancer treatment that achieves its antitumour effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Record the first or earliest date chemotherapy was administered during the initial course of treatment. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The start date of the chemotherapy is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of chemotherapy.

Multiple entries are not permitted.

Dates relating to targeted therapies using a chemotherapy agent are included. Targeted therapies are treatments that use drugs or other substances to identify and attack specific cancer cells.

Dates of surgery, radiotherapy and other systemic treatments are collected as separate items. However, if a patient receives treatment with a protocol that includes different types of systemic therapy agents, for example, a chemotherapy agent and a hormone therapy agent, record the start date of treatment in both relevant data items.

Collection methods: The information should be obtained from the patient's medical record.

Comments: Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references: See also Cancer treatment—chemotherapy completion date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—chemotherapy cycles administered, number of cycles N[NN] Health, Standard 07/12/2011

See also Cancer treatment—systemic therapy agent or protocol, text X[(149)] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Chemotherapy for cancer cluster Health, Standard 07/12/2011

Chest pain pattern category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—chest pain pattern, code N
METeOR identifier:	356738
Registration status:	Health, Standard 01/10/2008
Definition:	The person's chest pain pattern, as represented by a code.
Data Element Concept:	Person—chest pain pattern

Value domain attributes

Representational attributes

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

Permissible values:	Value	Meaning
	1	Atypical chest pain
	2	Stable chest pain pattern
	3	Unstable chest pain pattern: rest &/or prolonged
	4	Unstable chest pain pattern: new & severe
	5	Unstable chest pain pattern: accelerated & severe
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	Chest pain or discomfort of myocardial ischaemic origin is usually described as pain, discomfort or pressure in the chest or the upper body (neck and throat, jaw, shoulders, back, either or both arms, wrists and hands) or other equivalent discomfort suggestive of cardiac ischaemia. Ask the person when the symptoms first occurred or obtain this information from appropriate documentation.

CODE 1 Atypical chest pain

Use this code for pain, pressure, or discomfort in the chest, or upper body not clearly exertional or not otherwise consistent with pain or discomfort of myocardial ischaemic origin.

CODE 2 Stable chest pain pattern

Use this code for chest pain without a change in frequency or pattern for the 6 weeks before this presentation or procedure. Chest pain is controlled by rest and/or sublingual/oral/transcutaneous medications.

CODE 3 Unstable chest pain pattern: rest and/or prolonged

Use this code for chest pain that occurred at rest and was prolonged, usually lasting for at least 10 minutes

CODE 4 Unstable chest pain pattern: new and severe

Use this code for new-onset chest pain that could be described as at least Canadian Cardiovascular Society (CCS) classification 3 severity.

CODE 5 Unstable chest pain pattern: accelerated and severe

Use this code for recent acceleration of chest pain pattern that could be described by an increase in severity of at least 1 CCS class to at least CCS class 3.

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—chest pain pattern, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cholesterol—HDL (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—high-density lipoprotein cholesterol level (measured), total millimoles per litre [N].NN
METeOR identifier:	270401
Registration status:	Health, Standard 01/03/2005
Definition:	A person's high-density lipoprotein cholesterol (HDL-C), measured in mmol/L.
Data Element Concept:	Person—high-density lipoprotein cholesterol level

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
9.99	Not measured/inadequately described

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use:

When reporting, record whether or not the measurement of High-density Lipoprotein Cholesterol (HDL-C) was performed in a fasting specimen.

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

Collection methods:

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

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

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

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

National Diabetes Data Working Group

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

Relational attributes

Related metadata references: Supersedes Cholesterol-HDL - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

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

Cholesterol—LDL (calculated)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N
METeOR identifier:	359262
Registration status:	Health, Standard 01/10/2008
Definition:	A person's calculated low-density lipoprotein cholesterol (LDL-C) in millimoles per litre.
Data Element Concept:	Person—low-density lipoprotein cholesterol level

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use:

Formula:

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

Collection methods:

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

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

Note also that while cholesterol levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 8 weeks after an event.

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

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

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

The majority of the cholesterol in plasma is transported as a component of LDL-C. Recent trials support a target LDL-C of <2.0 mmol/L for high risk patients with existing coronary heart disease.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

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

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Position Statement on Lipid Management - 2005, Heart, Lung and Circulation 2005; 14: 275-291.

Relational attributes

Related metadata references: Is formed using Health service event—fasting indicator, code N Health, Standard 21/09/2005

Is formed using Person—cholesterol level (measured), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Is formed using Person—high-density lipoprotein cholesterol level (measured), total millimoles per litre [N].NN Health, Standard 01/03/2005

Supersedes Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Superseded 01/10/2008

	Is formed using Person—triglyceride level (measured), total millimoles per litre N[N].N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Cholesterol—total (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cholesterol level (measured), total millimoles per litre N[N].N
METeOR identifier:	359245
Registration status:	Health, Standard 01/10/2008
Definition:	A person's total cholesterol (TC), measured in millimoles per litre.
Data Element Concept:	Person—cholesterol level

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N].N	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	99.9	Not stated/inadequately described.
Unit of measure:	Millimole per litre (mmol/L)	

Data element attributes

Collection and usage attributes

Guide for use:

Measurement in mmol/L to 1 decimal place.

Record the absolute result of the total cholesterol measurement. When reporting, record whether or not the measurement of Cholesterol-total - measured was performed in a fasting specimen.

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

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

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

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

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

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

Large clinical trials have shown that people at highest risk of cardiovascular events (e.g. pre-existing ischaemic heart disease) will derive the greatest benefit from lipid lowering drugs. Recent trials have suggested that there should be no cholesterol level threshold for the initiation of treatment in tis group of patients. In October 2006, the PBS criteria for lipid-lowering drugs was expanded to include all patients identified as high-risk (based on PBS criteria) regardless of their cholesterol level.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

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

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Position Statement on Lipid Management - 2005, Heart Lung and Circulation 2005; 14: 275-291.

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. Version 4.0.

Relational attributes

Related metadata references:	Supersedes Person—cholesterol level (measured), total millimoles per litre N[N].N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Chronic condition indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—chronic condition indicator, yes/no code N
METeOR identifier:	399232
Registration status:	Health, Standard 25/08/2011
Definition:	A self-reported indicator of whether a person currently has a previously diagnosed chronic condition, as represented by a code.
Data Element Concept:	Person—chronic condition indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes

2	No

Data element attributes

Collection and usage attributes

Guide for use:

This data element should be used in conjunction with the data elements: *Person – type of chronic condition, code N* and *Person – specific chronic condition indicator, yes/no code N* to obtain information on a person's chronic condition status.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Person—specific chronic condition indicator, yes/no code N Health, Standard 25/08/2011

See also Person—type of chronic condition, code N Health, Standard 25/08/2011

Implementation in Data Set Specifications:

Chronic condition cluster Health, Standard 25/08/2011

Conditional obligation:
Conditional on the person being previously told they have a chronic condition.

Chronic obstructive pulmonary disease recorded indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—chronic obstructive pulmonary disease recorded indicator, yes/no code N

Synonymous names: COPD recorded indicator

METeOR identifier: 464928

Registration status: Health, Standard 07/12/2011

Definition: An indicator of whether a person has a chronic obstructive pulmonary disease (COPD) recorded on their clinical record, as represented by a code.

Data Element Concept: Person—chronic obstructive pulmonary disease recorded indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes

A person has a chronic obstructive pulmonary disease (COPD) recorded on their clinical record.

CODE 2 No

A person does not have a chronic obstructive pulmonary disease (COPD) recorded on their clinical record.

Chronic obstructive pulmonary disease (COPD) encompasses a number of conditions which obstruct airflow to the lungs, and individual diseases are classified as COPD or not by Patient Information Retrieval (PIRS) systems.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Class action indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim management episode—class action indicator, yes/no code N
METeOR identifier:	466010
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a medical indemnity claim is a **class action**, as represented by a code.
Data Element Concept:	Medical indemnity claim management episode—class action indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A medical indemnity claim was a **class action**.

CODE 2 No

A medical indemnity claim was not a **class action**.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Medical indemnity DSS Health, Standard 07/12/2011

Classification of health labour force job

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health professional—occupation, code ANN
METeOR identifier:	270140
Registration status:	Health, Standard 01/03/2005
Definition:	The position or job classification of a health professional, as represented by a code.
Data Element Concept:	Health professional—occupation

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Medicine - General practitioner working mainly in general practice
A02	Medicine - General practitioner working mainly in a special interest area
A03	Medicine - Salaried non-specialist hospital practitioner: Resident medical officer or intern
A04	Medicine - Salaried non-specialist hospital practitioner: other hospital career medical officer
A05	Medicine - Specialist
A06	Medicine - Specialist in training (e.g. registrar)
B01	Dentistry (private practice only) - Solo practitioner
B02	Dentistry (private practice only) - Solo

	principal with assistant(s)
B03	Dentistry (private practice only) - Partnership
B04	Dentistry (private practice only) - Associateship
B05	Dentistry (private practice only) - Assistant
B06	Dentistry (private practice only) - Locum
C01	Nursing - Enrolled nurse
C02	Nursing - Registered nurse
C03	Nursing - Clinical nurse
C04	Nursing - Clinical nurse consultant/supervisor
C05	Nursing - Nurse manager
C06	Nursing - Nurse educator
C07	Nursing - Nurse researcher
C08	Nursing - Assistant director of nursing
C09	Nursing - Deputy director of nursing
C10	Nursing - Director of nursing
C11	Nursing - Tutor/lecturer/senior lecturer in nursing (tertiary institution)
C12	Nursing - Associate professor/professor in nursing (tertiary institution)
C98	Nursing - Other (specify)
D01	Pharmacy (community pharmacist) - Sole proprietor
D02	Pharmacy (community pharmacist) - Partner-proprietor
D03	Pharmacy (community pharmacist) - Pharmacist-in-charge
D04	Pharmacy (community pharmacist) - Permanent assistant
D05	Pharmacy (community pharmacist) - Reliever, regular location

	D06	Pharmacy (community pharmacist) - Reliever, various locations
	E01	Pharmacy (Hospital/clinic pharmacist) - Director/deputy director
	E02	Pharmacy (Hospital/clinic pharmacist) - Grade III pharmacist
	E03	Pharmacy (Hospital/clinic pharmacist) - Grade II pharmacist
	E04	Pharmacy (Hospital/clinic pharmacist) - Grade I pharmacist
	E05	Pharmacy (Hospital/clinic pharmacist) - Sole pharmacist
	F01	Podiatry - Own practice (or partnership)
	F02	Podiatry - Own practice and sessional appointments elsewhere
	F03	Podiatry - Own practice and fee-for-service elsewhere
	F04	Podiatry - Own practice, sessional and fee-for-service appointments elsewhere
	F05	Podiatry - Salaried podiatrist
	F06	Podiatry - Locum, regular location
	F07	Podiatry - Locum, various locations
	F08	Podiatry - Other (specify)
	G01	Physiotherapy - Own practice (or partnership)
	G02	Physiotherapy - Own practice and sessional appointments elsewhere
	G03	Physiotherapy - Own practice and fee-for-service elsewhere
	G04	Physiotherapy - Own practice, sessional and fee-for-service appointments elsewhere
	G05	Physiotherapy - Salaried physiotherapist
	G06	Physiotherapy - Locum, regular location
	G07	Physiotherapy - Locum, various locations
Supplementary values:	C99	Nursing - Unknown/inadequately

described/not stated

Data element attributes

Collection and usage attributes

Comments:	Position or job classifications are specific to each profession and may differ by state or territory. The classifications above are simplified so that comparable data presentation is possible and possible confounding effects of enterprise specific structures are avoided. For example, for medicine, the job classification collected in the national health labour force collection is very broad. State/territory health authorities have more detailed classifications for salaried medical practitioners in hospitals. These classifications separate interns, the resident medical officer levels, registrar levels, career medical officer positions, and supervisory positions including clinical and medical superintendents. Space restrictions do not at present permit these classes to be included in the National Health Labour Force Collection questionnaire.

Source and reference attributes

Submitting organisation:	National Health Labour Force Data Working Group

Relational attributes

Related metadata references:	Supersedes Classification of health labour force job, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (24.7 KB)

Client type (alcohol and other drug treatment services)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—client type, code N
METeOR identifier:	270083
Registration status:	Health, Standard 01/03/2005
Definition:	The status of a person in terms of whether the treatment episode concerns their own alcohol and/or other drug use or that of another person, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—client type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Own alcohol or other drug use
2	Other's alcohol or other drug use

Collection and usage attributes

Guide for use:

CODE 1 Own alcohol or other drug use

Use this code for a client who receives treatment or assistance concerning their own alcohol and/or other drug use.

Use this code where a client is receiving treatment or assistance for both their own alcohol and/or other drug use and the alcohol and/or other drug use of another person.

CODE 2 Other's alcohol or other drug use

Use this code for a client who receives support and/or assistance in relation to the alcohol and/or other drug use of another person.

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

Data element attributes

Collection and usage attributes

Guide for use: Where Code 2 Other's alcohol or other drug use is reported, do not collect the following data elements:

Episode of treatment for alcohol and other drugs—drug of concern (principal), code (ASCDC 2000 extended) NNNN;

Episode of treatment for alcohol and other drugs—drug of concern (other), code (ASCDC 2000 extended) NNNN;

Client—injecting drug use status, code N; and

Client—method of drug use (principal drug of concern), code N.

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

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Client type - alcohol and other drug treatment services, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.5 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Clinical emergency indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—clinical emergency indicator, yes/no code N
METeOR identifier:	448126
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether the treatment required for the patient is clinically assessed as an emergency, as represented by a code.
Data Element Concept:	Patient—clinical emergency indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

The treating clinician has assessed the waiting time for treatment cannot exceed 24 hours.

CODE 2 No

The treating clinician has assessed the waiting time for treatment can exceed 24 hours.

Relational attributes

Implementation in Data Set Specifications: Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Conditional obligation:
This item must be completed if Patient—radiotherapy start date, DDMMYYYY exists.

Clinical evidence of acute coronary syndrome related medical history

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical evidence status (acute coronary syndrome related medical history), yes/no code N
METeOR identifier:	356777
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether there is objective evidence for a person's history of an acute coronary syndrome related medical condition, as represented by a code.
Data Element Concept:	Person—clinical evidence status (acute coronary syndrome related medical history)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

Use this code where there is objective evidence to support a history of an acute coronary syndrome related medical condition.

CODE 2 No

Use this code where the history is not supported by objective evidence.

Objective evidence for acute coronary syndrome related medical conditions are classified as:

Chronic lung disease:

Diagnosis supported by current use of chronic lung disease pharmacological therapy (e.g. inhalers, theophylline, aminophylline, or steroids), or a forced expiratory volume in 1 second (FEV1) less than 80% predicted FEV1/forced vital capacity (FVC) less than 0.7 (post bronchodilator). Respiratory failure partial pressure of oxygen (PaO2) less than 60 mmHg (8kPa), or partial pressure of carbon dioxide (PaCO2) greater than 50 mmHg (6.7 kPa).

Heart failure:

Current symptoms of heart failure (typically shortness of breath or fatigue), either at rest or during exercise and/or signs of pulmonary or peripheral congestion and objective evidence of cardiac dysfunction at rest. The diagnosis is derived from and substantiated by clinical documentation from testing according to current practices.

Stroke:

Diagnosis for ischaemic: non-haemorrhagic cerebral infarction or haemorrhagic: intracerebral haemorrhage supported by cerebral imaging (CT or MRI).

Peripheral arterial disease:

- Peripheral artery disease: diagnosis is derived from and substantiated by clinical documentation for a person with a history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.
- Aortic aneurysm: diagnosis of aneurysmal dilatation of the aorta (thoracic and or abdominal) supported and substantiated by appropriate documentation of objective testing.

- Renal artery stenosis: diagnosis of functional stenosis of one or both renal arteries is present and is supported and substantiated by appropriate documentation of objective testing.

Sleep apnoea:

Diagnosis derived from and substantiated by clinical documentation of sleep apnoea syndrome (SAS). SAS has been diagnosed from the results of a sleep study.

Other vascular conditions:

- Atrial fibrillation: diagnosis supported by electrocardiogram findings.
- Other cardiac arrhythmias and conductive disorders: diagnosis supported by electrocardiogram findings.
- Left ventricular hypertrophy: diagnosis supported by echocardiograph evidence.

Collection methods:

For each of the following medical conditions the clinical evidence status must also be recorded:

- Chronic lung disease
- Heart failure
- Stroke
- Peripheral arterial disease
- Sleep apnoea syndrome
- Other vascular conditions

Comments:

Heart failure:

Chronic heart failure is a complex clinical syndrome with typical symptoms (e.g. shortness of breath, fatigue) that can occur at rest or on effort, and is characterised by objective evidence of an underlying structural abnormality of cardiac dysfunction that impairs the ability of the ventricle to fill with or eject blood (particularly during physical activity).

The most widely available investigation for documenting left ventricular dysfunction is the transthoracic echocardiogram (TTE).
Other modalities include:

- transoesophageal echocardiography (TOE)
- gated radionuclide angiocardiography
- angiographic left ventriculography

In the absence of any adjunctive laboratory tests, evidence of supportive clinical signs of ventricular dysfunction. These include:

- cardiac auscultation (S3, cardiac murmurs),
- cardiomegaly,

- elevated jugular venous pressure (JVP),
- chest X-ray evidence of pulmonary congestion

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Reference documents: The Thoracic Society of Australia & New Zealand and the Australian Lung Foundation, Chronic Obstructive Pulmonary Disease (COPD) Australian & New Zealand Management Guidelines and the COPD Handbook. Version 1, November 2002.

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand (Chronic Heart Failure Guidelines Expert Writing Panel). Guidelines for the prevention, detection and management of chronic heart failure in Australia, 2006.

Relational attributes

Related metadata references: Supersedes Person—clinical evidence status (chronic lung disease), code N Health, Superseded 01/10/2008

Supersedes Person—clinical evidence status (heart failure), code N Health, Superseded 01/10/2008

Supersedes Person—clinical evidence status (peripheral arterial disease), code N Health, Superseded 01/10/2008

Supersedes Person—clinical evidence status (sleep apnoea syndrome), code N Health, Superseded 01/10/2008

Supersedes Person—clinical evidence status (stroke), code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Clinical procedure timing (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical procedure timing, code N
METeOR identifier:	356827
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of the provision of a clinical procedure, as represented by a code.
Data Element Concept:	Person—clinical procedure timing

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Procedure performed prior to this hospital presentation
2	Procedure performed during this hospital presentation

Data element attributes

Collection and usage attributes

Guide for use:	Record only for those procedure codes that apply.
Collection methods:	This data element should be recorded for each type of procedure performed that is pertinent to the treatment of acute coronary syndrome.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	See also Person—acute coronary syndrome procedure type, code NN Health, Standard 01/10/2008 Supersedes Person—clinical procedure timing, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Clinical service context

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health-care incident—clinical service context, code N[N]
METeOR identifier:	329822
Registration status:	Health, Standard 07/12/2011
Definition:	The area of clinical practice where the health-care incident occurred, as represented by a code.
Data Element Concept:	Health-care incident—clinical service context

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Emergency department
2	Cardiology
3	Dentistry
4	Cosmetic procedures (including elective plastic surgery)
5	Otolaryngology
6	General medicine (including internal medicine)

	7	General practice
	8	General surgery
	9	Gynaecology
	10	Hospital outpatient department
	11	Neurology
	12	Obstetrics
	13	Oncology
	14	Orthopaedics
	15	Paediatrics
	16	Perinatology (including neonatology)
	17	Plastic surgery (non-elective)
	18	Psychiatry
	19	Radiology
	20	Urology
	23	Cardio-thoracic surgery
	24	Community-based care
	25	Intensive care
	26	Neurosurgery
	27	Ophthalmology
	28	Oral and maxillofacial surgery
	29	Pathology
	30	Public health
	31	Rehabilitation
	32	Vascular surgery
	88	Other
Supplementary values:	97	Not applicable
	99	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: Only one code may be selected for this data element.

Where the incident occurred in a hospital, the name of the hospital department in which the incident occurred may provide the most appropriate description of the clinical service context. In many cases, the clinical service context will reflect the specialty of the main clinician treating the patient, but this will not always be the case. For example, where a patient is treated in the Emergency department by a gynaecologist, Code 1 'Emergency department' should be recorded.

Where the 'Primary incident or allegation type' is 'Anaesthetic', the code chosen for this item should relate to the main procedure that was being carried out, in the context of which the anaesthetic was being administered. Note that complications arising from the anaesthetic administration should not be used as the basis for selecting a category, for example broken teeth as a complication should not be coded as 'Dentistry'.

Where none of the other codes apply, select Code 88 'Other' and enter a brief description of the relevant clinical service area as described in the data element *Health-care incident—clinical service context, text X[X(39)].* Code 88 supersedes Code 21 previously used in historical data.

CODE 2 Cardiology

'Cardiology' excludes cardio-thoracic surgery.

CODE 3 Dentistry

'Dentistry' excludes oral and maxillofacial surgery.

CODE 8 General surgery

'General surgery' is used for all operations performed by surgeons and procedural general practitioners. Circumcision should also be included in this category.

CODE 9 Gynaecology

'Gynaecology' should only be recorded when the patient is female.

CODE 11 Neurology

'Neurology' excludes neurosurgery.

CODE 12 Obstetrics

'Obstetrics' should only be recorded when the patient is a baby (less than 1 year old) or a female of childbearing age.

CODE 13 Oncology

'Oncology' includes radiotherapy or nuclear medicine and gynae–oncology.

CODE 15 Paediatrics

'Paediatrics' excludes neonatology.

CODE 16 Perinatology (including neonatology)

'Perinatology (including neonatology)' is only recorded where the health-care incident that is the basis for the medical indemnity claim occurred shortly before or shortly after the birth of the patient.

CODE 24 Community-based care

'Community-based care' includes community care, hospital in the home, district nursing, and care delivered in nursing homes.

CODE 29 Pathology

'Pathology' includes cytology and tissue retention disputes.

CODE 30 Public health

'Public health' includes vaccination and screening programs, for example, Breastscreen.

CODE 88 Other

'Other' should be selected when none of the more specific codes above apply.

CODE 97 Not applicable

'Not applicable' covers claims for health-care incidents which lack an identifiable clinical service context, for instance incidents in a hospital's public access areas or complaints against disclosure of a patient's medical records.

CODE 99 Not stated/inadequately described

'Not stated/inadequately described' should be used when the information is not currently available. Not stated/inadequately described should not be used when a medical indemnity claim is closed.

Comments: In developing this data element, the Medical Indemnity Data Working Group initially agreed on a short list of key clinical areas of particular interest for medical indemnity claims analysis. The list has been expanded to make use of text descriptions previously provided by data suppliers in the free text field.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Health-care incident—clinical service context, text X[X(39)] Health, Standard 07/12/2011
Implementation in Data Set Specifications:	Medical indemnity DSS Health, Standard 07/12/2011

Clinical service context text

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health-care incident—clinical service context, text X[X(39)]
METeOR identifier:	441107
Registration status:	Health, Standard 07/12/2011
Definition:	The area of clinical practice where the health-care incident occurred, as represented by text.
Data Element Concept:	Health-care incident—clinical service context

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(39)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	This data element should be used in conjunction with the data element: *Health-care incident – clinical service context, code N[N]* Value 88 'Other'. It should contain a brief textual description of the area of clinical practice in cases where the area of clinical practice is not one of those included in the value domain for the related code-based data element.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Health-care incident—clinical service context, code N[N] Health, Standard 07/12/2011
Implementation in Data Set	Medical indemnity DSS Health, Standard 07/12/2011

Specifications:

Conditional obligation:
Conditional on recording Code 88 'Other' for the data element *Health-care incident—clinical service context, code N[N].*

Clinical urgency

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—clinical urgency, code N
METeOR identifier:	270008
Registration status:	Health, Standard 01/03/2005
Definition:	A clinical assessment of the urgency with which a patient requires elective hospital care, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—clinical urgency

Value domain attributes

Representational attributes

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

Permissible values:

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

Data element attributes

Collection and usage attributes

Guide for use:

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

Comments:

A patient's classification may change if he or she undergoes **clinical review** during the waiting period. The need for clinical review varies with the patient's condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (metadata item Elective care waiting list episode—category reassignment date, DDMMYYYY).

Source and reference attributes

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Clinical urgency, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.4 KB)

See also Elective surgery waiting list episode—overdue patient status, code N Health, Superseded 13/12/2011

See also Elective surgery waiting list episode—overdue patient status, code N Health, Standard 13/12/2011

Implementation in Data Set Specifications:

Elective surgery waiting times (census data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 30/09/2012

Elective surgery waiting times (removals data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 01/07/2012

Elective surgery waiting times cluster Health, Standard 07/12/2011

Clopidogrel therapy status

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—clopidogrel therapy status, code NN

METeOR identifier: 284873

Registration status: Health, Standard 04/06/2004

Definition: The person's clopidogrel therapy status, as represented by a code.

Data Element Concept: Person—clopidogrel therapy status

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: NN

Maximum character length: 2

	Value	Meaning
Permissible values:	10	Given
	21	Not given - therapy not indicated
	22	Not given - patient refusal
	23	Not given - true allergy to clopidogrel
	24	Not given - active bleeding
	25	Not given - bleeding risk
	26	Not given - thrombocytopenia
	27	Not given - severe hepatic dysfunction
	29	Not given - other
Supplementary values:	90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 21 - 29 Not given

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

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Clopidogrel therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Co-location status of mental health service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—co-location with acute care hospital, code N
METeOR identifier:	286995
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a mental health service is co-located with an acute care hospital, as represented by a code.
Data Element Concept:	Specialised mental health service—co-location with acute care hospital

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Co-located
2	Not co-located

Collection and usage attributes

Guide for use:

CODE 1 Co-located

Co-located health services are those that are established physically and organisationally as part of an acute care hospital service. There are two forms of co-location:

- a health service that is built and managed as a ward or unit within an acute care hospital; or
- the health service operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus.

In the second option, units and wards within a psychiatric hospital may be classified as co-located when all the following criteria apply:

- a single organisational or management structure covers the acute care hospital and the psychiatric hospital;

- a single employer covers the staff of the acute care hospital and the psychiatric hospital;
- the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus; and
- the patients of the psychiatric hospital are regarded as patients of the single integrated health service.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Collection methods: To be reported for mental health services that primarily provide overnight admitted patient care. Excludes residential mental health services and ambulatory mental health services.

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Compensable status

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Patient—compensable status, code N

METeOR identifier: 270100

Registration status: Health, Standard 01/03/2005

Definition: Whether or not a patient is a **compensable patient**, as represented by a code.

Data Element Concept: Patient—compensable status

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Compensable
	2	Non-compensable
Supplementary values:	9	Not stated/not known

Data element attributes

Collection and usage attributes

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

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

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Compensable status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.2 KB)

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Complex road name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Address—complex road name, text X[45]
Synonymous names:	Complex street name
METeOR identifier:	429376
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	The name of the road/thoroughfare of an address within a complex, as represented by text.
Data Element Concept:	Address—complex road name

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	X[45]
Maximum character length:	45

Data element attributes

Collection and usage attributes

Guide for use:

Complex addresses provide for the unique identification of secondary address sites within a larger, primary address site. A complex address requires both parts (secondary and primary) to provide unique definition.

Within a road name it is possible to find what appears to be a Road type. It is also possible to have a null Road type.

Usage Examples:

Biology Building B
20-24 Genetics Lane North (Complex road name is Genetics)
Blamey Research Institute
1-131 Sunshine Rd
CAIRNS QLD 4870

Rose Cottage
9 Garden Walk (Complex road name is Garden)
Happy Valley Retirement Village
75 Davis Street
NORWOOD SA 5067

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references: See also Address—complex road type, code AA[AA] Community Services, Standard 06/02/2012, Health, Standard 07/12/2011

Supersedes Person (address)—street name, text [A(30)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Supersedes Service provider organisation (address)—street name, text [A(30)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Public hospital establishment address details DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on this component being part of the address of the Public hospital establishment.

Complex road number 1

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Address—complex road number 1, road number X[6]
Synonymous names:	Complex house number 1; Complex street number 1
METeOR identifier:	429268
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	An alphanumeric identifier of an address, or the start number for a ranged address, in the road or thoroughfare within a complex.
Data Element Concept:	Address—complex road number 1

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	X[6]
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:

Complex addresses provide for the unique identification of secondary address sites within a larger, primary address site. A complex address requires both parts (secondary and primary) to provide unique definition.

In the case of a ranged address within a complex, this data element is used in combination with the *Address—complex road number 2, road number X[6]* data element to obtain the first and last numbers of the address.

Usage Examples:

Biology Building B
20-24 Genetics Lane North (Complex road number 1 is 20)
Blamey Research Institute
1-131 Sunshine Rd

CAIRNS QLD 4870

Rose Cottage
9 Garden Walk (Complex road number 1 is 9)
Happy Valley Retirement Village
75 Davis Street
Guide for use/examples
NORWOOD SA 5067

This data element is one of a number of items that can be used to create a primary address, as recommended by the AS 4590-2006 Interchange of client information standard. Components of the primary address are:

Address site (or Primary Complex) name
Address number or number range
Road name (name/type/suffix)
Locality
State/Territory
Postcode (optional)
Country (if applicable).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references: See also Address—complex road number 2, road number X[6] Community Services, Standard 06/02/2012, Health, Standard 07/12/2011

Supersedes Person (address)—house/property identifier, text [X(12)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Supersedes Service provider organisation (address)—house/property identifier, text [X(12)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Public hospital establishment address details DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on this component being part of the address of the Public hospital establishment.

Complex road number 2

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Address—complex road number 2, road number X[6]
Synonymous names:	Complex house number 2; Complex street number 2
METeOR identifier:	429264
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	An alphanumeric identifier for the last number for a ranged address in the road or thoroughfare in which a complex is located.
Data Element Concept:	Address—complex road number 2

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	X[6]
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:

Complex addresses provide for the unique identification of secondary address sites within a larger, primary address site. A complex address requires both parts (secondary and primary) to provide unique definition.

In the case of a ranged address within a complex, this data element is used in combination with the *Address—complex road number 1, road number X[6]* data element to obtain the first and last numbers of the address.

Usage Example:

Biology Building B
20-24 Genetics Lane North (Complex road number 2 is 24)
Blamey Research Institute
1-131 Sunshine Rd

CAIRNS QLD 4870

This data element is one of a number of items that can be used to create a primary address, as recommended by the AS 4590-2006 Interchange of client information standard. Components of the primary address are:

Address site (or Primary Complex) name
Address number or number range
Road name (name/type/suffix)
Locality
State/Territory
Postcode (optional)
Country (if applicable).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references: See also Address—complex road number 1, road number X[6] Community Services, Standard 06/02/2012, Health, Standard 07/12/2011

Supersedes Person (address)—house/property identifier, text [X(12)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Supersedes Service provider organisation (address)—house/property identifier, text [X(12)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Public hospital establishment address details DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on this component being part of the address of the Public hospital establishment.

Complex road type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Address—complex road type, code AA[AA]
Synonymous names:	Complex street type code; Complex road type code
METeOR identifier:	429387
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	An abbreviation used to distinguish the type of road or thoroughfare of an address within a complex.
Data Element Concept:	Address—complex road type

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	AA[AA]
Maximum character length:	4

Permissible values:

Value	Meaning
ACCS	Access
ALLY	Alley
ALWY	Alleyway
AMBL	Amble
APP	Approach
ARC	Arcade
ARTL	Arterial
ARTY	Artery
AV	Avenue
BA	Banan
BEND	Bend

BWLK	Boardwalk
BVD	Boulevard
BR	Brace
BRAE	Brae
BRK	Break
BROW	Brow
BYPA	Bypass
BYWY	Byway
CSWY	Causeway
CTR	Centre
CH	Chase
CIR	Circle
CCT	Circuit
CRCS	Circus
CL	Close
CON	Concourse
CPS	Copse
CNR	Corner
CT	Court
CTYD	Courtyard
COVE	Cove
CR	Crescent
CRST	Crest
CRSS	Cross
CSAC	Cul-de-sac
CUTT	Cutting
DALE	Dale
DIP	Dip
DR	Drive

DVWY	Driveway
EDGE	Edge
ELB	Elbow
END	End
ENT	Entrance
ESP	Esplanade
EXP	Expressway
FAWY	Fairway
FOLW	Follow
FTWY	Footway
FORM	Formation
FWY	Freeway
FRTG	Frontage
GAP	Gap
GDNS	Gardens
GTE	Gate
GLDE	Glade
GLEN	Glen
GRA	Grange
GRN	Green
GR	Grove
HTS	Heights
HIRD	Highroad
HWY	Highway
HILL	Hill
INTG	Interchange
JNC	Junction
KEY	Key
LANE	Lane

LNWY	Laneway
LINE	Line
LINK	Link
LKT	Lookout
LOOP	Loop
MALL	Mall
MNDR	Meander
MEWS	Mews
MTWY	Motorway
NOOK	Nook
OTLK	Outlook
PDE	Parade
PWY	Parkway
PASS	Pass
PSGE	Passage
PATH	Path
PWAY	Pathway
PIAZ	Piazza
PLZA	Plaza
PKT	Pocket
PNT	Point
PORT	Port
PROM	Promenade
QDRT	Quadrant
QYS	Quays
RMBL	Ramble
REST	Rest
RTT	Retreat
RDGE	Ridge

RISE	Rise
RD	Road
RTY	Rotary
RTE	Route
ROW	Row
RUE	Rue
SVWY	Serviceway
SHUN	Shunt
SPUR	Spur
SQ	Square
ST	Street
SBWY	Subway
TARN	Tarn
TCE	Terrace
THFR	Thoroughfare
TLWY	Tollway
TOP	Top
TOR	Tor
TRK	Track
TRL	Trail
TURN	Turn
UPAS	Underpass
VALE	Vale
VIAD	Viaduct
VIEW	View
VSTA	Vista
WALK	Walk
WKWY	Walkway
WHRF	Wharf

WYND	Wynd

Collection and usage attributes

Guide for use: The recommended code description is the list of standard street type abbreviations in AS/NZS 4819.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Data element attributes

Collection and usage attributes

Guide for use: Complex addresses provide for the unique identification of secondary address sites within a larger, primary address site. A complex address requires both parts (secondary and primary) to provide unique definition.

NOTE: Within a Road name it is possible to find what appears to be a Road type (e.g. The Boulevard). It is also possible to have a null Road type.

Usage Example:
Biology Building B
20-24 Genetics Lane North (Complex road type code is LA)
Blamey Research Institute
1-131 Sunshine Rd
CAIRNS QLD 4870

Rose Cottage
9 Garden Walk (Complex road type code is WK)
Happy Valley Retirement Village
75 Davis Street
NORWOOD SA 5067

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references: See also Address—complex road name, text X[45] Community Services, Standard 06/02/2012, Health, Standard 07/12/2011

Supersedes Person (address)—street type, code A[AAA] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Supersedes Service provider organisation (address)—street type, code A[AAA] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Implementation in Data Set Specifications:

Public hospital establishment address details DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on this component being part of the address of the Public hospital establishment.

Complication of labour and delivery

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—complication, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391338
Registration status:	Health, Standard 22/12/2009
Definition:	Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed delivery of the baby and placenta, as represented by a code.
Data Element Concept:	Birth event—complication

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

Guide for use:	There is no arbitrary limit on the number of conditions specified.
Comments:	Complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Birth event—complication, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Complications of pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy (current)—complication, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	405823
Registration status:	Health, Standard 22/12/2009
Definition:	Complications arising up to the period immediately preceding delivery that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome, as represented by a code
Data Element Concept:	Pregnancy (current)—complication

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

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

pregnancy, possibly resulting in hospital admissions and/or adverse effects on the fetus and perinatal morbidity.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Pregnancy (current)—complication, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Condition onset flag

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—condition onset flag, code N
METeOR identifier:	354816
Registration status:	Health, Standard 05/02/2008
Definition:	A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care, as represented by a code.
Data Element Concept:	Episode of admitted patient care—condition onset flag

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Condition with onset during the episode of admitted patient care
	2	Condition not noted as arising during the episode of admitted patient care
Supplementary values:	9	Not reported

Collection and usage attributes

Guide for use:

1 Condition with onset during the episode of admitted patient care

- a condition which arises during the episode of admitted patient care and would not have been present on admission

Includes:

Conditions resulting from misadventure during medical or surgical care during the episode of admitted patient care.

Abnormal reactions to, or later complication of, surgical or medical care arising during the episode of admitted patient care.

Conditions arising during the episode of admitted patient care not related to surgical or medical care (for example, pneumonia).

2 Condition not noted as arising during the episode of admitted patient care

- a condition present on admission such as the presenting problem, a comorbidity, chronic disease or disease status.
- a previously existing condition not diagnosed until the episode of admitted patient care.

Includes:

In the case of neonates, the conditions present at birth.

A previously existing condition that is exacerbated during the episode of admitted patient care.

Conditions that are suspected at the time of admission and subsequently confirmed during the episode of admitted patient care.

Conditions that were not diagnosed at the time of admission but clearly did not develop after admission (for example malignant neoplasm).

Conditions where the onset relative to the beginning of the episode of admitted patient care is unclear or unknown.

9 Not reported

The condition onset flag could no be reported due to limitations of the data management system.

Data element attributes

Collection and usage attributes

Guide for use:

Assign the relevant condition onset flag to ICD-10-AM diagnosis codes assigned in the principal diagnosis and additional diagnosis fields for the National Hospital Morbidity Database collection.

The sequencing of diagnosis codes must comply with the Australian Coding Standards and therefore diagnosis codes should not be re-sequenced in an attempt to list diagnosis codes with the same condition onset flag together.

When it is difficult to decide if a condition was present at the beginning of the episode of care or if it arose during the episode, assign a value of 2 - Condition not noted as arising during this episode of care.

The principal diagnosis should always have a condition onset flag value of 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

When a single diagnosis code describes a condition and that code contains more than one concept (e.g. diabetes with renal complications) and each concept within that code has a different condition onset flag, then assign a value of 2.

When a condition requires more than one diagnosis code to describe it, it is possible for each diagnosis code to have a different condition onset flag.

The flag on Z codes related to the outcome of delivery on the mother's record (Z37), should always be assigned a value of 2.

The flag on Z codes related to the outcome of delivery on the baby's record (Z38), should always be assigned a value of 2.

Collection methods: A condition onset flag should be recorded and coded upon completion of an episode of admitted patient care.

Comments: The condition onset flag is a means of differentiating those conditions which arise during, or arose before, an admitted patient episode of care. Having this information will provide an insight into the kinds of conditions patients already have when entering hospital and what arises during the episode of care. A better understanding of those conditions arising during the episode of care may inform prevention strategies particularly in relation to complications of medical care.

The flag only indicates when the condition had onset, and cannot be used to indicate whether a condition was considered to be preventable.

Source and reference attributes

Origin: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Episode of admitted patient care—diagnosis onset type, code N Health, Superseded 05/02/2008

Implementation in Data Set Specifications: Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Congenital malformations

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—congenital malformation, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	393436
Registration status:	Health, Standard 22/12/2009
Definition:	Structural abnormalities (including deformations) that are present at birth and diagnosed prior to **separation** from care, as represented by an ICD-10-AM code.
Context:	Admitted patient care
Data Element Concept:	Person—congenital malformation

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Source and reference attributes

Origin:	International Classification of Diseases - 10th Revision, Australian Modification National Centre for Classification in Health, Sydney.

Data element attributes

Collection and usage attributes

Guide for use:	Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients.
Comments:	Required to monitor trends in the reported incidence of congenital malformations, to detect new drug and

environmental teratogens, to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Person—congenital malformation, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Congenital malformations—BPA code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—congenital malformation, code (BPA 1979) ANN.N[N]
METeOR identifier:	270408
Registration status:	Health, Standard 01/03/2005
Definition:	Structural abnormalities (including deformations) that are present at birth and diagnosed prior to **separation** from care, as represented by a BPA code.
Context:	Perinatal statistics
Data Element Concept:	Person—congenital malformation

Value domain attributes

Representational attributes

Classification scheme:	British Paediatric Association Classification of Diseases 1979
Representation class:	Code
Data type:	String
Format:	ANN.N[N]
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:	Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients. For perinatal data collections, the use of British Paediatric Association (BPA) Classification of Diseases is preferred as this is more detailed.
Comments:	There is no arbitrary limit on the number of conditions specified. Most perinatal data groups and birth defects registers in the states and territories have used the 5-digit BPA Classification of Diseases to code congenital malformations since the early 1980s.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Origin: British Paediatric Association Classification of Diseases (1979)

Relational attributes

Related metadata references: Supersedes Congenital malformations - BPA code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Consumer committee representation arrangements

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer committee representation arrangements, code N
METeOR identifier:	288855
Registration status:	Health, Standard 08/12/2004
Definition:	Extent to which a specialised mental health service organisation has formal committee mechanisms in place to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer committee representation arrangements

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Formal position(s) for consumers exist on the organisation's management committee for the appointment of person(s) to represent the interests of consumers
2	Specific consumer advisory committee(s) exists to advise on all relevant mental health services managed by the organisation
3	Specific consumer advisory committee(s) exists to advise on some but not all relevant mental health services managed by the organisation
4	Consumers participate on a broadly based advisory committee which include a mixture of organisations and groups representing a wide range of interests

5	Consumers are not represented on any advisory committee but are encouraged to meet with senior representatives of the organisation as required
6	No specific arrangements exist for consumer participation in planning and evaluation of services

Collection and usage attributes

Guide for use: Select the option above that best describes the type of formal committee mechanisms within your organisation for ensuring participation by mental health consumers in the planning and evaluation of services.

Data element attributes

Collection and usage attributes

Guide for use: Select the option above that best describes the type of formal committee mechanisms with in your organisation for ensuring participation by mental health consumers in the planning and evaluation of services.

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Consumer participation arrangements—consumer consultants employed

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N
METeOR identifier:	288866
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service employs consumer consultants on a paid basis to represent the interests of consumers and advocate for their needs, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed)

Value domain attributes

Representational attributes

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

	Value	Meaning
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Don't know

Data element attributes

Relational attributes

Related metadata references: See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Consumer participation arrangements—consumer satisfaction surveys

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N
METeOR identifier:	290418
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service conducts consumer satisfaction surveys, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Boolean	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Don’t know

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—

consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Consumer participation arrangements—formal complaints mechanism

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N
METeOR identifier:	290415
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service has developed a formal internal complaints mechanism in which complaints can be made by consumers and are regularly reviewed by a committee that includes consumers, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (formal internal complaints mechanism)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Boolean	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Don’t know

Data element attributes

Relational attributes

Related metadata references: See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Consumer participation arrangements—formal participation policy

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N

METeOR identifier: 290410

Registration status: Health, Standard 08/12/2004

Definition: Whether the service has developed a formal and documented policy on participation by consumers, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.

Data Element Concept: Specialised mental health service organisation—consumer participation arrangements (formal participation policy)

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Don’t know

Data element attributes

Relational attributes

Related metadata references: See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—

consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Consumer participation arrangements—regular discussion groups

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N
METeOR identifier:	290408
Registration status:	Health, Standard 08/12/2004
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (regular discussion groups)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Boolean	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Don't know

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Contract establishment identifier

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Contracted hospital care—organisation identifier, NNX[X]NNNNN

METeOR identifier: 270013

Registration status: Health, Standard 01/03/2005

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

Data Element Concept: Contracted hospital care—organisation identifier

Value domain attributes

Representational attributes

Representation class: Identifier

Data type: String

Format: NNX[X]NNNNN

Maximum character length: 9

Data element attributes

Collection and usage attributes

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

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

Relational attributes

Related metadata references: Supersedes Contract establishment identifier, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Implementation in Data Set Specifications: Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Contract procedure flag

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care (procedure)—contracted procedure flag, code N
METeOR identifier:	270473
Registration status:	Health, Standard 01/03/2005
Definition:	Designation that a procedure was not performed in this hospital but was performed by another hospital as a contracted service, as represented by a code.
Data Element Concept:	Episode of care (procedure)—contracted procedure flag

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Contracted admitted procedure
2	Contracted non-admitted procedure

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

Relational attributes

Related metadata references: Supersedes Contract procedure flag, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.3 KB)

Contract role

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital—contract role, code A
METeOR identifier:	270114
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the hospital is the purchaser of hospital care or the provider of an admitted or non-admitted service, as represented by a code.
Data Element Concept:	Hospital—contract role

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
A	Hospital A
B	Hospital B

Collection and usage attributes

Guide for use:

CODE A Hospital A

Hospital A is the contracting hospital (purchaser).

CODE B Hospital B

Hospital B is the contracted hospital (provider).

Data element attributes

Relational attributes

Related metadata references:

Supersedes Contract role, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Is used in the formation of Episode of care—inter-hospital contracted patient status, code N Health, Standard

	01/03/2005
	Is used in the formation of Episode of care—inter-hospital contracted patient status, code N Health, Standard 11/04/2012

Contract type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital—contract type, code N
METeOR identifier:	270475
Registration status:	Health, Standard 01/03/2005
Definition:	The type of contract arrangement between contractor and the contracted hospital, as represented by a code.
Data Element Concept:	Hospital—contract type

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

Guide for use:

The contracting hospital (purchaser) is termed Hospital A. The contracted hospital (provider) is termed Hospital B.

CODE 1 Contract Type B

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

CODE 2 Contract Type ABA

Patient admitted by Hospital A. Hospital A contracts Hospital B for admitted or non-admitted patient service. Patient returns to Hospital A on completion of service by Hospital B.

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

CODE 3 Contract Type AB

Patient admitted by Hospital A. Hospital A contracts Hospital B for admitted or non-admitted patient service. Patient does not return to Hospital A on completion of service by Hospital B.
For example, a patient has a hip replacement at Hospital A and then receives aftercare at Hospital B, under contract to Hospital A. Patient is separated from Hospital B.

CODE 4 Contract Type (A)B

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

CODE 5 Contract Type BA

Hospital A contracts Hospital B for an admitted patient service following which the patient moves to Hospital A for remainder of care. For example, a patient is admitted to Hospital B for a gastric resection procedure under contract to Hospital A and Hospital A provides after care.

Data element attributes

Relational attributes

Related metadata references:

Supersedes Contract type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Is used in the formation of Episode of care—inter-hospital contracted patient status, code N Health, Standard 01/03/2005

Is used in the formation of Episode of care—inter-hospital contracted patient status, code N Health, Standard 11/04/2012

Contracted care commencement date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Contracted hospital care—contracted care commencement date, DDMMYYYY

METeOR identifier: 270105

Registration status: Health, Standard 01/03/2005

Definition: The date the period of contracted care commenced.

Data Element Concept: Contracted hospital care—contracted care commencement date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: This metadata item is to be used by the contracting hospital to record the commencement date of the contracted hospital care and will be the admission date for the contracted hospital.

Relational attributes

Related metadata references: Supersedes Contracted care commencement date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)

Contracted care completion date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Contracted hospital care—contracted care completed date, DDMMYYYY

METeOR identifier: 270106

Registration status: Health, Standard 01/03/2005

Definition: The date the period of contracted care is completed.

Data Element Concept: Contracted hospital care—contracted care completed date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: This metadata item is to be used by the contracting hospital to record the date of completion of the contracted hospital care and will be the separation date for the contracted hospital.

Relational attributes

Related metadata references: Supersedes Contracted care completion date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)

Coordinator of volunteers indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—coordinator of volunteers indicator, yes/no code N
METeOR identifier:	352862
Registration status:	Health, Standard 05/12/2007
Definition:	An indicator of whether a service provider organisation has at least one designated person to coordinate their volunteer labour force, as represented by a code.
Data Element Concept:	Service provider organisation—coordinator of volunteers indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

A coordinator of volunteers may be employed part-time or full-time and may be engaged on a paid or unpaid basis.
The duties of a volunteer coordinator may include:

- managing the workloads of volunteer staff;
- liaising with clinical staff regarding clients' needs;
- assessing human resource needs of the organisation;
- recruiting volunteers;
- developing orientation kits and programs;
- developing volunteer policies;

- arranging training and development opportunities; and
- maintaining volunteer records.

CODE 1 Yes

The organisation has a designated coordinator of volunteers.

CODE 2 No

The organisation does not have a designated coordinator of volunteers.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

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

Coronary artery bypass graft location

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—coronary artery bypass graft location, code N
METeOR identifier:	347161
Registration status:	Health, Standard 01/10/2008
Definition:	The location of the artery where a coronary artery bypass graft has been performed, as represented by a code.
Data Element Concept:	Person—coronary artery bypass graft location

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Left anterior descending artery (LAD)
	2	Diagonal artery
	3	Left circumflex artery (LCx)
	4	Inferior surface artery
	5	Posterior descending artery
	6	Right coronary artery
	8	Other artery
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

A bypass may be performed on more than one artery. In these cases more than one code may be recorded.

For each graft location the data elements Person-coronary artery stenosis location, code N; Person-maximum stenosis coronary artery, percentage N[NN] must also be recorded.

Relational attributes

Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008 *Conditional obligation:* Record when a coronary artery bypass graft is performed.

Coronary artery disease—history of intervention or procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—coronary artery disease intervention (history), code N
METeOR identifier:	270227
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has undergone a coronary artery by-pass grafting (CABG), angioplasty or stent, as represented by a code.
Data Element Concept:	Person—coronary artery disease intervention

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	CABG, angioplasty or stent - undertaken in last 12 months
2	CABG, angioplasty or stent - undertaken prior to the last 12 months
3	CABG, angioplasty or stent - both within and prior to the last 12 months

	4	No CABG, angioplasty or stent undertaken
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Comments:

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

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

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

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

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

Data element attributes

Collection and usage attributes

Collection methods: Ask the individual if he/she has had a CABG, angioplasty or coronary stent. If so determine when it was undertaken within or prior to the last 12 months (or both).

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

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

Relational attributes

Related metadata references: Supersedes Coronary artery disease - history of intervention or procedure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

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

Coronary artery stenosis location

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—coronary artery stenosis location, code N
METeOR identifier:	361087
Registration status:	Health, Standard 01/10/2008
Definition:	The coronary artery in which stenosis is located, as represented by a code.
Data Element Concept:	Person—coronary artery stenosis location

Value domain attributes

Representational attributes

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

	Value	Meaning
Permissible values:		
	1	Left anterior descending artery (LAD)
	2	Diagonal artery
	3	Left circumflex artery (LCx)
	4	Left main coronary artery
	5	Inferior surface artery
	6	Posterior descending artery
	7	Right coronary artery
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

More than one code may be recorded.

Record all codes that apply.

For each coronary artery where stenosis is located the data element Person-maximum stenosis coronary artery, percentage N[NN] must also be recorded.

Collection methods: This data is derived from visual reporting by the physician reporting the angiogram.

Relational attributes

Related metadata references: See also Person—maximum stenosis coronary artery, percentage N[NN] Health, Standard 01/10/2008

Implementation in Data Set Specifications: Coronary artery cluster Health, Standard 01/10/2008

Country identifier (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—country identifier, code (SACC 2011) NNNN
METeOR identifier:	459971
Registration status:	Community Services, Standard 28/02/2012 Health, Standard 28/02/2012
Definition:	The country component of the address of a person, as represented by a code.
Data Element Concept:	Person (address)—country identifier

Value domain attributes

Representational attributes

Classification scheme:	Standard Australian Classification of Countries 2011
Representation class:	Code
Data type:	Number
Format:	NNNN
Maximum character length:	4

Collection and usage attributes

Guide for use:

The Standard Australian Classification of Countries 2011 (SACC) is a four-digit, three-level hierarchical structure specifying major group, minor group and country.

A country, even if it comprises other discrete political entities such as states, is treated as a single unit for all data domain purposes. Parts of a political entity are not included in different groups. Thus, Hawaii is included in Northern America (as part of the identified country United States of America), despite being geographically close to and having similar social and cultural characteristics as the units classified to Polynesia.

Data element attributes

Collection and usage attributes

Collection methods: Collect the data at the 4-digit level.

Comments: Note that the Standard Australian Classification of Countries (SACC) is mappable to but not identical to Australian Standard Classification of Countries for Social Statistics (ASCCSS).

Source and reference attributes

Reference documents: Standard Australian Classification of Countries Edition 1, Catalogue number 1269.0, 2011, Canberra: Australian Bureau of Statistics

Relational attributes

Related metadata references: Supersedes Person (address)—country identifier, code (SACC 2008) NNNN Community Services, Superseded 28/02/2012, Health, Superseded 28/02/2012

Country of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—country of birth, code (SACC 2011) NNNN
METeOR identifier:	459973
Registration status:	Community Services, Standard 13/10/2011 Housing assistance, Standard 13/10/2011 Health, Standard 13/10/2011 Homelessness, Standard 13/10/2011
Definition:	The country in which the person was born, as represented by a code.
Data Element Concept:	Person—country of birth

Value domain attributes

Representational attributes

Classification scheme:	Standard Australian Classification of Countries 2011
Representation class:	Code
Data type:	Number
Format:	NNNN
Maximum character length:	4

Collection and usage attributes

Guide for use:

The Standard Australian Classification of Countries 2011 (SACC) is a four-digit, three-level hierarchical structure specifying major group, minor group and country.

A country, even if it comprises other discrete political entities such as states, is treated as a single unit for all data domain purposes. Parts of a political entity are not included in different groups. Thus, Hawaii is included in Northern America (as part of the identified country United States of America), despite being geographically close to and having similar social and cultural characteristics as the units classified to Polynesia.

Data element attributes

Collection and usage attributes

Collection methods:

Some data collections ask respondents to specify their country of birth. In others, a pre-determined set of countries is specified as part of the question, usually accompanied by an 'other (please specify)' category.

Recommended questions are:

In which country were you/was the person/was (name) born?

Australia

Other (please specify)

Alternatively, a list of countries may be used based on, for example common Census responses.

In which country were you/was the person/was (name) born?

Australia

England

New Zealand

Italy

Viet Nam

India

Scotland

Philippines

Greece

Germany

Other (please specify)

In either case coding of data should conform to the SACC.

Sometimes respondents are simply asked to specify whether they were born in either 'English speaking' or 'non-English speaking' countries but this question is of limited use and this method of collection is not recommended.

Comments:

This metadata item is consistent with that used in the ABS collection methods and is recommended for use whenever there is a requirement for comparison with ABS data (last viewed 2/6/2008).

Relational attributes

Related metadata references:

Supersedes Person—country of birth, code (SACC 2008) NNNN Community Services, Superseded 13/10/2011, Housing assistance, Superseded 13/10/2011, Health, Superseded 22/11/2011, Homelessness, Superseded 13/10/2011, Tasmanian Health, Proposed 28/09/2011

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Country of employment in registered profession

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—country of employment in registered profession, Australia/other country code N
METeOR identifier:	383407
Registration status:	Health, Standard 10/12/2009
Definition:	The country in which a registered health professional is working in their profession, as represented by a code.
Data Element Concept:	Registered health professional—country of employment in registered profession

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Australia
	2	Other country
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 AUSTRALIA

The definition of Australia is based on the Standard Australian Classification of Countries (SACC). It includes Australia, Norfolk Island and Australian External Territories n.f.d.

CODE 2 OTHER COUNTRY

This includes all countries in the Standard Australian Classification of Countries (SACC) not included in Code 1 above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: This data element is applicable to registered health professionals who are employed in the registered profession only.

Data is self-reported based on the country of employment in the registered profession in the week before registration.

Where a health professional works in their profession in Australia and another country, then code one should selected.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Labour force status cluster Health, Standard 10/12/2009

Creatine kinase isoenzyme—upper limit of normal range (U/L)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase isoenzyme, total units per litre N[NNN]
METeOR identifier:	349630
Registration status:	Health, Standard 01/10/2008
Definition:	Laboratory standard for the value of creatine kinase (CK) isoenzyme measured in units per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Unit of measure: Units per litre (U/L)

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of the creatine kinase normal reference range for the testing laboratory.

Comments: There are three different CK isoenzyme sub-forms:

- CK-MM (skeletal muscle)
- CK-MB (cardiac muscle)
- CK-BB (brain tissue)

Relational attributes

Related metadata references: See also Person—creatine kinase isoenzyme level (measured), total units per litre N[NNN] Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatine kinase level (U/L)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase isoenzyme level (measured), total units per litre N[NNN]
Synonymous names:	CK measured (U/L)
METeOR identifier:	349536
Registration status:	Health, Standard 01/10/2008
Definition:	A person's measured creatine kinase (CK) isoenzyme level in units per litre.
Data Element Concept:	Person—creatine kinase isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Unit of measure: Units per litre (U/L)

Data element attributes

Collection and usage attributes

Guide for use:

CODE 8888 if test for CK was not done for this hospital presentation.

Where possible, several CK measures should be recorded and their associated date and time. At a minimum, an initial, peak and late value should be recorded.

When only one CK level is recorded, this should be the peak level.

Comments:

Elevation of CK isoenzyme is an indication of damage to muscle.

There are three different CK isoenzyme sub-forms:

- CK-MM (skeletal muscle)

- CK-MB (cardiac muscle)

- CK-BB (brain tissue)

Relational attributes

Related metadata references: See also Laboratory standard—upper limit of normal range for creatine kinase isoenzyme, total units per litre N[NNN] Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatine kinase MB isoenzyme level (index code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), index code X[XXX]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284903
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme level, as represented by an index.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	X[XXX]
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 88888 if test for CK-MB was not done on this admission.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: The National Heart Foundation of Australia and The

Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)

See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, index code X[XXX] Health, Standard 04/06/2004

Creatine kinase MB isoenzyme level (kCat per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), total kCat per litre N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284915
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme in kCat per litre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Unit of measure: Catalytic rate of an enzyme (kCat/L)

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

CODE 8888 if test for CK-MB was not done on this admission.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

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

Relational attributes

Related metadata references:

Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)

See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total kCat per litre N[NNN] Health, Standard 04/06/2004

Creatine kinase MB isoenzyme level (micrograms per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase-myocardial band isoenzyme level (measured), total micrograms per litre N[NNN]
METeOR identifier:	356833
Registration status:	Health, Standard 01/10/2008
Definition:	A person's measured creatine kinase-myocardial band (CK-MB) isoenzyme level in micrograms per litre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Unit of measure: Microgram per litre (µg/L)

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

CODE 9998 if test for CK-MB was not done for this hospital presentation.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN] Health, Superseded 01/10/2008 Supersedes Person—creatine kinase-myocardial band isoenzyme level (measured), total micrograms per litre N[NNNN] Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatine kinase MB isoenzyme level (nanograms per decilitre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), total nanograms per decilitre N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284923
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme in nanograms per decilitre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Unit of measure: Nanogram per decilitre (ng/dl)

Data element attributes

Collection and usage attributes

Guide for use:

CODE 8888 if test for CK-MB was not done on this admission.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)

Creatine kinase MB isoenzyme level (percentage)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), percentage N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284913
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme as a percentage.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

CODE 8888 if test for CK-MB was not done on this admission.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

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

Relational attributes

Related metadata references:

Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)

See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, percentage N[NNN] Health, Standard 04/06/2004

Creatine kinase MB isoenzyme level (units per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase-myocardial band isoenzyme level (measured), total units per litre N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	356830
Registration status:	Health, Standard 01/10/2008
Definition:	A person's measured creatine kinase-myocardial band (CK-MB) isoenzyme level in units per litre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Unit of measure: Units per litre (U/L)

Data element attributes

Collection and usage attributes

Guide for use:

CODE 9998 if test for CK-MB was not done for this hospital presentation.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total units per litre N[NNN] Health, Standard 01/10/2008 Supersedes Person—creatine kinase-myocardial band isoenzyme level (measured), total international units N[NNN] Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatine kinase MB isoenzyme—upper limit of normal range (units per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total units per litre N[NNN]
METeOR identifier:	356596
Registration status:	Health, Standard 01/10/2008
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in units per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[NNN]	
Maximum character length:	4	
Supplementary values:	Value	Meaning
	9998	Not measured
	9999	Not stated/inadequately described
Unit of measure:	Units per litre (U/L)	

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group.

Relational attributes

Related metadata references:

Supersedes Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total international units N[NNN] Health, Superseded 01/10/2008

See also Person—creatine kinase-myocardial band isoenzyme level (measured), total units per litre N[NNN] Health, Standard 01/10/2008

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatine kinase MB isoenzyme—upper limit of normal range (index code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, index code X[XXX]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - units
METeOR identifier:	284931
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured as an index that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	X[XXX]	
Maximum character length:	4	
Supplementary values:	Value	Meaning
	9999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group.

Relational attributes

Related metadata references:	Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB) See also Person—creatine kinase myocardial band isoenzyme level (measured), index code X[XXX] Health, Standard 04/06/2004

Creatine kinase MB isoenzyme—upper limit of normal range (kCat per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total kCat per litre N[NNN]
METeOR identifier:	284963
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme in kCat per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[NNN]	
Maximum character length:	4	
Supplementary values:	Value	Meaning
	8888	Not measured
	9999	Not stated/inadequately described
Unit of measure:	Catalytic rate of an enzyme (kCat/L)	

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group.

Relational attributes

Related metadata references: Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

See also Person—creatine kinase myocardial band isoenzyme level (measured), total kCat per litre N[NNN] Health, Standard 04/06/2004

Creatine kinase MB isoenzyme—upper limit of normal range (micrograms per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN]
METeOR identifier:	359287
Registration status:	Health, Standard 01/10/2008
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in micrograms per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[NNN]	
Maximum character length:	4	
Supplementary values:	Value	Meaning
	9998	Not measured
	9999	Not stated/inadequately described
Unit of measure:	Microgram per litre (µg/L)	

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing

laboratory.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group.

Relational attributes

Related metadata references: Supersedes Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN] Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatine kinase MB isoenzyme—upper limit of normal range (nanograms per decilitre)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total nanograms per decilitre N[NNN]

METeOR identifier: 285957

Registration status: Health, Standard 04/06/2004

Definition: Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in nanograms per decilitre that is the upper boundary of the normal reference range.

Data Element Concept: Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNN]

Maximum character length: 4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Unit of measure: Nanogram per decilitre (ng/dl)

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group.

Relational attributes

Related metadata references: Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Creatine kinase MB isoenzyme—upper limit of normal range (percentage)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, percentage N[NNN]
METeOR identifier:	284961
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured as a percentage that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group.

Relational attributes

Related metadata references: Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

See also Person—creatine kinase myocardial band isoenzyme level (measured), percentage N[NNN] Health, Standard 04/06/2004

Creatinine serum level (measured)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—creatinine serum level, total micromoles per litre NN[NN]

METeOR identifier: 360936

Registration status: Health, Standard 01/10/2008

Definition: A person's serum creatinine level measured in micromoles per litre.

Data Element Concept: Person—creatinine serum level

Value domain attributes

Representational attributes

Representation class: Total

Data type: String

Format: NN[NN]

Maximum character length: 4

Unit of measure: Micromole per litre (µmol/L)

Data element attributes

Collection and usage attributes

Guide for use: There is no agreed standard as to which units serum creatinine should be recorded in.

Note: If the measurement is obtained in mmol/L it is to be multiplied by 1000.

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

- Single venous blood test taken at the time of other screening blood tests.
- Fasting not required.

Comments: Serum creatinine can be used to help determine renal function. Serum creatinine by itself is an insensitive measure of renal function because it does not increase until more than 50% of renal function has been lost.

Serum creatinine together with a patient's age, weight and sex can be used to calculate glomerular filtration rate (GFR), which is an indicator of renal status/ function. The calculation uses the Cockcroft-Gault formula.

Creatinine is normally produced in fairly constant amounts in the muscles, as a result the breakdown of phosphocreatine. It passes into the blood and is excreted in the urine. Serum creatinine can be used to help determine renal function. The elevation in the creatinine level in the blood indicates disturbance in kidney function.

GFR decreases with age, but serum creatinine remains relatively stable. When serum creatinine is measured, renal function in the elderly tends to be overestimated, and GFR should be used to assess renal function, according to the Cockcroft-Gault formula:

$$\text{GFR (ml/min)} = \frac{\text{(140 - age [yrs]) x body wt (kg)}}{\text{814 x serum creatinine (mmol/l)}} \quad \text{[x 0.85 (for women)]}$$

An alternative formula is derived from the Modification of Diet in Renal Disease (MDRD) study and does not rely on knowledge of body weight:

GFR (ml/min/1.73m2) = 32788 x creatinine$^{-1.154}$ (umol/L) x age$^{-0.203}$ x (males: 1, females: 0.742).

To determine the degree of chronic renal impairment

GFR > 90ml/min - normal

GFR >60 - 90ml/min - mild renal impairment

GFR >30 - 60ml/min - moderate renal impairment

GFR 0 - 30 ml/min - severe renal impairment

Note: The above GFR measurement should be for a period greater than 3 months. GFR may also be assessed by 24-hour creatinine clearance adjusted for body surface area.

In general, patients with GFR < 30 ml/min are at high risk of progressive deterioration in renal function and should be referred to a nephrology service for specialist management of renal failure.

Patients should be assessed for the complications of chronic renal impairment including anaemia, hyperparathyroidism and be referred for specialist management if required.

Patients with rapidly declining renal function or clinical features to suggest that residual renal function may decline rapidly (ie. hypertensive, proteinuric (>1g/24hours), significant comorbid illness) should be considered for referral to a nephrologist well before function declines to less than 30ml/min. (Draft CARI Guidelines 2002. Australian Kidney Foundation). Patients in whom the cause of renal impairment is uncertain should be referred to a nephrologist for assessment.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

National Diabetes Data Working Group

Origin: Caring for Australians with Renal Impairment (CARI) Guidelines. Australian Kidney Foundation

Relational attributes

Related metadata references: Supersedes Person—creatinine serum level, micromoles per litre NN[NN] Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Current opioid pharmacotherapy treatment program indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—current opioid pharmacotherapy treatment program indicator, yes/no code N

Synonymous names: Opiate replacement program

METeOR identifier: 404745

Registration status: Health, Standard 25/08/2011

Definition: An indicator of a person's current participation in a drug-based opioid dependence treatment program, as represented by a code.

Data Element Concept: Person—current opioid pharmacotherapy treatment program indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data element: *Person – type of opioid pharmacotherapy treatment, code N* to provide information on a person's current opioid pharmacotherapy treatment.

Comments: Imprisonment may provide an opportunity to access drug treatments including pharmacotherapy and counselling programs.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Kastelic A, Pont J & Stover H 2008. Opioid substitution treatment in custodial settings: a practical guide. Oldenburg: BIS-Verlag.

Relational attributes

Related metadata references: See also Person—previous opioid pharmacotherapy treatment program indicator, yes/no code N Health, Standard 25/08/2011

See also Person—type of opioid pharmacotherapy treatment, code N Health, Standard 25/08/2011

Implementation in Data Set Specifications: Opioid pharmacotherapy treatment cluster Health, Standard 25/08/2011

Current smoking status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—current smoking status indicator, yes/no/not stated/inadequately described code N
METeOR identifier:	399538
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether a person reports being a current smoker, as represented by a code.
Data Element Concept:	Person—current smoking status indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data element *Person – tobacco smoking frequency, current tobacco smoking frequency code N* to define a person's current smoking status.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: ABS (Australian Bureau of Statistics) 2009. National health survey: summary of results, 2007-08. ABS cat. no. 4364.0. Canberra: ABS

Relational attributes

Related metadata references: See also Person—tobacco smoking frequency, current tobacco smoking frequency code N Health, Standard 25/08/2011

Implementation in Data Set Specifications: Smoking status cluster Health, Standard 25/08/2011

Conditional obligation:
Conditional on the person indicating that they have ever smoked a full cigarette.

CVD drug therapy—condition

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cardiovascular disease condition targeted by drug therapy, code NN
METeOR identifier:	270193
Registration status:	Health, Standard 01/03/2005
Definition:	The condition(s) for which drug therapy is being used for the prevention or long-term treatment of cardiovascular disease, as represented by a code.
Data Element Concept:	Person—cardiovascular disease condition targeted by drug therapy

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Heart failure
02	Ischaemic heart disease
03	Hypertension
04	Atrial fibrillation (AF)
05	Other dysrhythmia or conductive disorder
06	Dyslipidaemia
07	Peripheral vascular disease (PVD)
08	Renal vascular disease
09	Stroke
10	Transient ischaemic attack (TIA)
97	Other

	98	No CVD drugs prescribed
Supplementary values:	99	Not recorded

Collection and usage attributes

Guide for use: The categorisations may be made using the most recent version of the Australian Modification of the appropriate International Classification of Diseases codes.

Data element attributes

Collection and usage attributes

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

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

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references: Supersedes CVD drug therapy - condition, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.0 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Date accuracy indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Date—accuracy indicator, code AAA
METeOR identifier:	294429
Registration status:	Community Services, Standard 30/09/2005 Housing assistance, Standard 23/08/2010 Health, Standard 04/05/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010
Definition:	An indicator of the accuracy of the components of a reported date, as represented by a code.
Data Element Concept:	Date—accuracy indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AAA
Maximum character length:	3

Permissible values:

Value	Meaning
AAA	Day, month and year are accurate
AAE	Day and month are accurate, year is estimated
AAU	Day and month are accurate, year is unknown
AEE	Day is accurate, month and year are estimated
AEU	Day is accurate, month is estimated, year is unknown
AUU	Day is accurate, month and year are unknown
AUA	Day is accurate, month is unknown, year is accurate

AUE	Day is accurate, month is unknown, year is estimated
AEA	Day is accurate, month is estimated, year is accurate
EAA	Day is estimated, month and year are accurate
EAE	Day is estimated, month is accurate, year is estimated
EAU	Day is estimated, month is accurate, year is unknown
EEA	Day and month are estimated, year is accurate
EEE	Day, month and year are estimated
EEU	Day and month are estimated, year is unknown
EUA	Day is estimated, month is unknown, year is accurate
EUE	Day is estimated, month is unknown, year is estimated
EUU	Day is estimated, month and year are unknown
UAA	Day is unknown, month and year are accurate
UAE	Day is unknown, month is accurate, year is estimated
UAU	Day is unknown, month is accurate, year is unknown
UEA	Day is unknown, month is estimated, year is accurate
UEE	Day is unknown, month and year are estimated
UEU	Day is unknown, month is estimated, year is unknown
UUA	Day and month are unknown, year is accurate
UUE	Day and month are unknown, year is estimated

UUU	Day, month and year are unknown

Collection and usage attributes

Guide for use:

Any combination of the values A, E, U representing the corresponding level of accuracy of each date component of the reported date.

This data element consists of a combination of three codes, each of which denotes the accuracy of one date component:

A – the referred date component is accurate

E – the referred date component is not known but is estimated

U – the referred date component is not known and not estimated.

This data element contains positional fields (DMY) that reflects the order of the date components in the format (DDMMYYYY) of the reported date:

Field 1 (D) – refers to the accuracy of the day component;

Field 2 (M) – refers to the accuracy of the month component;

Field 3 (Y) – refers to the accuracy of the year component.

Data domain	Date component (for a format DDMMYYYY)		
	(D)ay	(M)onth	(Y)ear
Accurate	A	A	A
Estimated	E	E	E
Unknown	U	U	U

This data element is valid only for use with dates that are reported/exchanged in the format (DDMMYYYY).

Example 1: A date has been sourced from a reliable source and is known as accurate then the Date accuracy indicator should be informed as (AAA).

Example 2: If only the age of the person is known and there is no certainty of the accuracy of this, then the Date accuracy indicator should be informed as (UUE). That is the day and month are “unknown” and the year is “estimated”.

Example 3: If a person was brought in unconscious to an emergency department of a hospital and the only information available was from a relative who was certain of the age and the birthday's 'month' then the Date accuracy indicator should be informed as (UAA). A year derived from an accurate month and accurate age is always an accurate year.

The Date accuracy indicator can be useful for operational purposes to indicate the level of accuracy that a date has been collected at any point in time. It can indicate whether the stored date needs to be followed up until it reaches the intended minimal required accuracy. For example, if a person was brought in unconscious to an emergency department of a hospital the level of accuracy of the date collected at that point may not be satisfactory. It is likely that the correct date of birth can be obtained at a later date. The Date accuracy indicator provides information on the accuracy of the entered dates that may require further action.

For future users of the data it may also be essential they know the accuracy of the date components of a reported date.

Data element attributes

Collection and usage attributes

Collection methods:

Collection constraints:

If constraints for the collection of the date are imposed, such as 'a valid date must be input in an information system for unknown date components', the Date accuracy indicator should be used along with the date as a way of avoiding the contamination of the valid dates with the same value on the respective date components.

Example:

Some jurisdictions use 0107YYYY and some use 0101YYYY when only the year is known. When month and year are known some use the 15th day as the date i.e. 15MMYYYY. Where this occurs in a data collection that is used for reporting or analysis purposes there will be dates in the collection with the attributes 0107YYYY etc that are accurate and some that are not accurate. Without a corresponding flag to determine this accuracy the analysis or report will be contaminated by those estimated dates.

Comments:

Provision of a date is often a mandatory requirement in data collections.

Most computer systems require a valid date to be recorded in a date field i.e. the month part must be an integer between 1 and 12, the day part must be an integer between 1 and 31 with rules about the months with less than 31 days, and the year part should include the century. Also in many systems, significant dates (e.g. date of birth) are mandatory requirements.

However, in actual practice, the date or date components are often not known (e.g. date of birth, date of injury) but, as stated above, computer systems require a valid date. This means that a date MUST be included and it MUST follow the rules for a valid date. It therefore follows that, while such a date will contain valid values according to the rules for a date, the date is in fact an ‘unknown’ or ‘estimated’ date. For future users of the data it is essential they know that a date is accurate, unknown or estimated and which components of the date are accurate, unknown or estimated.

Source and reference attributes

Submitting organisation: Standards Australia

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

Relational attributes

Related metadata references:

See also Health-care incident—date health-care incident occurred, DDMMYYYY Health, Standard 07/12/2011

See also Individual service provider—occupation end date, DDMMYYYY Community Services, Standard 30/09/2005, Health, Standard 04/05/2005

See also Individual service provider—occupation start date, DDMMYYYY Community Services, Standard 30/09/2005, Health, Standard 04/05/2005

See also Medical indemnity claim management episode—medical indemnity claim finalisation date, DDMMYYYY Health, Standard 07/12/2011

See also Medical indemnity claim management episode—reserve placement date, DDMMYYYY Health, Standard 07/12/2011

See also Medical indemnity claim—medical indemnity claim commencement date, DDMMYYYY Health, Standard 07/12/2011

See also Person—date of birth, DDMMYYYY Community Services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010, Tasmanian Health, Proposed 28/09/2011

See also Person—date of birth, MMYYYY Health, Standard 10/12/2009

See also Record—linkage key, code 581 XXXXXDDMMYYYYN Community Services, Standard 21/05/2010, Housing assistance, Standard 23/08/2010, Health, Standard 07/12/2011, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

See also Statistical linkage key 581 cluster Community Services, Standard 21/05/2010, Housing assistance, Standard 23/08/2010, Health, Standard 07/12/2011, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Standard 07/12/2011

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Medical indemnity DSS Health, Standard 07/12/2011

Statistical linkage key 581 cluster Community Services, Standard 21/05/2010
Housing assistance, Standard 23/08/2010
Health, Standard 07/12/2011
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Conditional obligation:
Where a date of birth is estimated the date accuracy indicator should be used

Date C-reactive protein level measured

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—C-reactive protein level measured date, DDMMYYYY

Synonymous names: CRP measured date

METeOR identifier: 338280

Registration status: Health, Standard 01/10/2008

Definition: The date a person's C-reactive protein (CRP) level is measured.

Data Element Concept: Person—C-reactive protein level measured date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Collection methods: The date C-reactive protein (CRP) is measured should be recorded from the laboratory report.

Relational attributes

Related metadata references: See also Person—C-reactive protein level (measured), total milligrams per litre N[NN].N Health, Standard 01/10/2008

See also Person—C-reactive protein level measured time, hhmm Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date creatine kinase MB isoenzyme measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme measured date, DDMMYYYY
METeOR identifier:	284973
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which the person's creatine kinase myocardial band isoenzyme (CK-MB) is measured.
Data Element Concept:	Person—creatine kinase myocardial band isoenzyme measured date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item pertains to the measuring of creatine kinase myocardial band (CK-MB) isoenzyme at any time point during this current event.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Date creatine kinase MB isoenzyme (CK-MB) measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)
Implementation in Data Set	Acute coronary syndrome (clinical) DSS Health, Standard

Specifications: 01/10/2008

Date creatinine serum level measured

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—creatinine serum level measured date, DDMMYYYY

METeOR identifier: 343843

Registration status: Health, Standard 01/10/2008

Definition: The date when the person's creatinine serum level was measured.

Data Element Concept: Person—creatinine serum level measured date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Collection methods: Record the date of the most recent creatinine serum level measurement taken in the last 12 months.

Date to be recorded from documentation on the laboratory test results and/or the medical record.

Relational attributes

Related metadata references: See also Person—creatinine serum level, micromoles per litre NN[NN] Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date health-care incident occurred

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health-care incident—date health-care incident occurred, DDMMYYYY
METeOR identifier:	329661
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which a health-care incident occurred, expressed as DDMMYYYY.
Data Element Concept:	Health-care incident—date health-care incident occurred

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

The date should reflect when the primary incident or allegation type occurred. Where the 'Primary incident or allegation type' reflects a series of events that occurred over a period of months (for example, repeated failure to diagnose a condition), the date when the first event occurred should be recorded. For example, where a missed diagnosis was the main, dominant or primary cause giving rise to a medical indemnity claim, the date recorded should reflect when the diagnosis should first have been made, but was not.

This data element should be used in conjunction with the data element: *Date—accuracy indicator, code AAA* to flag whether each component of the date reported is accurate, estimated or unknown.

Comments:

This data element is equivalent to the Australian Prudential Regulation Authority (2006) National Claims and Policies Database data item 9 'Date of loss' which collects information on the date on which the incident giving rise to the claim is believed to have occurred.

It is recognised that 'date of discoverability' is recorded in some jurisdictions, and may also be used in the specification of the statutes of limitations in some jurisdictions. The date of discoverability may be some time after the health-care incident occurred; for example, where a doctor fails to diagnose a problem, this may not be discovered for some months. After discussion the Medical Indemnity Data Working Group agreed that the date 'when something went wrong' is likely to be more relevant in the context of the Medical Indemnity National Collection (Public Sector) than 'when it was discovered that something had gone wrong'.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: APRA (Australian Prudential Regulation Authority) 2006. Data specifications National Claims and Policies Database document number 3.1. Canberra: APRA

Relational attributes

Related metadata references: See also Date—accuracy indicator, code AAA Community Services, Standard 30/09/2005, Housing assistance, Standard 23/08/2010, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Date of acute coronary syndrome related clinical event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—acute coronary syndrome related clinical event date, DDMMYYYY
METeOR identifier:	349645
Registration status:	Health, Standard 01/10/2008
Definition:	The date a person experienced an acute coronary syndrome related clinical event.
Data Element Concept:	Person with acute coronary syndrome—acute coronary syndrome related clinical event date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

A date should be recorded for each of the specified clinical events that the person experiences while in hospital.

Comments:

An acute coronary syndrome (ACS) related clinical event is a clinical event which can affect the health outcomes of a person with ACS.

Information on the occurrence of these clinical events in people with ACS is required due to an emerging appreciation of their relationship with late mortality.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome clinical event cluster Health, Standard 01/10/2008

Conditional obligation:

If a clinical event has occurred, record the date when it was experienced by the person.

Date of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—date of birth, DDMMYYYY
METeOR identifier:	287007
Registration status:	Community Services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005 Health, Standard 04/05/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010 Tasmanian Health, Proposed 28/09/2011
Definition:	The date of birth of the person.
Data Element Concept:	Person—date of birth

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

If date of birth is not known or cannot be obtained, provision should be made to collect or estimate age. Collected or estimated age would usually be in years for adults, and to the nearest three months (or less) for children aged less than two years. Additionally, an estimated date flag or a date accuracy indicator should be reported in conjunction with all estimated dates of birth.

For data collections concerned with children's services, it is suggested that the estimated date of birth of children aged under 2 years should be reported to the nearest 3 month period, i.e. 0101, 0104, 0107, 0110 of the estimated year of birth. For example, a child who is thought to be aged 18 months in October of one year would have his/her estimated date of birth reported as 0104 of the previous year. Again, an estimated date flag or date accuracy indicator should be reported in conjunction with all estimated dates of birth.

Collection methods: Information on date of birth can be collected using the one question:

What is your/(the person's) date of birth?

In self-reported data collections, it is recommended that the following response format is used:

Date of birth: _ _ / _ _ / _ _ _ _

This enables easy conversion to the preferred representational layout (DDMMYYYY).

For record identification and/or the derivation of other metadata items that require accurate date of birth information, estimated dates of birth should be identified by a date accuracy indicator to prevent inappropriate use of date of birth data. The linking of client records from diverse sources, the sharing of patient data, and data analysis for research and planning all rely heavily on the accuracy and integrity of the collected data. In order to maintain data integrity and the greatest possible accuracy an indication of the accuracy of the date collected is critical. The collection of an indicator of the accuracy of the date may be essential in confirming or refuting the positive identification of a person. For this reason it is strongly recommended that the data element Date—accuracy indicator, code AAA also be recorded at the time of record creation to flag the accuracy of the data.

Comments: Privacy issues need to be taken into account in asking persons their date of birth.

Wherever possible and wherever appropriate, date of birth should be used rather than age because the actual date of birth allows a more precise calculation of age.

When date of birth is an estimated or default value, national health and community services collections typically use 0101 or 0107 or 3006 as the estimate or default for DDMM.

It is suggested that different rules for reporting data may apply when estimating the date of birth of children aged under 2 years because of the rapid growth and development of children within this age group which means that a child's development can vary considerably over the course of a year. Thus, more specific reporting of estimated age is suggested.

Source and reference attributes

Origin:

National Health Data Committee

National Community Services Data Committee

Reference documents:

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

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

Relational attributes

Related metadata references:

See also Date—accuracy indicator, code AAA Community Services, Standard 30/09/2005, Housing assistance, Standard 23/08/2010, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

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

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

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

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

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

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient

care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Supersedes Person—date of birth, DDMMYYYY Community Services, Superseded 25/08/2005, Health, Superseded 04/05/2005

Is used in the formation of Record—linkage key, code 581 XXXXXDDMMYYYYN Community Services, Standard 21/05/2010, Housing assistance, Standard 23/08/2010, Health, Standard 07/12/2011, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Cancer (clinical) DSS Health, Standard 07/12/2011

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

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

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Medical indemnity DSS Health, Standard 07/12/2011

Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Prison clinic contact DSS Health, Standard 25/08/2011

Prison entrants DSS Health, Standard 25/08/2011

Prisoners in custody repeat medications DSS Health, Standard 25/08/2011

Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Statistical linkage key 581 cluster Community Services, Standard 21/05/2010
Housing assistance, Standard 23/08/2010
Health, Standard 07/12/2011
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Date of cessation of treatment episode for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—treatment cessation date, DDMMYYYY
METeOR identifier:	270067
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a treatment episode for alcohol and other drugs ceases.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment cessation date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Refers to the date of the last service contact in a treatment episode between the client and staff of the treatment provider. In situations where the client has had no contact with the treatment provider for three months, nor is there a plan in place for further contact, the date of last service contact should be used. Refer to the glossary item **Cessation of treatment episode for alcohol and other drugs** to determine when a treatment episode ceases.

The date must be later than or the same as the treatment commencement date for the episode of treatment for alcohol and other drugs.

Comments:

Required to identify the cessation of a treatment episode by an alcohol and other drug treatment service.

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:	Supersedes Date of cessation of treatment episode for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)
Implementation in Data Set Specifications:	Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Date of change to qualification status

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY

METeOR identifier: 270034

Registration status: Health, Standard 01/03/2005

Definition: The date, within a newborn episode of care, on which the newborn's **Qualification status** changes from acute (qualified) to unqualified or vice versa.

Data Element Concept: Episode of admitted patient care (newborn)—date of change to qualification status

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: Record the date or dates on which the newborn's **Qualification status** changes from acute (qualified) to unqualified or vice versa.

If more than one change of qualification status occurs on a single day, the day is counted against the final qualification status.

Must be greater than or equal to admission date.

Relational attributes

Related metadata references: Supersedes Date of change to qualification status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Is used in the formation of Episode of admitted patient care (newborn)—number of qualified days, total N[NNNN]

Date of commencement of treatment episode for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—treatment commencement date, DDMMYYYY
METeOR identifier:	270069
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which the first service contact within the treatment episode when assessment and/or treatment occurs.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment commencement date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

- their treatment delivery setting for alcohol and other drugs has changed.

Comments: Required to identify the commencement of a treatment episode by an alcohol and other drug treatment service.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Commencement of treatment episode for alcohol and other drugs, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB)

Supersedes Date of commencement of treatment episode for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Date of completion of last previous pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy (last previous)—pregnancy completion date, DDMMYYYY
METeOR identifier:	270002
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which the pregnancy preceding the current pregnancy was completed.
Data Element Concept:	Pregnancy (last previous)—pregnancy completion date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Estimate day of month (DD), if first day is unknown.

Comments:

This metadata item is recommended by the World Health Organization. It is currently collected in some states and territories.

Interval between pregnancies may be an important risk factor for the outcome of the current pregnancy, especially for preterm birth and low **birthweight**.

Source and reference attributes

Submitting organisation:

National Perinatal Data Development Committee

Relational attributes

Related metadata references:

Supersedes Date of completion of last previous pregnancy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.6 KB)

Date of coronary artery bypass graft

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—coronary artery bypass graft date, DDMMYYYY
Synonymous names:	CABG date
METeOR identifier:	344424
Registration status:	Health, Standard 01/10/2008
Definition:	The date on which a coronary artery bypass graft (CABG) procedure is performed on a person.
Data Element Concept:	Person—coronary artery bypass graft date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Record the date of each CABG if more than one has been performed.

CABG includes grafts and valve replacement, but does not include valve replacement alone.

Collection methods:

The date/s should be recorded from the medical record.

Relational attributes

Implementation in Data Set Specifications:

Coronary artery cluster Health, Standard 01/10/2008

Conditional obligation:
Record when a coronary artery bypass graft is performed.

Date of death

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—date of death, DDMMYYYY
METeOR identifier:	287305
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The date of death of the person.
Data Element Concept:	Person—date of death

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Recorded for persons who have died.

Where Date of birth is collected, Date of death must be equal to or greater than Date of birth for the same person.

Collection methods:

It is recommended that in cases where all components of the date of death are not known or where an estimate is arrived at from age, a valid date be used together with a flag to indicate that it is an estimate.

For record identification and/or the derivation of other metadata items that require accurate date of death information, estimated dates of death should be identified by a date accuracy indicator to prevent inappropriate use of date of death data. The linking of client records from diverse sources, the sharing of patient data, and data analysis for research and planning all rely heavily on the accuracy and integrity of the collected data. In order to maintain data integrity and the greatest possible accuracy an indication of the accuracy of the date collected is critical. The collection of Date accuracy indicator may be essential in confirming or refuting the positive identification of a person. For this reason it is strongly recommended that the data element Date accuracy indicator also be recorded at the time of record creation to flag the accuracy of the data.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Health Data Standards Committee

Relational attributes

Related metadata references: Supersedes Date of death, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:
Recorded when the patient has died.

Health care provider identification DSS Health, Standard 03/12/2008

Date of diagnosis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date, DDMMYYYY
METeOR identifier:	270544
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a patient is diagnosed with a particular condition or disease.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Comments:

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

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Date of diagnosis, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (13.9 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Date of diagnosis of cancer

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Patient—diagnosis date of cancer, DDMMYYYY

METeOR identifier: 416129

Registration status: Health, Standard 07/12/2011

Definition: The date on which the patient was first diagnosed with cancer (whether at its primary site or as a metastasis), expressed as DDMMYYYY.

Data Element Concept: Patient—diagnosis date of cancer

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: Date of diagnosis must be:

- Greater than or equal to date of birth
- Less than or equal to date of death

Diagnosis of cancer after death:

If the patient is first diagnosed with the cancer in an autopsy report the date of diagnosis is the date of death as stated on the patient's death certificate.

Incidental diagnosis of cancer:

If a patient is admitted for another condition (for example a broken leg or pregnancy), and a cancer is diagnosed incidentally then the date of diagnosis is the date the cancer was diagnostically determined, not the admission date.

Collection methods: Reporting rules:

The date of diagnosis is the date of the pathology report, if any, that first confirmed the diagnosis of cancer. This date may be found attached to a letter of referral or a patient's medical record from another institution or hospital. If this date is unavailable, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence:

- Date of the consultation at, or admission to, the hospital, clinic or institution when the cancer was first diagnosed. Note: DO NOT use the admission date of the current admission if the patient had a prior diagnosis of this cancer.
- Date of first diagnosis as stated by a recognised medical practitioner or dentist. Note: This date may be found attached to a letter of referral or a patient's medical record from an institution or hospital.
- Date the patient states they were first diagnosed with cancer. Note: This may be the only date available in a few cases (for example, patient was first diagnosed in a foreign country).

If components of the date are not known, an estimate should be provided with an estimated date flag to indicate that it is estimated. If an estimated date is not possible, a standard date of 15 June 1900 should be used with a flag to indicate the date is not known. Additionally, a date accuracy indicator should be recorded in conjunction with the estimated date.

Comments: Patient administration system, cancer notification system, population cancer statistics, research.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: International Agency for Research on Cancer

World Health Organization

International Association of Cancer Registries

Reference documents: Modified from the definition presented by the New South Wales Inpatient Statistics Collection Manual 2000/2001

Relational attributes

Related metadata references: Supersedes Patient—diagnosis date (cancer), DDMMYYYY Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Date of diagnosis of first recurrence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date (first recurrence of cancer), DDMMYYYY
METeOR identifier:	288596
Registration status:	Health, Standard 04/06/2004
Definition:	The date a medical practitioner confirms the diagnosis of a recurrent or metastatic cancer of the same histology.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	The term `recurrence' defines the return, reappearance or metastasis of cancer (of the same histology) after a disease free period.
Comments:	This item is collected for determining the time interval from diagnosis to recurrence, from treatment to recurrence and from recurrence to death.

Source and reference attributes

Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Date of diagnosis of first recurrence, version 1,

	DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB)

Date of diagnosis of first recurrence as distant metastasis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date of first recurrence as distant metastasis, DDMMYYYY
METeOR identifier:	393841
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which a patient is diagnosed with the first recurrence as a distant metastasis of the same histology as the primary cancer, expressed as DDMMYYYY.
Data Element Concept:	Patient—diagnosis date of first recurrence as distant metastasis

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Record the date the first recurrence as distant metastasis is diagnosed.

The term recurrence defines the return, reappearance or metastasis of cancer (of the same histology) after a disease-free intermission or remission.

Distant metastasis refers to the spread of cancer of the same histology as the original (primary) tumour to distant organs or distant lymph nodes.

The date is based on the most definitive diagnostic information available and ideally will correspond to the date of the investigation recorded in data element *Person with cancer—most valid basis of diagnosis of the first recurrence, code N.* For instance, record the date of the first histological or, if unavailable, cytological investigation confirming the diagnosis of recurrence. If these investigations have not been performed, record the date of confirmation by clinical investigation.

This information should be obtained from the patient's medical record. In the first instance, the diagnosis date should be derived from the relevant investigation report; for example, tissue diagnosis from the pathology report and imaging from the imaging reports.

If the diagnosis is made on the basis of clinical examination, record the date this is performed. For example, this may be the date of a consultation, an outpatient appointment or the date the patient is admitted to hospital.

If the patient was diagnosed by clinical examination and/or investigations performed elsewhere, the date may be found in a letter of referral from a recognised medical practitioner or dentist. Usually the relevant test result, if applicable, will be attached to this.

In some cases, the date the patient states they were diagnosed with recurrence will be the only date available and should be recorded here. For example, the patient may have been diagnosed whilst overseas.

If components of the date are not known, an estimate should be provided where possible with an estimated date flag to indicate that it is estimated. If an estimated date is not possible, a standard date of 15 June 1900 should be used with a flag to indicate the date is not known.

Collection methods: This information should be obtained from the patient's medical record.

Comments: This data item is used to measure the efficacy of the initial course of treatment through evaluating the time interval from diagnosis to recurrence, treatment to recurrence and recurrence to death.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data

Standards (ROADS), Volume II, Commission on Cancer

Relational attributes

Related metadata references:

See also Patient—diagnosis date of first recurrence as locoregional cancer, DDMMYYYY Health, Standard 07/12/2011

See also Person with cancer—most valid basis of diagnosis of the first recurrence, code N Health, Standard 07/12/2011

See also Person with cancer—region of first recurrence as distant metastasis, topography code (ICD-O-3) ANN.N Health, Standard 07/12/2011

See also Person with cancer—region of first recurrence as locoregional cancer, topography code (ICD-O-3) ANN.N Health, Standard 07/12/2011

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on the patient being diagnosed with recurrence involving a distant metastasis.

Date of diagnosis of first recurrence as locoregional cancer

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Patient—diagnosis date of first recurrence as locoregional cancer, DDMMYYYY

METeOR identifier: 393837

Registration status: Health, Standard 07/12/2011

Definition: The date on which a patient is diagnosed with the first recurrence as locoregional cancer of the same histology as the primary cancer, expressed as DDMMYYYY.

Data Element Concept: Patient—diagnosis date of first recurrence as locoregional cancer

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: Record the date the first recurrence as locoregional cancer is diagnosed.

The term recurrence defines the return, reappearance or metastasis of cancer (of the same histology) after a disease free period.

Locoregional recurrence refers to the recurrence of cancer cells at the same site as the original (primary) tumour or the regional lymph nodes. A list of those lymph nodes defined as regional lymph nodes for each cancer site can be found in the TNM Classification of Malignant Tumours International Union Against Cancer (UICC) and the American Joint Committee on Cancer (AJCC) Cancer Staging Manual; the latest editions are recommended.

The date is based on the most definitive diagnostic information available and ideally should correspond to the date of the investigation recorded in data element *Person with cancer-most valid basis of diagnosis of the first recurrence, code N*. For instance, record the date of the first histological or if unavailable, cytological investigation confirming the diagnosis of recurrence. If these investigations have not been performed, record the date of confirmation by clinical investigation.

This information should be obtained from the patient's medical record. In the first instance, the diagnosis date should be derived from the relevant investigation report; for example, tissue diagnosis from the pathology report and imaging from the imaging reports.

If the diagnosis is made on the basis of clinical examination, record the date this is performed. For example, this may be the date of a consultation, an outpatient appointment or the date the patient is admitted to hospital.

If the patient was diagnosed by clinical examination and/or investigations performed elsewhere, the date may be found in a letter of referral from a recognised medical practitioner or dentist. Usually the relevant test result, if applicable, will be attached to this.

In some cases, the date the patient states they were diagnosed with recurrence will be the only date available and should be recorded here. For example, the patient may have been diagnosed whilst overseas.

If components of the date are not known, an estimate should be provided where possible with an estimated date flag to indicate that it is estimated. If an estimated date is not possible, a standard date of 15 June 1900 should be used with a flag to indicate the date is not known.

Collection methods: This information should be obtained from the patient's medical record.

Comments: This data item is used to measure the efficacy of the initial course of treatment through evaluating the time interval from diagnosis to recurrence, treatment to recurrence and recurrence to death.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data

Standards (ROADS), Volume II, Commission on Cancer

Relational attributes

Related metadata references:

See also Patient—diagnosis date of first recurrence as distant metastasis, DDMMYYYY Health, Standard 07/12/2011

See also Person with cancer—most valid basis of diagnosis of the first recurrence, code N Health, Standard 07/12/2011

See also Person with cancer—region of first recurrence as distant metastasis, topography code (ICD-O-3) ANN.N Health, Standard 07/12/2011

See also Person with cancer—region of first recurrence as locoregional cancer, topography code (ICD-O-3) ANN.N Health, Standard 07/12/2011

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on the patient being diagnosed with recurrence of locoregional cancer.

Date of diagnostic cardiac catheterisation

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—diagnostic cardiac catheterisation date, DDMMYYYY

Synonymous names: Date of coronary angiography

METeOR identifier: 359791

Registration status: Health, Standard 01/10/2008

Definition: The date when cardiac catheterisation is performed for diagnostic purposes.

Data Element Concept: Person—diagnostic cardiac catheterisation date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: This metadata item includes coronary angiography which is performed using a catheter.

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of electrocardiogram

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Electrocardiogram— electrocardiogram date, DDMMYYYY

Synonymous names: Date of ECG

METeOR identifier: 343820

Registration status: Health, Standard 01/10/2008

Definition: The date an electrocardiogram (ECG) is performed for a person.

Data Element Concept: Electrocardiogram—electrocardiogram date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Collection methods: The date of ECG should be recorded irrespective of the setting (e.g. pre-hospital setting, emergency department or inpatient ward).

The date of ECG should be recorded each time an ECG is performed.

Relational attributes

Implementation in Data Set Specifications: Electrocardiogram cluster Health, Standard 01/10/2008

Date of first contact

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Community nursing service episode—first contact date, DDMMYYYY

METeOR identifier: 270190

Registration status: Health, Standard 01/03/2005

Definition: The date of first contact with the community nursing service for an episode of care, between a staff member and a person or a person's family.

Data Element Concept: Community nursing service episode—first contact date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: This should occur after a previous last contact date of a previous care episode and prior to or on the same as first service delivery date.

Includes:

- visits made to a person in institutional settings such as liaison visits or discharge planning visits, made in a hospital or residential aged care service with the intent of planning for the future delivery of service at home;
- telephone contacts when these are in lieu of a first home or hospital visit for the purpose of preliminary assessment for care at home;
- visits made to the person's home prior to admission for the purpose of assessing the suitability of the home environment for the person's care.

This applies irrespective of whether the person is present or not.

Excludes:

- first visits where the visit objective is not met, such as first visit made where no one is home.

Collection methods: The first contact date can be the same as first service delivery date and apply whether a person is entering care for the first time or any subsequent episode. This date should be recorded when it is the same as the first delivery of service date.

Comments: This metadata item is recommended for use in community services which are funded for liaison or discharge planning positions or provide specialist consultancy or assessment services. Further developments in community care, including casemix and coordinated care will require collection of data relating to resource expenditure across the sector.

To enable analysis of time periods throughout a care episode, especially the pre-admission period and associated activities. This metadata item enables the capture of the commencement of care irrespective of the setting in which the activities took place.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Date of first contact, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.9 KB)

Date of first delivery of service

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of care (community setting)—first service delivery date, DDMMYYYY

METeOR identifier: 270210

Registration status: Health, Standard 01/03/2005

Definition: The date of first delivery of service to a person in a non-institutional setting.

Data Element Concept: Episode of care—first service delivery date (community setting)

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: This date may occur on the same day or prior to the Date of last delivery of service, but must never occur after that date within the current episode of care. The date may be the same as the Community nursing service episode—first contact date, DDMMYYYY.

Collection methods: As long as contact is made with the person in a non-institutional setting, the Episode of care (community setting)—first service delivery date, DDMMYYYY must be recorded. Normally this will be the first home or clinic visit and is the date most often referred to in a service agency as the admission. This date applies whether a person is being admitted for the first time, or is being re-admitted for care.

Comments: This metadata item is used for the analysis of time periods within a care episode and to locate that episode in time. The date relates to the first delivery of formal services within the community setting.

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

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Date of first delivery of service, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.2 KB)

Date of functional stress test

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Functional stress test—test date, DDMMYYYY
METeOR identifier:	347054
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a functional stress test is performed on a person.
Data Element Concept:	Functional stress test—test date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use: The date should always be recorded when a functional stress test is performed.

Relational attributes

Implementation in Data Set Specifications: Functional stress test cluster Health, Standard 01/10/2008

Conditional obligation:
To be provided when a functional stress test is performed.

Date of implantable cardiac defibrillator procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—implantable cardiac defibrillator procedure date, DDMMYYYY
Synonymous names:	ICD procedure date
METeOR identifier:	359611
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a procedure is performed for insertion of an implantable cardiac defibrillator (ICD).
Data Element Concept:	Person—implantable cardiac defibrillator procedure date

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of intra-aortic balloon pump procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—intra-aortic balloon pump procedure date, DDMMYYYY
METeOR identifier:	359623
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a procedure is performed for insertion of an intra-aortic balloon pump.
Data Element Concept:	Person—intra-aortic balloon pump procedure date

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of intravenous fibrinolytic therapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—intravenous fibrinolytic therapy date, DDMMYYYY
METeOR identifier:	356921
Registration status:	Health, Standard 01/10/2008
Definition:	The date intravenous (IV) fibrinolytic therapy was first administered or initiated.
Data Element Concept:	Person—intravenous fibrinolytic therapy date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	If initiated by a bolus dose whether in a pre-hospital setting, emergency department or inpatient unit/ward, the date the initial bolus was administered should be recorded.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—intravenous fibrinolytic therapy date, DDMMYYYY Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008 *Conditional obligation:* If prescribed, provide the date when the fibrinolytic therapy is administered.

Date of last contact

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Community nursing service episode—last contact date, DDMMYYYY
METeOR identifier:	270191
Registration status:	Health, Standard 01/03/2005
Definition:	Date of the last contact between a staff member of the community service and a person in any setting.
Data Element Concept:	Community nursing service episode—last contact date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

This could be the same as the date of discharge.

Includes:

- visits made to persons in institutional settings for the purpose of handing over or otherwise completing a care episode;
- bereavement visits in any setting;
- visits made to the person's home to complete the service, including the collection of equipment.

Excludes:

- visits made by liaison/discharge planning staff of a community service for the purpose of assessment of need related to a subsequent episode of care.

Comments:

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

To enable analysis of time periods throughout a care episode, especially the bereavement period. This date has been included in order to capture the end of a care episode in terms of involvement of the community nursing service.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Date of last contact, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Date of last contact—cancer patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—date of last contact, DDMMYYY
METeOR identifier:	394060
Registration status:	Health, Standard 07/12/2011
Definition:	The date of last contact with the patient, expressed as DDMMYYYY.
Data Element Concept:	Patient—date of last contact

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Record the date on which the patient was last known to be alive.

The date of last contact may be used for administrative purposes in conjunction with the patient's last known cancer status to identify how complete the treatment information is.

The last contact date may, for example, be the discharge date of an inpatient stay, the date of an outpatient appointment, the date of an investigation such as a scan or the date of a home visit by, for instance, a palliative care nurse or occupational therapist.

The last contact date may also be derived from an official source, for example, a letter from a physician detailing the patient's last follow-up appointment.

Many hospitals conduct routine follow-up of patients and the last contact date may result from a phone call to the patient.

The date of last contact should be updated as required.

If the patient has multiple primary cancers, all records should have the same date of last contact.

The date of death is collected as a separate item.

The date of last contact must be:

- Greater than the date of diagnosis, and
- Less than or equal to the date of death.

Collection methods: The information should be collected from the patient's medical record.

Comments: This information is used for patient follow-up and outcome studies.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents:

Relational attributes

Related metadata references: See also Patient—cancer status, code N Health, Standard 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Date of most recent stroke

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—most recent stroke date, DDMMYYYY
Synonymous names:	CVA date
METeOR identifier:	338263
Registration status:	Health, Standard 01/10/2008
Definition:	The date of the most recent cerebrovascular accident or stroke experienced by a person.
Data Element Concept:	Person—most recent stroke date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Collection methods:	The date should be self-reported by the person or recorded by the clinician based on the notes in the medical record. The occurrence of a stroke should be evidenced by a record of cerebral imaging (CT or MRI).

Relational attributes

Related metadata references:	See also Person—clinical evidence status (stroke), code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of non-invasive ventilation administration

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—non-invasive ventilation administration date, DDMMYYYY

METeOR identifier: 359637

Registration status: Health, Standard 01/10/2008

Definition: The date when non-invasive ventilation is administered.

Data Element Concept: Person—non-invasive ventilation administration date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of onset of acute coronary syndrome symptoms

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—acute coronary syndrome symptoms onset date, DDMMYYYY
Synonymous names:	Date of onset of ACS symptoms
METeOR identifier:	321201
Registration status:	Health, Standard 01/10/2008
Definition:	The date on which a person experienced acute coronary syndrome symptoms that prompted the person to seek medical attention, either at the hospital or from a general practitioner.
Data Element Concept:	Person—acute coronary syndrome symptoms onset date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Acute coronary syndrome symptoms may include:

- tightness, pressure, heaviness, fullness or squeezing in the chest which may spread to the neck and throat, jaw, shoulders, the back, upper abdomen, either or both arms and even into the wrist and hands
- dyspnoea, nausea/vomiting, cold sweat or syncope.

Seeking medical attention could include the person presenting to their GP who then refers them to hospital or the person presenting directly to hospital (via ambulance or own form of transport).

If the person is already a patient at the hospital for another reason then the date would be when they advised hospital staff of their symptoms.

Collection methods: Record the date that the person identifies as being when the most significant acute coronary syndrome symptom/s occurred that prompted them to seek medical attention.

Relational attributes

Related metadata references: See also Person—acute coronary syndrome risk stratum, code N Health, Superseded 01/10/2008

See also Person—acute coronary syndrome symptoms onset time, hhmm Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of pacemaker insertion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—pacemaker insertion date, DDMMYYYY
METeOR identifier:	359591
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a procedure is performed for insertion of a pacemaker.
Data Element Concept:	Person—pacemaker insertion date

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of primary percutaneous coronary intervention

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—primary percutaneous coronary intervention date, DDMMYYYY
Synonymous names:	Primary PCI date
METeOR identifier:	359175
Registration status:	Health, Standard 01/10/2008
Definition:	Date of the primary percuatenous coronary intervention (PCI).
Data Element Concept:	Person—primary percutaneous coronary intervention date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Primary PCI relates to the first balloon angioplasty inflation and/or stent implantation for reperfusion therapy of a ST-segment-elevation myocardial infarction (STEMI).

The date or the first balloon angioplasty inflation should be recorded, even if this includes implantation of a stent.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Related metadata references: Supersedes Person—first angioplasty balloon inflation or stenting date, DDMMYYYY Health, Superseded 01/10/2008

Implementation in Data Set Coronary artery cluster Health, Standard 01/10/2008

Specifications: *Conditional obligation:*
Record when a primary percutaneous coronary intervention is performed.

Date of procedure

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of admitted patient care (procedure)—procedure commencement date, DDMMYYYY

METeOR identifier: 270298

Registration status: Health, Standard 01/03/2005

Definition: The date on which a procedure commenced during an inpatient episode of care.

Data Element Concept: Episode of admitted patient care (procedure)—procedure commencement date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: Admitted patients:

Record date of procedure for all procedures undertaken during an episode of care in accordance with the current edition of ICD-10-AM.

Collection methods: Date of procedure >= admission date

Date of procedure <= separation date

Comments: The National Centre for Classification in Health advises the Health Data Standards Committee of relevant changes to the ICD-10-AM.

Required to provide information on the timing of the procedure in relation to the episode of care.

Source and reference attributes

Origin: National Centre for Classification in Health

National Health Data Committee

Reference documents: Australian Institute of Health and Welfare (AIHW) 2000. Australian hospital statistics 1998-1999. AIHW cat. no. HSE 11. Canberra: AIHW (Health Services Series no. 15)

Relational attributes

Related metadata references: Supersedes Date of procedure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Date of referral to rehabilitation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—referral to rehabilitation service date, DDMMYYYY
METeOR identifier:	269993
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a person is referred to a rehabilitation service.
Data Element Concept:	Health service event—referral to rehabilitation service date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	If date of referral is not known then provision should be made to collect month and year as a minimum, using 01 as DD (as the date part) if only the month and year are known.
Collection methods:	To be collected at the time of commencement of rehabilitation.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Date of referral to rehabilitation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.2 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Date of rescue percutaneous coronary intervention

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—rescue percutaneous coronary intervention date, DDMMYYYY

Synonymous names: Rescue PCI date

METeOR identifier: 359580

Registration status: Health, Standard 01/10/2008

Definition: The date when rescue percutaneous coronary intervention (PCI) is performed.

Data Element Concept: Person—rescue percutaneous coronary intervention date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: Rescue PCI relates to balloon angioplasty inflation and/or stent implantation performed following failed fibrinolysis in patients with continuing or recurrent myocardial ischaemia.

Source and reference attributes

Reference documents: National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Coronary artery cluster Health, Standard 01/10/2008

Specifications:	*Conditional obligation:* Record when a rescue percutaneous coronary intervention is performed.

Date of revascularisation percutaneous coronary intervention

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—revascularisation percutaneous coronary intervention date, DDMMYYYY
Synonymous names:	Revascularisation PCI date
METeOR identifier:	359731
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a percutaneous coronary intervention (PCI) is performed for revascularisation.
Data Element Concept:	Person—revascularisation percutaneous coronary intervention date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Revascularisation PCI relates to balloon angioplasty inflation and/or stent implantation performed for subsequent restoration of blood flow.
Comments:	Routine revascularisation PCI may be performed after ST-segment-elevation myocardial infarction for people with objective evidence of recurrent myocardial infarction in whom there is spontaneous or inducible ischaemia or haemodynamic instability. Revascularisation PCI may also be performed for

treatment of high-risk non-ST-segment-elevation acute coronary syndrome.

Source and reference attributes

Reference documents: National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specifications: Coronary artery cluster Health, Standard 01/10/2008

Conditional obligation:
Record when a percutaneous coronary intervention is performed for revascularisation.

Date of triage

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—triage date, DDMMYYYY
Synonymous names:	Triage date
METeOR identifier:	474189
Registration status:	Health, Standard 30/01/2012
Definition:	The date on which the patient is **triaged**, expressed as DDMMYYYY.
Context:	Emergency department care.
Data Element Concept:	Non-admitted patient emergency department service episode—triage date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	This data element should not be completed for patients who have a Type of visit of 'Dead on arrival'.
Collection methods:	Collected in conjunction with the data element 'Non-admitted patient emergency department service episode—triage time, hhmm'.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:	Supersedes Non-admitted patient emergency department service episode—triage date, DDMMYYYY Health,

Superseded 30/01/2012

See also Non-admitted patient emergency department service episode—triage time, hhmm Health, Standard 30/01/2012

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:

This data item is to be recorded for patients who have one of the following Type of visit values recorded:

- Emergency department presentation;
- Return visit, planned;
- Pre-arranged admission;
- Patient in transit.

Date of ventricular ejection fraction test

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Ventricular ejection fraction test—test date, DDMMYYYY
Synonymous names:	Date EF measured
METeOR identifier:	344274
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a person's ventricular ejection fraction is measured.
Data Element Concept:	Ventricular ejection fraction test—test date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

Implementation in Data Set Specifications:

Ventricular ejection fraction cluster Health, Standard 01/10/2008

Conditional obligation:
To be provided when the ventricular ejection fraction is measured.

Date patient presents

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—presentation date, DDMMYYYY
METeOR identifier:	270393
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The date on which the patient/client presents for the delivery of a service.
Data Element Concept:	Health service event—presentation date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

For community health care, outreach services and services provided via telephone or telehealth, this may be the date on which the service provider presents to the patient or the telephone/telehealth session commences.

The date of patient presentation at the **Emergency department** is the earliest occasion of being registered clerically or triaged.

The date that the patient presents is not necessarily:

- the listing date for care (see listing date for care), nor
- the date on which care is scheduled to be provided, nor
- the date on which commencement of care actually occurs (for admitted patients see admission date, for hospital non-admitted patient care and community health care see service commencement date).

Source and reference attributes

Submitting organisation: National Institution Based Ambulatory Model Reference Group

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Date patient presents, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

See also Emergency department stay—presentation date, DDMMYYYY Health, Standard 22/12/2011

Is used in the formation of Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN Health, Superseded 23/05/2012

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

Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to service delivery), total minutes NNNNN Health, Superseded 22/12/2009

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date patient presents—emergency department stay

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Emergency department stay—presentation date, DDMMYYYY

METeOR identifier: 471886

Registration status: Health, Standard 22/12/2011

Definition: The date on which the patient/client presents for the delivery of an emergency department service, expressed as DDMMYYYY.

Data Element Concept: Emergency department stay—presentation date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: The date of patient presentation at the emergency department is the date of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process whichever happens first.

Source and reference attributes

Submitting organisation: National Institution Based Ambulatory Model Reference Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: See also Health service event—presentation date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN Health, Superseded 30/01/2012

Is used in the formation of Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN Health, Standard 30/01/2012

Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Date troponin measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin level measured date, DDMMYYYY
METeOR identifier:	359422
Registration status:	Health, Standard 01/10/2008
Definition:	Date the person's troponin assay is measured.
Data Element Concept:	Person—troponin level measured date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item pertains to the measuring of troponin at any time point during this current event.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Person—troponin level measured date, DDMMYYYY Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Day program attendances

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of day centre attendances, total N[NNNN]
METeOR identifier:	270245
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the number of patient/client visits to day centres.
Data Element Concept:	Establishment—number of day centre attendances

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN]
Maximum character length:	5
Unit of measure:	Attendance

Data element attributes

Collection and usage attributes

Comments:

This metadata item is derived from components that are not currently specified in METeOR, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc.

Required to measure adequately non-admitted patient services in psychiatric hospitals and alcohol and drug hospitals.

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

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Day program attendances, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Degree of spread of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—degree of spread of a cancer, code N
METeOR identifier:	270180
Registration status:	Health, Standard 01/03/2005
Definition:	Degree of spread of cancer is a measure of the progression/extent of cancer at a particular point in time, as represented by a code.
Data Element Concept:	Person with cancer—degree of spread of a cancer

Value domain attributes

Representational attributes

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

	Value	Meaning
Permissible values:	1	Localised to the tissue of origin
	2	Invasion of adjacent tissue or organs
	3	Regional lymph nodes
	4	Distant metastases
	5	Not Applicable
Supplementary values:	9	Unknown

Collection and usage attributes

Guide for use:

The valid values for the variable are listed below.

CODE 1 Localised to the tissue of origin

Includes a primary cancer where the spread is contained within the organ of origin. Note: this includes in situ breast (D05.0-D05.9) and in situ melanoma (D03.0-D03.9)

Example 1: For colon cancer, the cancer has not progressed into the adventitia (peritoneal layer) surrounding the colon.

Example 2: For breast cancer, the cancer has not progressed into the underlying muscle layer (pectoral) or externally to the skin.

Example 3: For melanoma of the skin, the cancer has not invaded the subcutaneous fat layer (that is, it is contained within the dermis and epidermis).

Example 4: For lung cancer, the cancer has not invaded the pleura.

CODE 2 Invasion of adjacent tissue or organs

A primary cancer has spread to adjacent organs or tissue not forming part of the organ of origin. This category includes sub-cutaneous fat or muscle and organs adjacent to the primary cancer site.

Example 1: For colon cancer, the cancer has progressed into the adventitia (peritoneal layer) surrounding the colon.

Example 2:For breast cancer, the degree of spread has progressed into the underlying muscle layer (pectoral) or externally into the skin.

Example 3: For melanoma of the skin, the cancer has invaded into subcutaneous fat or muscle.

Example 4: For lung cancer, the cancer has invaded the pleura or tissues of the mediastinum.

CODE 3 Regional lymph nodes

The primary cancer has metastasised to the nearby draining lymph nodes. The list below shows the regional lymph nodes by site of primary cancer (International Union Against Cancer's definition).

Head and neck - Cervical nodes

Larynx - Cervical nodes

Thyroid - Cervical and upper mediastinal nodes

Stomach - Perigastric nodes along the lesser and greater curvatures

Colon and Rectum - Pericolic, perirectal, and those located along the ileocolic, right colic, middle colic, left colic, inferior mesenteric and superior rectal

Anal - Perirectal, internal iliac, and inguinal lymph nodes

Liver - Hilar nodes, e.g. the hepatoduodenal ligament

Pancreas - Peripancreatic nodes

Lung - Intrathoracic, scalene and supraclavicular

Breast - Axillary, interpectoral, internal mammary

Cervix - Paracervical, parametrial, hypogastric, common, internal and external iliac, presacral and sacral

Ovary - Hypogastric (obturator), common iliac, external iliac, lateral, sacral, para-aortic and inguinal

Prostate and bladder - Pelvic nodes below the bifurcation of the common iliac arteries

Testes - Abdominal, para-aortic and paracaval nodes, the intrapelvic and inguinal nodes

Kidney - Hilar, abdominal, para-aortic or paracaval.

CODE 4 Distant metastases

The primary cancer has spread to sites distant to the primary site, for example liver and lung and bone, or any lymph nodes not stated as regional to the site (see '3 - Regional lymph nodes' above).

CODE 5 Not applicable

This category applies for lymphatic and haematopoietic cancers, e.g. myelomas, leukaemias and lymphomas (C81.0 - C96.9) only.

CODE 9 Unknown

No information is available on the degree of spread at this episode or the available information is insufficient to allow classification into one of the preceding categories.

Data element attributes

Source and reference attributes

Submitting organisation: World Health Organization
New South Wales Health Department

Origin: International Classification of Diseases for Oncology, Second Edition (ICD-O-2) New South Wales Inpatient Statistics Collection Manual-2000/2001

Relational attributes

Related metadata references: Supersedes Degree of spread of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.6 KB)

Department of Veterans' Affairs file number

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—government funding identifier, Department of Veterans' Affairs file number AAXXNNNNA

METeOR identifier: 339127

Registration status: Community Services, Standard 31/08/2007
Health, Standard 29/11/2006

Definition: A unique personal identifier issued to a veteran by the Department of Veterans' Affairs.

Data Element Concept: Person—government funding identifier

Value domain attributes

Representational attributes

Representation class: Identifier

Data type: String

Format: AAXXNNNN[A]

Maximum character length: 9

Collection and usage attributes

Guide for use: 1st character is the state code (an alphabetic character) - N, V, Q, W, S or T for the appropriate state/territory. Australian Capital Territory is included in New South Wales (N) and Northern Territory with South Australia (S).

Next 7 characters are the file number, made up of:
War code + numeric digits, where:
if War code is 1 alphabetic character, add 6 numeric characters (ANNNNNN)

Where there is no war code as is the case with World War 1 veterans, insert a blank and add 6 numeric characters (NNNNNN)

if War code is 2 alphabetic characters, add 5 numeric characters (AANNNNN)
if War code is 3 alphabetic characters, add 4 numeric characters (AAANNNN)

The 9th character is the segment link. For dependents of veterans, the 9th character is always an alphabetic character. The alphabetic code is generated in the order by which the cards are issued. For example A, B, C, D etc.

CAUTIONARY NOTE: For veterans the 9th character is left blank

Data element attributes

Collection and usage attributes

Collection methods:

The Department of Veterans' Affairs file number should only be collected from persons eligible to receive health services that are to be funded by the DVA. The number may be reported to the appropriate government agency to reconcile payment for the service provided.

DVA card number:

This number is the digitised version of the file number. If paper claims are optically scanned by the Health Insurance Commission, the digitised version of the file number is picked up by the scanner and converted to the normal file number format. For manual claims, the gold and white cards may be used in conjunction with the data element and an imprinter. This method records the DVA file number and other card details on a manual voucher.

The data should not be used by private sector organisations for any purpose unless specifically authorised by law. For example, private sector organisations should not use the DVA file number for data linking unless specifically authorised by relevant privacy legislation.

This number must be recorded by a service provider each time a service is provided to a person who holds the entitlement for reimbursement purposes.

Comments:

All veterans and veteran community clients are issued with a DVA file number. The veteran community may access many different benefits, ranging from pensions to health services, through their DVA file number.

Note that Veterans may have a Medicare card number and a Department of Veterans Affairs (DVA) number or only a DVA number.

DVA has three (3) types of health cards:

- Gold Card
- White Card
- Repatriation Pharmaceutical Benefits Card.

Each card indicates, to the health provider, the level of health services the holder is eligible for, at the DVA expense.

The Gold card enables the holder to access a comprehensive range of health care and related services, for all conditions, whether they are related to war service or not.

The White card enables the holder to access health care and associated services for war or service-related conditions. Veterans of Australian forces may also be issued this card to receive treatment for malignant cancer, pulmonary tuberculosis and post traumatic stress disorder and, for Vietnam veterans only, anxiety or depression, irrespective of whether these conditions are related to war service or not.

The white card holders are eligible to receive, for specific conditions, treatment from registered medical, hospital, pharmaceutical, dental and allied health care providers with whom DVA has arrangements.

A white card is also issued to eligible ex-service personnel who are from other countries, which enter into arrangements with the Australian government for the treatment of the conditions that these countries accept as war related.

When a gold/white card holder accesses health services at DVA expense, the DVA File Number is critical and should be used. The person's Medicare card number is not required or relevant.

It should be noted that there are a number of gold card holders who do not have a Medicare card.

The Repatriation Pharmaceutical Benefits card is an orange coloured card issued to eligible veterans and merchant mariners from Britain and the Commonwealth and other allied countries. This card enables the holder to access the range of pharmaceutical items available under the Repatriation Pharmaceutical Benefits Scheme. It does not provide access to other health services.

Source and reference attributes

Origin: Department of Veterans' Affairs

Relational attributes

Related metadata references: Supersedes Person—government funding identifier, Department of Veterans' Affairs file number AAXXNNNN[A] Health, Superseded 29/11/2006

Department of Veterans' Affairs patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—funding eligibility indicator (Department of Veterans Affairs), code N
METeOR identifier:	270092
Registration status:	Health, Standard 01/03/2005
Definition:	Whether an eligible person's charges for this hospital **admission** are met by the Department of Veterans' Affairs (DVA), as represented by a code.
Context:	Health services
Data Element Concept:	Episode of care—funding eligibility indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:	Refer to the Veterans' Entitlements Act 1986 for details of eligible DVA beneficiaries.
Collection methods:	Whether or not charges for this episode of care are met by the DVA is routinely established as part of hospital admission processes.
Comments:	Eligible veterans and war widow/widowers can receive free treatment at any public hospital, former Repatriation Hospitals (RHs) or a Veteran Partnering (VP) contracted private hospital as a private patient in a shared ward, with

the doctor of their choice. Admission to a public hospital does not require prior approval from the DVA.

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

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

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

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

To assist in analyses of utilisation and health care funding.

Relational attributes

Related metadata references: Supersedes Department of Veterans' Affairs patient, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.9 KB)

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Dependency in activities of daily living—bathing

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—dependency in activities of daily living (bathing), code N

METeOR identifier: 270413

Registration status: Health, Standard 01/03/2005

Definition: An indicator of a person's need for assistance with bathing, as represented by a code.

Context: Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.

Data Element Concept: Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some

	assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

Guide for use:

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—bed mobility

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—dependency in activities of daily living (bed mobility), code N

METeOR identifier: 270416

Registration status: Health, Standard 01/03/2005

Definition: An indicator of the level of a person's need for assistance with bed mobility, as represented by a code.

Context: Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.

Data Element Concept: Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance

3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent) - a hoist is used
5	2 persons physical assist is required

Data element attributes

Collection and usage attributes

Guide for use: Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores. Code 4: A hoist is used. Code 5: 2 persons physical assist is required.

Collection methods: Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—bladder continence

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—dependency in activities of daily living (bladder continence), code N

METeOR identifier: 270417

Registration status: Health, Standard 01/03/2005

Definition: An indicator of the level of a person's bladder continence, as represented by a code.

Context: Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.

Data Element Concept: Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Continent of urine (includes independence in use of device)
2	Incontinent less than daily

3	Incontinent once per 24 hour period
4	Incontinent 2-6 times per 24 hour period
5	Incontinent more than 6 times per 24 hour period
6	Incontinent more than once at night only

Data element attributes

Collection and usage attributes

Guide for use:

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—bowel continence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (bowel continence), code N
METeOR identifier:	270418
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the level of a person's bowel continence, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Continent of faeces (includes independence in use of device)
2	Incontinent less than daily

3	Incontinent once per 24 hour period
4	Incontinent regularly, more than once per 24 hour period
5	Incontinent more than once at night only

Data element attributes

Collection and usage attributes

Guide for use:

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—day-time technical nursing care requirement

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—technical nursing care requirement (day-time), total minutes NNN

METeOR identifier: 270420

Registration status: Health, Standard 01/03/2005

Definition: An indicator of a person's need for day-time technical nursing care per week measured in minutes.

Context: Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.

Data Element Concept: Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: NNN

Maximum character length: 3

Supplementary values:

Value	Meaning
1	No technical care requirements

Unit of measure: Minute (m)

Data element attributes

Collection and usage attributes

Guide for use:

Record the minutes of day-time technical care required per week.

Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

- medication administration (including injections)
- dressings and other procedures
- venipuncture
- monitoring of dialysis
- implementation of pain management technology.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—dressing

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—dependency in activities of daily living (dressing), code N

METeOR identifier: 270414

Registration status: Health, Standard 01/03/2005

Definition: An indicator of a person's need for assistance with dressing, as represented by a code.

Context: Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.

Data Element Concept: Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some

	assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

Guide for use:

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—eating

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—dependency in activities of daily living (eating), code N

METeOR identifier: 270415

Registration status: Health, Standard 01/03/2005

Definition: An indicator of a person's need for assistance with eating, as represented by a code.

Context: Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.

Data Element Concept: Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance

4	Full assistance required (totally dependent)
5	Tube-fed only

Data element attributes

Collection and usage attributes

Guide for use:

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—evening technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (evening), total minutes NNN
METeOR identifier:	270421
Registration status:	Health, Standard 01/03/2005
Definition:	A person's need for evening technical nursing care per week measured in minutes.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	1	No technical care requirements
Unit of measure:	Minute (m)	

Data element attributes

Collection and usage attributes

Guide for use: Record the minutes of evening technical care required per week.

Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

- medication administration (including injections)
- dressings and other procedures
- venipuncture
- monitoring of dialysis
- implementation of pain management technology.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods: Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—extra surveillance

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (extra surveillance), code N
METeOR identifier:	270419
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for additional individual attention and/or planned intervention in carrying out activities of daily living, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	No additional attention required
2	Less than 30 minutes individual attention

	per day
3	More than 30 and more than or equal to 90 minutes individual attention per day
4	Requires at least two hours intervention per week on an episodic basis
5	More than 90 minutes but less than almost constant individual attention
6	Requires almost constant individual attention
7	Cannot be left alone at all

Data element attributes

Collection and usage attributes

Guide for use:

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

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

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—infrequent technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (infrequent), total minutes NNN
METeOR identifier:	270423
Registration status:	Health, Standard 01/03/2005
Definition:	A person's need for infrequent technical nursing care per month measured in minutes.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNN
Maximum character length:	3
Supplementary values:	Value Meaning
	1 No technical care requirements
Unit of measure:	Minute (m)

Data element attributes

Collection and usage attributes

Guide for use:

Record the minutes of infrequent technical care required per month.

Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

- medication administration (including injections)
- dressings and other procedures
- venipuncture
- monitoring of dialysis
- implementation of pain management technology.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—mobility

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (mobility), code N
METeOR identifier:	270410
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with mobility, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some

	assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

Guide for use: Applies to walking, walking aid or wheelchair.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods: Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCN

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—night-time technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (night-time), total minutes NNN
METeOR identifier:	270422
Registration status:	Health, Standard 01/03/2005
Definition:	A person's need for night-time technical nursing care per week measured in minutes.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	1	No technical care requirements
Unit of measure:	Minute (m)	

Data element attributes

Collection and usage attributes

Guide for use:

Record the minutes of night-time technical care required per week.

Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

- medication administration (including injections)
- dressings and other procedures
- venipuncture
- monitoring of dialysis
- implementation of pain management technology.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—toileting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (toileting), code N
METeOR identifier:	270411
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with toileting, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some

	assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

Guide for use:

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups, etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data is gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in the Guide for Use.

The Person - Dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Reference documents:

ACCNS 1997. Community nursing minimum data set Australian version 2.0: data dictionary and guidelines. Melbourne: ACCNS.

Relational attributes

Related metadata references:

Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—transferring

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (transferring), code N
METeOR identifier:	270412
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with transferring, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some

	assistance
4	Full assistance required (totally dependent)
5	Person is bedfast

Data element attributes

Collection and usage attributes

Guide for use:

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Code 5: Person is bedfast.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Diabetes status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—diabetes mellitus status, code NN
METeOR identifier:	270194
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a person has or is at risk of diabetes, as represented by a code.
Data Element Concept:	Person—diabetes mellitus status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Permissible values:	Value	Meaning
	01	Type 1 diabetes
	02	Type 2 diabetes
	03	Gestational diabetes mellitus (GDM)
	04	Other (secondary diabetes)
	05	Previous gestational diabetes mellitus (GDM)
	06	Impaired fasting glucose (IFG)
	07	Impaired glucose tolerance (IGT)
	08	Not diagnosed with diabetes
	09	Not assessed
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use: Note that where there is a Gestational diabetes mellitus (GDM) or Previous GDM (i.e. permissible values 3 & 5) and a current history of Type 2 diabetes then record 'Code 2' Type 2 diabetes.

This same principle applies where a history of either Impaired fasting glycaemia (IFG) or Impaired glucose tolerance (IGT) and a current history and Type 2 diabetes, then record 'Code 2' Type 2 diabetes.

CODE 01 Type 1 diabetes

Beta-cell destruction, usually leading to absolute insulin deficiency. Includes those cases attributed to an autoimmune process, as well as those with beta-cell destruction and who are prone to ketoacidosis for which neither an aetiology nor pathogenesis is known (idiopathic). It does not include those forms of beta-cell destruction or failure to which specific causes can be assigned (e.g. cystic fibrosis, mitochondrial defects). Some subjects with Type 1 diabetes can be identified at earlier clinical stages than 'diabetes mellitus'.

CODE 02 Type 2 diabetes

Type 2 includes the common major form of diabetes, which results from defect(s) in insulin secretion, almost always with a major contribution from insulin resistance.

CODE 03 Gestational diabetes mellitus (GDM)

GDM is a carbohydrate intolerance resulting in hyperglycaemia of variable severity with onset or first recognition during pregnancy. The definition applies irrespective of whether or not insulin is used for treatment or the condition persists after pregnancy. Diagnosis is to be based on the Australian Diabetes in Pregnancy Society (ADIPS) Guidelines.

CODE 04 Other (secondary diabetes)

This categorisation include less common causes of diabetes mellitus, but are those in which the underlying defect or disease process can be identified in a relatively specific manner. They include, for example, genetic defects of beta-cell function, genetic defects in insulin action, diseases of the exocrine pancreas, endocrinopathies, drug or chemical-induced, infections, uncommon forms of immune-mediated diabetes, other genetic syndromes sometimes associated with diabetes.

CODE 05 Previous GDM

Where the person has a history of GDM.

CODE 06 Impaired fasting glycaemia (IFG)

IFG or 'non-diabetic fasting hyperglycaemia' refers to fasting glucose concentrations, which are lower than those required to diagnose diabetes mellitus but higher than the normal reference range. An individual is considered to have IFG if they have a fasting plasma glucose of 6.1 or greater and less than 7.0 mmol/L if challenged with an oral glucose load, they have a fasting plasma glucose concentration of 6.1 mmol/L or greater, but less than 7.0 mmol/L, AND the 2 hour value in the Oral Glucose Tolerance Test (OGTT) is less than 7.8 mmol/L.

CODE 07 Impaired glucose tolerance (IGT)

IGT is categorised as a stage in the natural history of disordered carbohydrate metabolism; subjects with IGT have an increased risk of progressing to diabetes. IGT refers to a metabolic state intermediate between normal glucose homeostasis and diabetes. Those individuals with IGT manifest glucose intolerance only when challenged with an oral glucose load. IGT is diagnosed if the 2 hour value in the OGTT is greater than 7.8 mmol/L. and less than 11.1 mmol/L AND the fasting plasma glucose concentration is less than 7.0 mmol/L.

CODE 08 Not diagnosed with diabetes

The subject has no known diagnosis of Type 1, Type 2, GDM, Previous GDM, IFG, IGT or Other (secondary diabetes).

CODE 09 Not assessed

The subject has not had their diabetes status assessed.

CODE 99 Not stated/inadequately described

This code is for unknown or information unavailable.

Collection methods: The diagnosis is derived from and must be substantiated by clinical documentation.

Source and reference attributes

Origin: Developed based on Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications Part 1: Diagnosis and Classifications of Diabetes Mellitus Provisional Report of a World Health Organization Consultation (Alberti & Zimmet 1998).

Data element attributes

Collection and usage attributes

Collection methods: Diabetes (clinical):

A type of diabetes should be recorded and coded for each episode of patient care.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

National Diabetes Data Working Group

Relational attributes

Related metadata references: Supersedes Diabetes status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (27.3 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

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

Indigenous primary health care DSS Health, Standard 07/12/2011

Diabetes therapy type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—diabetes therapy type, code NN
METeOR identifier:	270236
Registration status:	Health, Standard 01/03/2005
Definition:	The type of diabetes therapy the person is currently receiving, as represented by a code.
Data Element Concept:	Person—diabetes therapy type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Diet and exercise only
02	Oral hypoglycaemic - sulphonylurea only
03	Oral hypoglycaemic - biguanide (eg metformin) only
04	Oral hypoglycaemic - alpha-glucosidase inhibitor only
05	Oral hypoglycaemic - thiazolidinedione only
06	Oral hypoglycaemic - meglitinide only
07	Oral hypoglycaemic - combination (eg biguanide & sulphonylurea)
08	Oral hypoglycaemic - other
09	Insulin only
10	Insulin plus oral hypoglycaemic
98	Nil - not currently receiving diabetes

		treatment
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 01 Diet & exercise only

This code includes the options of generalised prescribed diet; avoid added sugar/simple carbohydrates (CHOs); low joule diet; portion exchange diet and uses glycaemic index and a recommendation for increased exercise.

CODE 98 Nil - not currently receiving diabetes treatment

This code is used when there is no current diet, tablets or insulin therapy(ies).

CODE 99 Not stated/inadequately described

Use this code when missing information.

Data element attributes

Collection and usage attributes

Collection methods: To be collected at the commencement of treatment and at each review.

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

The main use of this data element is to enable categorisation of management regimes against best practice for diabetes.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Cardiovascular Data Working Group

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

Relational attributes

Related metadata references: Supersedes Diabetes therapy type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.1 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Standard

22/12/2009

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

Diagnosis related group

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA
METeOR identifier:	391295
Registration status:	Health, Standard 22/12/2009 Tasmanian Health, Proposed 28/09/2011
Definition:	A patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital, as represented by a code.
Data Element Concept:	Episode of admitted patient care—diagnosis related group

Value domain attributes

Representational attributes

Classification scheme:	Australian Refined Diagnosis Related Groups version 6
Representation class:	Code
Data type:	String
Format:	ANNA
Maximum character length:	4

Data element attributes

Collection and usage attributes

Comments:	The Australian Refined Diagnosis Related Group is derived from a range of data collected on admitted patients, including diagnosis and procedure information, classified using ICD-10-AM. The data elements required are described in Related data elements.

Source and reference attributes

Origin:	National Centre for Classification in Health

Relational attributes

Related metadata references:	Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard

01/03/2005, Tasmanian Health, Proposed 28/09/2011

Supersedes Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is formed using Episode of admitted patient care—intended length of hospital stay, code N Health, Standard 01/03/2005

See also Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Episode of admitted patient care—procedure, code (ACHI 7th edn) NNNNN-NN Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Episode of admitted patient care—separation mode, code N Health, Standard 01/03/2005

Is formed using Episode of care—additional diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

Is formed using Episode of care—mental health legal status, code N Health, Superseded 07/12/2011

Is formed using Episode of care—principal diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is formed using Person—date of birth, DDMMYYYY Community Services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010, Tasmanian Health, Proposed 28/09/2011

Is formed using Person—sex, code N Community Services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Is formed using Person—weight (measured), total grams

NNNN Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Difficulty with activities

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—level of difficulty with activities in life areas, code (ICF 2001) N
METeOR identifier:	320120
Registration status:	Community Services, Standard 16/10/2006 Health, Standard 29/11/2006
Definition:	The level of difficulty a person has in performing the tasks and actions involved in specified life areas, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—level of difficulty with activities in a life area

Value domain attributes

Representational attributes

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

Permissible values:	Value	Meaning
	0	No difficulty
	1	Mild difficulty
	2	Moderate difficulty
	3	Severe difficulty
	4	Complete difficulty
Supplementary values:	8	Not specified
	9	Not applicable

Collection and usage attributes

Guide for use:

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

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

Difficulties with activities can arise when there is a qualitative or quantitative alteration in the way in which these activities are carried out. Difficulty includes matters such as 'with pain', 'time taken', 'number of errors', clumsiness', 'modification of manner in which an activity is performed' e.g. sitting to get dressed instead of standing. 'Difficulty' is a combination of the frequency with which the problem exists, the duration of the problem and the intensity of the problem. Activity limitations are assessed against a generally accepted population standard, relative to cultural and social expectations.

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

The user will select the code that most closely summarises, in terms of duration, frequency, manner or outcome, the level of difficulty of the person for whom the data is recorded.

CODE 0 No difficulty in this life area

Is used when there is no difficulty in performing this activity. This scale has a margin of error of 5%. [0-4%]

CODE 1 Mild difficulty

Is recorded for example, when the level of difficulty is below the threshold for medical intervention, the difficulty is experienced less than 25% of the time, and/or with a low alteration in functioning which may happen occasionally over the last 30 days. [5-24%]

CODE 2 Moderate difficulty

Is used for example when the level of difficulty is experienced less than 50% of the time and/or with a significant, but moderate effect on functioning (Up to half the scale of total performance) which may happen regularly over the last 30 days. [25-49%]

CODE 3 Severe difficulty

Is used for example when performance in this life area can be achieved, but with only extreme difficulty, and/or with an extreme effect on functioning which may happen often over the last 30 days. [50-95%]

CODE 4 Complete difficulty

Is used when the person can not perform in this life area due of the difficulty in doing so. This scale has a margin of error of 5%. [96-100%]

CODE 8 Not specified

Is used where a person has difficulty with activities in a life area but there is insufficient information to use codes 0-4.

CODE 9 Not applicable

Is used where a life area is not applicable to this person, e.g. domestic life for a child under 5.

Source and reference attributes

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

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

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

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

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

Data element attributes

Collection and usage attributes

Guide for use: This data element, in conjunction with Person—activities and participation life area, code (ICF 2001) AN[NNN], indicates the presence and extent of activity limitation in a given domain of activity.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health

Organization Family of International Classifications.

Relational attributes

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

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

Distress related to current imprisonment indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Prison entrant—distress related to current imprisonment indicator, yes/no/not applicable code N
METeOR identifier:	376102
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether any feelings of distress experienced by the prison entrant are related to their current imprisonment, as represented by a code.
Data Element Concept:	Prison entrant—distress related to current imprisonment indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not applicable

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Comments:

Perceived psychological distress is a non-specific dimension of psychopathology and it indicates that something is wrong. It does not necessarily involve a mental illness or require services from the mental health system. However, cultural variations in experiencing and expressing the inner feelings and emotions have to be taken into account when interpreting the results

(ECHIM 2008).

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	ECHIM (European Community Health Indicators Monitoring) 2008. Psychological Distress. ECHIM Products website, version 1.1, ECHIM project.

Relational attributes

Implementation in Data Set Specifications:	Prison entrants DSS Health, Standard 25/08/2011

Division of General Practice number

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Division of general practice—organisation identifier, NNN

METeOR identifier: 270014

Registration status: Health, Standard 01/03/2005

Definition: The unique identifier for the Division of general practice number as designated by the Commonwealth Government of Australia. Each separately administered Division of general practice has a unique identifying number.

Data Element Concept: Division of general practice—organisation identifier

Value domain attributes

Representational attributes

Representation class: Identifier

Data type: Number

Format: NNN

Maximum character length: 3

Data element attributes

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: The actual Division of General Practice numbers can be obtained by selecting the individual State or Territory from the *Divisions Directory* found within the Australian Division of General Practice website

Relational attributes

Related metadata references: Supersedes Division of general practice number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.2 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Dyslipidaemia treatment indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dyslipidaemia treatment with anti-lipid medication indicator (current), code N
METeOR identifier:	302440
Registration status:	Health, Standard 21/09/2005
Definition:	Whether a person is being currently treated for dyslipidaemia using anti-lipid medication, as represented by a code.
Data Element Concept:	Person—dyslipidaemia treatment with anti-lipid medication indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes: Record if a person is being treated for dyslipidaemia using anti-lipid medication.

CODE 2 No: Record if a person is not being treated for dyslipidaemia using anti-lipid medication.

Collection methods: Ask the individual if he/she is currently treated with anti-lipid medication. Alternatively obtain the relevant information from appropriate documentation.

Source and reference attributes

Submitting organisation: National diabetes data working group

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

Relational attributes

Related metadata references: Supersedes Person—dyslipidaemia treatment status (anti-lipid medication), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

ECG - Q waves indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—electrocardiogram Q waves indicator, yes/no code N
METeOR identifier:	347711
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether Q waves are present on a person's follow-up electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Person— electrocardiogram Q waves indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

Code 1 Yes

Record if Q waves are identified on the follow-up electrocardiogram.

Code 2 No

Record if no Q waves are identified on the follow-up electrocardiogram.

Collection methods:

Do not record the presence of Q waves for the initial ECG. This data element should only be collected for follow-up ECGs.

Relational attributes

Related metadata references:

See also Electrocardiogram—new Q waves indicator, yes/no code N Health, Standard 01/10/2008

Implementation in Data Set Specifications:

Electrocardiogram cluster Health, Standard 01/10/2008

Conditional obligation:
Record for all follow up electrocardiograms performed after the initial electrocardiogram.

Education attendance status 30 days prior to imprisonment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Prison entrant—education attendance status 30 days prior to imprisonment, education attendance status code N
METeOR identifier:	412959
Registration status:	Health, Standard 25/08/2011
Definition:	The self-reported education attendance status of a prison entrant 30 days prior to imprisonment, as represented by a code.
Data Element Concept:	Prison entrant—education attendance status 30 days prior to imprisonment

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Full-time study
	2	Part-time study
	3	Not studying
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Only one option may be selected.

CODE 1 Full-time study

According to the *Social Security Act 2001*, a person is considered a full-time student in respect of a course if:

(a) in the case of a person who is enrolled in the course for a particular study period (for example, a semester), the person is undertaking at least three-quarters of the normal amount of full-time study in respect of the course for that period; or

(b) in the case of a person who intends to enrol in the course for a particular study period, the person intends to undertake at least three-quarters of the normal amount of full-time study in respect of the course for that period.

CODE 2 Part-time study

This code is used when the study load is less than 75% of a full-time load.

CODE 9 Not stated/ inadequately described

Is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Australian Government. Social Security Act 1991. Viewed 18 October 2010

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data element *Prison entrant—labour force status 30 days prior to imprisonment, code N* to capture information on the extent of a person's engagement in employment and education.

Respondents should identify the level of study/training they were involved in prior to entering prison. Respondents can identify courses classified as full or part-time by the definition used by the education institution providing the course, regardless of hours involved or use the Centrelink and Department of Education, Employment and Workplace Relations definition outlined in the *Social Security Act*.

Comments: Capturing the extent of engagement in employment and education of people entering prison is an important factor when following a throughcare approach to reducing recidivism and increasing protective factors for people involved in the criminal justice system. Information on the activities undertaken by a person immediately prior to entering prison will assist in identifying a person's pathway to prison and thereafter.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Australian Government. Social Security Act 1991. Viewed 18 October 2010.

Relational attributes

Related metadata references: See also Prison entrant—labour force status 30 days prior to imprisonment, code N Health, Standard 25/08/2011

Implementation in Data Set Specifications: Prison entrants DSS Health, Standard 25/08/2011

Electrocardiogram—new Q waves indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Electrocardiogram—new Q waves indicator, yes/no code N

Synonymous names: ECG - new Q waves

METeOR identifier: 343902

Registration status: Health, Standard 01/10/2008

Definition: Whether the Q waves identified on a person's follow-up electrocardiogram (ECG) is new, as represented by a code.

Data Element Concept: Electrocardiogram—new Q waves indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes (New Q waves)

Use this code where the follow-up ECG identifies Q waves >=0.03 seconds in width and >=1mm (0.1mV) in depth in at least 2 contiguous leads that were not seen on the initial

ECG

CODE 2 No (Pre-existing Q waves)

Use this code where the follow-up ECG identifies Q waves >=0.03 seconds in width and >=1mm (0.1mV) in depth in at least 2 contiguous leads that were already seen on the initial ECG

CODE 9 Not stated/inadequately described

Includes unknown

Collection methods: Do not record whether the Q waves are new or not on the initial ECG. This data element should only be recorded for follow-up ECGs.

Comments: This data element identifies if new Q waves are present on the follow-up ECG. This information is valuable in coding transmural myocardial infarction.

Relational attributes

Related metadata references: See also Person—electrocardiogram Q waves indicator, yes/no code N Health, Standard 01/10/2008

Implementation in Data Set Specifications: Electrocardiogram cluster Health, Standard 01/10/2008

Conditional obligation:
Record if Q waves are present on the follow up electrocardiogram.

Electrocardiogram—lead V4R presence indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram—lead V4R presence indicator, yes/no code N
Synonymous names:	ECG - lead V4R indicator
METeOR identifier:	349656
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether lead V4R was performed on a person's electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—lead V4R presence indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Comments:

Lead V4R represents a lead placed on the chest aligned with the right mid-clavicular line, in the 5th intercostal space. The measurements from this lead can identify right ventricular infarction.

Lead V4R should be performed in the context of inferior infarction, especially in the presence of haemodynamic compromise.

Relational attributes

Related metadata references:	See also Electrocardiogram— ST-segment-elevation in lead V4R indicator, yes/no code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008

Electrocardiogram—ST-segment-elevation in lead V4R

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram— ST-segment-elevation in lead V4R indicator, yes/no code N
Synonymous names:	ECG - ST-segment-elevation lead V4R
METeOR identifier:	343889
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether ST-segment-elevation of greater than or equal to 1mm (0.1mV) in lead V4R of the electrocardiogram (ECG) is present, as represented by a code.
Data Element Concept:	Electrocardiogram—electrocardiogram ST-segment-elevation in lead V4R indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

ST-segment-elevation >= 1 mm (0.1 mV) in lead V4R

CODE 2 No

ST-segment-elevation in lead V4R of <= 1 mm (0.1 mV) or no ST-segment-elevation in lead V4R

CODE 9 Not stated/inadequately described

Includes unknown

Collection methods:

The presence (or absence) of ST-segment elevation in lead V4R should be recorded when right-sided precordial leads are performed in the ECG.

Comments:

ST-segment elevation in lead V4R represents right ventricular infarction.

Relational attributes

Related metadata references:

See also Electrocardiogram—lead V4R presence indicator, yes/no code N Health, Standard 01/10/2008

Implementation in Data Set Specifications:

Electrocardiogram cluster Health, Standard 01/10/2008

Conditional obligation:
Record when lead V4R was performed on the electrocardiogram.

Electrocardiogram change location

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram—change location, code N
METeOR identifier:	356835
Registration status:	Health, Standard 01/10/2008
Definition:	The area in which the change is located on the electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—change location

Value domain attributes

Representational attributes

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

	Value	Meaning
Permissible values:	1	Inferior leads: II, III, aVF
	2	Anterior leads: V1 to V4
	3	Lateral leads: I, aVL, V5 to V6
	4	True posterior: V1 V2
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 4 True posterior: V1 V2

True posterior is relevant only for tall R waves.

Data element attributes

Collection and usage attributes

Guide for use:

More than one code may be recorded.

Report in order of significance.

Where a change is located in all leads of the ECG codes 1, 2 and 3 should be recorded.

Record all codes that apply (code 9 is excluded from multiple coding).

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Related metadata references: Supersedes Person—electrocardiogram change location, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Electrocardiogram cluster Health, Standard 01/10/2008

Electrocardiogram change type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram—change type, code N
METeOR identifier:	356856
Registration status:	Health, Standard 01/10/2008
Definition:	The type of change to the heart rhythm seen on a person's electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—change type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	NN	
Maximum character length:	2	
Permissible values:	Value	Meaning
	10	ST-segment-elevation >= 1 mm (0.1 mV) in >= 2 contiguous limb leads
	11	ST-segment-elevation >= 2 mm (0.2 mV) in >= 2 contiguous chest leads
	12	ST-segment depression >= 0.5 mm (0.05 mV) in >= 2 contiguous leads (includes reciprocal changes)
	20	T-wave inversion >= 2 mm (0.1 mV)
	30	Significant Q waves
	40	Left bundle-branch block (BBB)
	41	Right bundle-branch block (BBB)
	42	Indeterminate bundle-branch block (BBB)
	90	Non specific
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

ST-segment changes

CODE 10 ST-segment-elevation >= 1 mm (0.1 mV) in >= 2 contiguous limb leads

ST-segment-elevation indicates greater than or equal to 1 mm (0.1 mV) elevation in 2 or more contiguous limb leads.

CODE 11 ST-segment-elevation >= 2 mm (0.2 mV) in >= 2 contiguous chest leads

ST-segment-elevation indicates greater than or equal to 2 mm (0.2 mV) elevation in 2 or more contiguous chest leads.

CODE 12 ST-segment depression >= 0.5 mm (0.05 mV) in >= 2 contiguous leads (includes reciprocal changes)

ST-segment depression of at least 0.5 mm (0.05 mV) in 2 or more contiguous leads (includes reciprocal changes).

T-wave changes

CODE 20 T-wave inversion >= 2 mm (0.2 mV)

T-wave inversion of at least 2 mm (0.2 mV) including inverted T waves that are not indicative of acute MI.

Q wave changes

CODE 30 Significant Q waves

Q waves refer to the presence of Q waves that are greater than or equal to 0.03 seconds in width and greater than or equal to 1 mm (0.1 mV) in depth in at least 2 contiguous leads.

Bundle-branch block changes

CODE 40 Left bundle branch block (BBB)

Diffuse left bundle-branch block pattern.

CODE 41 Right bundle-branch block (BBB)

Diffuse right bundle-branch block pattern.

CODE 42 Indeterminate bundle-branch block (BBB)

Bundle-branch block pattern identified, but left or right location is unclear.

CODE 90 Non-specific

Changes not meeting the above criteria.

CODE 99 Not stated/inadequately described

Includes unknown.

Data element attributes

Collection and usage attributes

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

Record all that apply (codes 90 and 99 are excluded from multiple coding).

Collection methods: Where codes 40, 41 or 42 are recorded Electrocardiogram - bundle-branch block status, code N must also be recorded.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Related metadata references: Supersedes Person—electrocardiogram change type, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Electrocardiogram cluster Health, Standard 01/10/2008

Electronic communication address (person)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person (address)—electronic communication address, text [X(250)]

Synonymous names: Electronic communication details

METeOR identifier: 287469

Registration status: Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005
Tasmanian Health, Proposed 30/09/2011

Definition: A unique combination of characters used as input to electronic communication equipment for the purpose of contacting a person, as represented by text.

Data Element Concept: Person (address)—electronic communication address

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: [X(250)]

Maximum character length: 250

Data element attributes

Collection and usage attributes

Guide for use: Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and usage code assigned.

Universal Resource Locator (URL)

One form of electronic address used as a locator for an internet-based web site.

Example: http://www.aihw.gov.au This is the full address, however, it is not essential to record 'http://www' as the commonly used internet browsers assume these characters are included. Therefore, the URL address could be recorded as 'aihw.gov.au'.

Email addresses

Email addresses are a combination of a username and an internet domain name (URL) joined by an @ symbol. The use of the full URL is not valid in an email address.

Example: myuserid@bigpond.net.au

Telephone numbers

- Record the prefix plus telephone number. For example, 08 8226 6000 or 0417 123456.
- Do not record punctuation in telephone numbers. For example, (08) 8226 6000 or 08-8226 6000 would not be correct.

Unknown contact details

Leave the field blank.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

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

AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Electronic communication address (service provider organisation)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Service provider organisation (address)—electronic communication address, text [X(250)]

METeOR identifier: 287480

Registration status: Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Definition: A unique combination of characters used as input to electronic communication equipment for the purpose of contacting an organisation, as represented by text.

Data Element Concept: Service provider organisation (address)—electronic communication address

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: [X(250)]

Maximum character length: 250

Data element attributes

Collection and usage attributes

Guide for use: Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and usage code assigned.

Universal Resource Locator (URL)

One form of electronic address used as a locator for an internet-based web site.

Example: http://www.aihw.gov.au This is the full address, however, it is not essential to record 'http://www' as the commonly used internet browsers assume these characters are included. Therefore, the URL address could be recorded as 'aihw.gov.au'.

Email addresses

Email addresses are a combination of a username and an internet domain name (URL) joined by an @ symbol. The use of the full URL is not valid in an email address.

Example: myuserid@bigpond.net.au

Telephone numbers

Record the prefix plus telephone number. For example, 08 8226 6000 or 0417 123456.
Do not record punctuation in telephone numbers. For example, (08) 8226 6000 or 08-8226 6000 would not be correct.
Unknown contact details

Leave the field blank.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

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

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

In AS5017 this data element is represented by 'Telephone number (client)'. In AS4846 this data element is represented by 'Provider electronic communication details'. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications: Health care provider identification DSS Health, Standard 03/12/2008

Indigenous primary health care DSS Health, Standard 07/12/2011

Electronic communication medium (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—electronic communication medium, code N
METeOR identifier:	287519
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	A type of communication mechanism used by a person, as represented by a code.
Data Element Concept:	Person (address)—electronic communication medium

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Telephone (excluding mobile telephone)
2	Mobile (cellular) telephone
3	Facsimile machine
4	Pager
5	e-mail
6	URL
8	Other

Data element attributes

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Reference documents:	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008

Electronic communication medium (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—electronic communication medium, code N
METeOR identifier:	287521
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	A type of communication mechanism used by an organisation, as represented by a code.
Data Element Concept:	Service provider organisation (address)—electronic communication medium

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Telephone (excluding mobile telephone)
2	Mobile (cellular) telephone
3	Facsimile machine
4	Pager
5	e-mail
6	URL
8	Other

Data element attributes

Collection and usage attributes

Guide for use: Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and Electronic communication usage code assigned.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

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

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

Relational attributes

Implementation in Data Set Specifications: Health care provider identification DSS Health, Standard 03/12/2008

Indigenous primary health care DSS Health, Standard 07/12/2011

Electronic communication usage code (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—electronic communication usage, code N
METeOR identifier:	287579
Registration status:	Community Services, Superseded 06/02/2012 Health, Standard 04/05/2005
Definition:	The manner of use that a person applies to an electronic communication address, as represented by a code.
Data Element Concept:	Person (address)—electronic communication usage code

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Business use only
2	Personal use only
3	Both business and personal use

Data element attributes

Collection and usage attributes

Guide for use:	Only applicable to individuals, and not organisations.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

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

In AS5017 an alternative data element is presented as 'Telephone number type (client)'. In AS4846 this data element is called 'Provider electronic communication type'. In both instances alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Emergency department arrival mode - transport

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—transport mode (arrival), code N
METeOR identifier:	471921
Registration status:	Health, Standard 22/12/2011
Definition:	The mode of transport by which the person arrives at the emergency department, as represented by a code.
Data Element Concept:	Emergency department stay—transport mode

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Ambulance, air ambulance or helicopter rescue service
	2	Police/correctional services vehicle
	8	Other
Supplementary values:	9	Not stated/unknown

Collection and usage attributes

Guide for use:

CODE 8 Other

Includes walking, private transport, public transport, community transport, and taxi.

Data element attributes

Source and reference attributes

Submitting organisation: National reference group for non-admitted patient data development, 2001-02

Relational attributes

Related metadata references: Supersedes Non-admitted patient emergency department service episode—transport mode (arrival), code N Health, Superseded 22/12/2011

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Emergency department clinical care commencement date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—clinical care commencement date, DDMMYYYY
METeOR identifier:	474116
Registration status:	Health, Standard 30/01/2012
Definition:	The date on which emergency department non-admitted clinical care commences, expressed as DDMMYYYY.
Context:	Emergency department care.
Data Element Concept:	Non-admitted patient emergency department service episode—clinical care commencement date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Emergency department non-admitted clinical care can be commenced by a doctor, nurse, mental health practitioner or other health professional, when investigation, care and/or treatment is provided in accordance with an established clinical pathway defined by the emergency department. Placement of a patient in a cubicle and observations taken to monitor a patient pending a clinical decision regarding commencement of a clinical pathway, do not constitute commencement.

Patients with an episode end status of 'Did not wait to be attended by a healthcare professional' should not have a clinical care commencement date, because they left before investigation, care and/or treatment was commenced by a health professional in accordance with an established clinical pathway defined by the emergency department.

The following examples illustrate the commencement of emergency department non-admitted clinical care.

Example 1

- A patient presents at the emergency department with mild asthma. At triage, the patient is categorised as category three and returns to the waiting area.

- The patient has a more severe asthma attack in the waiting area, is re-triaged to category two and shown to a cubicle where standard observations are taken.

- A nurse comes to the cubicle and commences treatment based on an acknowledged clinical pathway of the emergency department. At this point: **emergency department clinical care has commenced.**

Example 2

- A patient presents at the emergency department in an agitated, delusional state. At triage, the patient is categorised as category two and placed in a cubicle and the mental health practitioner notified.

- Observations are taken and nursing staff continue to observe the patient.

- The mental health practitioner arrives, assesses the patient and develops a management plan. At this point: **emergency department clinical care has commenced.**

Example 3

- A patient presents at the emergency department with an ankle injury from football. At triage, the patient is categorised as category four and moved to the 'fast track area'.

- The physiotherapist attends, examines the patient, makes an assessment (including diagnostic imaging requirements) and determines a treatment plan. At this point: **emergency department clinical care has commenced.**

Example 4

- A patient presents at the emergency department with a sore arm, following a fall, with limited arm movement possible.

- The patient is categorised as category three at triage and placed in a cubicle.

- A nurse provides analgesia and assesses the patient, including ordering diagnostic imaging. At this point: **emergency department clinical care has commenced.**

Example 5

- A patient presents at the emergency department feeling vague and having been generally unwell for a day or two. The patient has a slight cough. At triage, the patient is categorised as category three.

- The patient is placed in a cubicle where standard observations are taken. Respiration is 26 bpm, BP is 90/60 and the patient is hypoxic. The patient is given oxygen, and the treating clinician attends and provides instruction regarding patient care. At this point: **emergency department clinical care has commenced.**

Example 6

- A patient presents at the emergency department with chest pain. Triage category two is allocated. The patient is placed in a cubicle and a nurse gives oxygen and Anginine, takes blood samples and conducts an ECG. The ECG is reviewed. At this point: **emergency department clinical care has commenced.**

- A doctor subsequently arrives and the patient is transferred to the catheter lab after examination.

Example 7

- The emergency department is notified by ambulance that a patient is being transported having severe behavioural problems.

- The patient is taken to an appropriate cubicle and restrained.

- A clinician administers sedation and requests the attendance of a mental health practitioner. At this point: **emergency department clinical care has commenced.**

Collection methods: Collected in conjunction with emergency department clinical care commencement time.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:

Supersedes Non-admitted patient emergency department service episode—clinical care commencement date, DDMMYYYY Health, Superseded 30/01/2012

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:

This data item is to be recorded if the patient has one of the following Episode end status values recorded:

- Admitted to this hospital (either short stay unit, hospital in the home or non-emergency department hospital ward);
- Non-admitted patient emergency department service episode completed—departed without being admitted or referred to another hospital;
- Non-admitted patient emergency department service episode completed—referred to another hospital for admission;
- Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed;
- Died in emergency department as a non-admitted patient;
- Dead on arrival, emergency department clinician certified the death of the patient.

Emergency department clinical care commencement time

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Non-admitted patient emergency department service episode—clinical care commencement time, hhmm

METeOR identifier: 474118

Registration status: Health, Standard 30/01/2012

Definition: The time at which emergency department non-admitted clinical care commences, expressed as hhmm.

Context: Emergency department care.

Data Element Concept: Non-admitted patient emergency department service episode—clinical care commencement time

Value domain attributes

Representational attributes

Representation class: Time

Data type: Date/Time

Format: hhmm

Maximum character length: 4

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use: Emergency department non-admitted clinical care can be commenced by a doctor, nurse, mental health practitioner or other health professional, when investigation, care and/or treatment is provided in accordance with an established clinical pathway defined by the emergency department. Placement of a patient in a cubicle and observations taken to monitor a patient pending a clinical decision regarding commencement of a clinical pathway, do not constitute commencement.

Patients with an episode end status of 'Did not wait to be attended by a healthcare professional' should not have a clinical care commencement time, because they left before investigation, care and/or treatment was commenced by a health professional in accordance with an established clinical pathway defined by the emergency department.

The following examples illustrate the commencement of emergency department non-admitted clinical care.

Example 1

- A patient presents at the emergency department with mild asthma. At triage, the patient is categorised as category three and returns to the waiting area.
- The patient has a more severe asthma attack in the waiting area, is re-triaged to category two and shown to a cubicle where standard observations are taken.
- A nurse comes to the cubicle and commences treatment based on an acknowledged clinical pathway of the emergency department. At this point: **emergency department clinical care has commenced**.

Example 2

- A patient presents at the emergency department in an agitated, delusional state. At triage, the patient is categorised as category two and placed in a cubicle and the mental health practitioner notified.
- Observations are taken and nursing staff continue to observe the patient.
- The mental health practitioner arrives, assesses the patient and develops a management plan. At this point: **emergency department clinical care has commenced**.

Example 3

- A patient presents at the emergency department with an ankle injury from football. At triage, the patient is categorised as category four and moved to the 'fast track area'.
- The physiotherapist attends, examines the patient, makes an assessment (including diagnostic imaging requirements) and determines a treatment plan. At this point: **emergency department clinical care has commenced**.

Example 4

- A patient presents at the emergency department with a sore arm, following a fall, with limited arm movement possible.

- The patient is categorised as category three at triage and placed in a cubicle.
- A nurse provides analgesia and assesses the patient, including ordering diagnostic imaging. At this point: **emergency department clinical care has commenced**.

Example 5

- A patient presents at the emergency department feeling vague and having been generally unwell for a day or two. The patient has a slight cough. At triage, the patient is categorised as category three.
- The patient is placed in a cubicle where standard observations are taken. Respiration is 26 bpm, BP is 90/60 and the patient is hypoxic. The patient is given oxygen, and the treating clinician attends and provides instruction regarding patient care. At this point: **emergency department clinical care has commenced**.

Example 6

- A patient presents at the emergency department with chest pain. Triage category two is allocated. The patient is placed in a cubicle and a nurse gives oxygen and Anginine, takes blood samples and conducts an ECG. The ECG is reviewed. At this point: **emergency department clinical care has commenced**.
- A doctor subsequently arrives and the patient is transferred to the catheter lab after examination.

Example 7

- The emergency department is notified by ambulance that a patient is being transported having severe behavioural problems.
- The patient is taken to an appropriate cubicle and restrained.
- A clinician administers sedation and requests the attendance of a mental health practitioner. At this point: **emergency department clinical care has commenced**.

Collection methods: Collected in conjunction with emergency department clinical care commencement date.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: Supersedes Non-admitted patient emergency department service episode—clinical care commencement time, hhmm

Health, Superseded 30/01/2012

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:

This data item is to be recorded if the patient has one of the following Episode end status values recorded:

- Admitted to this hospital (either short stay unit, hospital in the home or non-emergency department hospital ward);
- Non-admitted patient emergency department service episode completed—departed without being admitted or referred to another hospital;
- Non-admitted patient emergency department service episode completed—referred to another hospital for admission;
- Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed;
- Died in emergency department as a non-admitted patient;
- Dead on arrival, emergency department clinician certified the death of the patient.

Emergency department date of commencement of service event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—service commencement date, DDMMYYYY
METeOR identifier:	390398
Registration status:	Health, Standard 22/12/2009
Definition:	The date on which a non-admitted emergency department service event commences.
Context:	Emergency Department care
Data Element Concept:	Non-admitted patient emergency department service episode—service commencement date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

An Emergency Department service event can be commenced by a doctor, nurse, mental health practitioner or other health professional, when investigation, care and/or treatment is provided in accordance with an established clinical pathway defined by the Emergency Department. Placement of a patient in a cubicle and observations taken to monitor a patient pending a clinical decision regarding commencement of a clinical pathway, do not constitute commencement.

The following examples illustrate the commencement of an Emergency Department service event.

Example 1

- A patient presents at the Emergency Department with mild asthma. At triage, the patient is categorised as category three and returns to the waiting area.

- The patient has a more severe asthma attack in the waiting area, is re-triaged to category two and shown to a cubicle where standard observations are taken.

- A nurse comes to the cubicle and commences treatment based on an acknowledged clinical pathway of the Emergency Department. At this point : **Emergency Department service event has commenced.**

Example 2

- A patient presents at the Emergency Department in an agitated, delusional state. At triage, the patient is categorised as category two and placed in a cubicle and the mental health practitioner notified.

- Observations are taken and nursing staff continue to observe the patient.

- The mental health practitioner arrives, assesses the patient and develops a management plan. At this point : **Emergency Department service event has commenced.**

Example 3

- A patient presents at the Emergency Department with an ankle injury from football. At triage, the patient is categorised as category four and moved to the 'fast track area'.

- The physiotherapist attends, examines the patient, makes an assessment (including diagnostic imaging requirements) and determines a treatment plan. At this point : **Emergency Department service event has commenced.**

Example 4

- A patient presents at the Emergency Department with a sore arm, following a fall, with limited arm movement possible.

- The patient is categorised as category three at triage and placed in a cubicle.

- A nurse provides analgesia and assesses the patient, including ordering diagnostic imaging. At this point : **Emergency Department service event has commenced.**

Example 5

- A patient presents at the Emergency Department feeling vague and having been generally unwell for a day or two. The patient has a slight cough. At triage, the patient is categorised as category three.

- The patient is placed in a cubicle where standard observations are taken. Respiration is 26 bpm, BP is 90/60 and the patient is hypoxic. The patient is given oxygen, and the treating clinician attends and provides instruction regarding patient care. At this point : **Emergency Department service event has commenced.**

Example 6

- A patient presents at the Emergency Department with chest pain. Triage category two is allocated. The patient is placed in a cubicle and a nurse gives oxygen and Anginine, takes blood samples and conducts an ECG. The ECG is reviewed. At this point : **Emergency Department service event has commenced.**

- A doctor subsequently arrives and the patient is transferred to the catheter lab after examination.

Example 7

- The Emergency Department is notified by ambulance that a patient is being transported having severe behavioural problems.

- The patient is taken to an appropriate cubicle and restrained.

- A clinician administers sedation and requests the attendance of a mental health practitioner. At this point : **Emergency Department service event has commenced.**

Collection methods: Collected in conjunction with emergency department service commencement time.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: See also Non-admitted patient emergency department service episode—clinical care commencement date, DDMMYYYY Health, Superseded 30/01/2012

Supersedes Non-admitted patient emergency department service episode—service commencement date, DDMMYYYY Health, Superseded 22/12/2009

Emergency department episode end date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Non-admitted patient emergency department service episode—episode end date, DDMMYYYY

METeOR identifier: 474138

Registration status: Health, Standard 30/01/2012

Definition: The date on which the non-admitted patient emergency department service episode ends, expressed as DDMMYYYY.

Context: Emergency department care.

Data Element Concept: Non-admitted patient emergency department service episode—episode end date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: The value of the episode end status should guide the selection of the value to be recorded as the end date of a non-admitted patient emergency department service episode as follows:

- If the patient is subsequently admitted to this hospital (including those who are admitted and subsequently die before leaving the emergency department), then record the date the patient's emergency department non-admitted clinical care is completed.

- If the service episode is completed without the patient being admitted, then record the date the patient's emergency department non-admitted clinical care is completed.
- If the service episode is completed and the patient is referred to another hospital for admission, then record the date the patient's emergency department non-admitted clinical care is completed.
- If the patient did not wait, then record the date the patient leaves the emergency department or was first noticed as having left.
- If the patient left at their own risk, then record the date the patient leaves the emergency department or was first noticed as having left.
- If the patient died in the emergency department as a non-admitted patient, then record the date the patient was certified dead.
- If the patient was dead on arrival, then record the date the patient was certified dead.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: Supersedes Non-admitted patient emergency department service episode—episode end date, DDMMYYYY Health, Superseded 30/01/2012

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Emergency department episode end time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—episode end time, hhmm
METeOR identifier:	474169
Registration status:	Health, Standard 30/01/2012
Definition:	The time at which the non-admitted patient emergency department service episode ends, expressed as hhmm.
Context:	Emergency department care.
Data Element Concept:	Non-admitted patient emergency department service episode—episode end time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

The value of the episode end status should guide the selection of the value to be recorded as the end time of a non-admitted patient emergency department service episode as follows:

- If the patient is subsequently admitted to this hospital (including those who are admitted and subsequently die before leaving the emergency department), then record the time the patient's emergency department non-admitted clinical care is completed.

- If the service episode is completed without the patient being admitted, then record the time the patient's emergency department non-admitted clinical care is completed.
- If the service episode is completed and the patient is referred to another hospital for admission, then record the time the patient's emergency department non-admitted clinical care is completed.
- If the patient did not wait, then record the time the patient leaves the emergency department or was first noticed as having left.
- If the patient left at their own risk, then record the time the patient leaves the emergency department or was first noticed as having left.
- If the patient died in the emergency department as a non-admitted patient, then record the time the patient was certified dead.
- If the patient was dead on arrival, then record the time the patient was certified dead.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: Supersedes Non-admitted patient emergency department service episode—episode end time, hhmm Health, Superseded 30/01/2012

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Emergency department physical departure date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Emergency department stay—physical departure date, DDMMYYYY

METeOR identifier: 474436

Registration status: Health, Standard 30/01/2012

Definition: The date on which a patient departs an emergency department after a stay, expressed as DDMMYYYY.

Context: Emergency department care.

Data Element Concept: Emergency department stay—physical departure date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: The episode end status should guide the selection of the value to be recorded in this field:

- If the patient is subsequently admitted to this hospital (either short stay unit, hospital-in-the-home or non-emergency department hospital ward), then record the date the patient leaves the emergency department to go to the admitted patient facility.

  Patients admitted to any other ward or bed within the emergency department have not physically departed the emergency department until they leave the emergency department.

  If the patient is admitted and subsequently dies before leaving the emergency department, then record the date the body was removed from the emergency department.

- If the service episode is completed without the patient being admitted, then record the date the patient's emergency department non-admitted clinical care ended.
- If the service episode is completed and the patient is referred to another hospital for admission, then record the date the patient leaves the emergency department.
- If the patient did not wait, then record the date the patient leaves the emergency department or was first noticed as having left.
- If the patient leaves at their own risk, then record the date the patient leaves the emergency department or was first noticed as having left.
- If the patient died in the emergency department, then record the date the body was removed from the emergency department.
- If the patient was dead on arrival, then record the date the body was removed from the emergency department. If an emergency department physician certified the death of the patient outside the emergency department, then record the date the patient was certified dead.

Collection methods: Collected in conjunction with emergency department physical departure time.

Comments: This data element has been developed for the purpose of State and Territory compliance with the Australian Health Care Agreement and the agreed national access performance indicator.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: Supersedes Emergency department stay—physical departure date, DDMMYYYY Health, Superseded 30/01/2012

See also Emergency department stay—physical departure time, hhmm Health, Standard 30/01/2012

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Emergency department physical departure time

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Emergency department stay—physical departure time, hhmm

METeOR identifier: 474438

Registration status: Health, Standard 30/01/2012

Definition: The time at which a patient departs an emergency department after a stay, expressed as hhmm.

Context: Emergency department care.

Data Element Concept: Emergency department stay—physical departure time

Value domain attributes

Representational attributes

Representation class: Time

Data type: Date/Time

Format: hhmm

Maximum character length: 4

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use: The episode end status should guide the selection of the value to be recorded in this field:

- If the patient is subsequently admitted to this hospital (either short stay unit, hospital-in-the-home or non-emergency department hospital ward), then record the time the patient leaves the emergency department to go to the admitted patient facility.

  Patients admitted to any other ward or bed within the emergency department have not physically departed the emergency department until they leave the emergency department.

If the patient is admitted and subsequently dies before leaving the emergency department, then record the time the body was removed from the emergency department.

- If the service episode is completed without the patient being admitted, then record the time the patient's emergency department non-admitted clinical care ended.
- If the service episode is completed and the patient is referred to another hospital for admission, then record the time the patient leaves the emergency department.
- If the patient did not wait, then record the time the patient leaves the emergency department or was first noticed as having left.
- If the patient leaves at their own risk, then record the time the patient leaves the emergency department or was first noticed as having left.
- If the patient died in the emergency department, then record the time the body was removed from the emergency department.
- If the patient was dead on arrival, then record the time the body was removed from the emergency department. If an emergency department physician certified the death of the patient outside the emergency department, then record the time the patient was certified dead.

Collection methods: Collected in conjunction with emergency department physical departure date.

Comments: This data element has been developed for the purpose of State and Territory compliance with the Australian Health Care Agreement and the agreed national access performance indicator.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: See also Emergency department stay—physical departure date, DDMMYYYY Health, Standard 30/01/2012

Supersedes Emergency department stay—physical departure time, hhmm Health, Superseded 30/01/2012

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Emergency department service episode end status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—episode end status, code N
METeOR identifier:	474159
Registration status:	Health, Standard 30/01/2012
Definition:	The status of the patient at the end of the non-admitted patient emergency department service episode, as represented by a code.
Context:	Emergency department care.
Data Element Concept:	Non-admitted patient emergency department service episode—episode end status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Admitted to this hospital (either short stay unit, hospital-in-the-home or non-emergency department hospital ward)
2	Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital
3	Non-admitted patient emergency department service episode completed - referred to another hospital for admission

4	Did not wait to be attended by a health care professional
5	Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed
6	Died in emergency department as a non-admitted patient
7	Dead on arrival, emergency department clinician certified the death of the patient

Collection and usage attributes

Guide for use:

CODE 1 Admitted to this hospital (either short stay unit, hospital-in-the-home or non-emergency department hospital ward)

This code includes patients who are admitted to this hospital and subsequently die before leaving the emergency department.

CODE 2 Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital

This code includes patients who departed under their own care, under police custody, under the care of a residential aged care facility or other carer.

This code excludes those who died in the emergency department as a non-admitted patient. Such instances should be coded to Code 6.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Data element attributes

Collection and usage attributes

Guide for use: Episode end status should be recorded when Episode end date and Episode end time are recorded.

Collection methods: Some data systems may refer to this data element as ‘Departure status’.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: Supersedes Non-admitted patient emergency department service episode—episode end status, code N Health, Superseded 30/01/2012

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Emergency department time of commencement of service event

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Non-admitted patient emergency department service episode—service commencement time, hhmm

METeOR identifier: 390401

Registration status: Health, Standard 22/12/2009

Definition: The time at which a non-admitted emergency department service event commences.

Context: Emergency Department care

Data Element Concept: Non-admitted patient emergency department service episode—service commencement time

Value domain attributes

Representational attributes

Representation class: Time

Data type: Date/Time

Format: hhmm

Maximum character length: 4

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

An Emergency Department service event can be commenced by a doctor, nurse, mental health practitioner or other health professional, when investigation, care and/or treatment is provided in accordance with an established clinical pathway defined by the Emergency Department. Placement of a patient in a cubicle and observations taken to monitor a patient pending a clinical decision regarding commencement of a clinical pathway, do not constitute commencement.

The following examples illustrate the commencement of an Emergency Department service event.

Example 1

- A patient presents at the Emergency Department with mild asthma. At triage, the patient is categorised as category three and returns to the waiting area.

- The patient has a more severe asthma attack in the waiting area, is re-triaged to category two and shown to a cubicle where standard observations are taken.
- A nurse comes to the cubicle and commences treatment based on an acknowledged clinical pathway of the Emergency Department. At this point : **Emergency Department service event has commenced.**

Example 2

- A patient presents at the Emergency Department in an agitated, delusional state. At triage, the patient is categorised as category two and placed in a cubicle and the mental health practitioner notified.
- Observations are taken and nursing staff continue to observe the patient.
- The mental health practitioner arrives, assesses the patient and develops a management plan. At this point : **Emergency Department service event has commenced.**

Example 3

- A patient presents at the Emergency Department with an ankle injury from football. At triage, the patient is categorised as category four and moved to the 'fast track area'.

- The physiotherapist attends, examines the patient, makes an assessment (including diagnostic imaging requirements) and determines a treatment plan. At this point : **Emergency Department service event has commenced.**

Example 4

- A patient presents at the Emergency Department with a sore arm, following a fall, with limited arm movement possible.
- The patient is categorised as category three at triage and placed in a cubicle.
- A nurse provides analgesia and assesses the patient, including ordering diagnostic imaging. At this point : **Emergency Department service event has commenced.**

Example 5

- A patient presents at the Emergency Department feeling vague and having been generally unwell for a day or two. The patient has a slight cough. At triage, the patient is categorised as category three.
- The patient is placed in a cubicle where standard observations are taken. Respiration is 26 bpm, BP is 90/60 and the patient is hypoxic. The patient is given oxygen, and the treating clinician attends and provides instruction regarding patient care. At this point : **Emergency Department service event has commenced.**

Example 6

- A patient presents at the Emergency Department with chest pain. Triage category two is allocated. The patient is placed in a cubicle and a nurse gives oxygen and Anginine, takes blood samples and conducts an ECG. The ECG is reviewed. At this point : **Emergency Department service event has commenced.**
- A doctor subsequently arrives and the patient is transferred to the catheter lab after examination.

Example 7

- The Emergency Department is notified by ambulance that a patient is being transported having severe behavioural problems.
- The patient is taken to an appropriate cubicle and restrained.
- A clinician administers sedation and requests the attendance of a mental health practitioner. At this point : **Emergency Department service event has commenced.**

Collection methods: Collected in conjunction with emergency department service episode service commencement date.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: See also Non-admitted patient emergency department service episode—clinical care commencement time, hhmm Health, Superseded 30/01/2012

Supersedes Non-admitted patient emergency department service episode—service commencement time, hhmm Health, Superseded 22/12/2009

Emergency department waiting time to admission

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN

METeOR identifier: 270004

Registration status: Health, Standard 01/03/2005

Definition: The time elapsed for each patient from presentation to the emergency department to **admission** to hospital.

Data Element Concept: Non-admitted patient emergency department service episode—waiting time (to hospital admission)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: NNNN

Maximum character length: 4

Unit of measure: Hour and minute

Collection and usage attributes

Guide for use: HHMM

Data element attributes

Collection and usage attributes

Guide for use: Calculated from admission date and time minus date and time patient presents for those emergency department patients who are admitted.

Collection methods: To be collected on patients presenting to emergency department for unplanned care in public hospitals with emergency department and private hospitals providing contracted services for the public sector.

Comments: This is a critical waiting times metadata item. It is used to examine the length of waiting time, for performance indicators and benchmarking. Information based on this metadata item will have many uses including to assist in the planning and management of hospitals and in health care research.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Emergency department waiting time to admission, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Episode of admitted patient care—admission time, hhmm Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Health service event—presentation date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Health service event—presentation time, hhmm Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Non-admitted patient emergency department service episode—patient departure status, code N Health, Superseded 24/03/2006

Emergency department waiting time to clinical care commencement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—waiting time (to commencement of clinical care), total minutes NNNNN
METeOR identifier:	471932
Registration status:	Health, Standard 22/12/2011
Definition:	The time elapsed in minutes for each patient from presentation in the emergency department to the commencement of the emergency department non-admitted clinical care.
Data Element Concept:	Emergency department stay—waiting time (to commencement of clinical care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNNN
Maximum character length:	5
Unit of measure:	Minute (m)

Data element attributes

Collection and usage attributes

Guide for use:

Calculated by subtracting the date and time the patient presents to the emergency department from the date and time the emergency department non-admitted clinical care commenced. Although triage category 1 is measured in seconds, it is recognised that the data will not be collected with this precision.

This data element should not be completed for patients who have an Episode end status of 'Did not wait'.

Comments:

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

Source and reference attributes

Submitting organisation: National reference group for non-admitted patient data development, 2001-02

Relational attributes

Related metadata references: Supersedes Non-admitted patient emergency department service episode—waiting time (to service delivery), total minutes NNNNN Health, Superseded 22/12/2011

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:

This data item is to be recorded if the patient has one of the following Episode end status values recorded:

- Admitted to this hospital (either short stay unit, hospital in the home or non-emergency department hospital ward);
- Non-admitted patient emergency department service episode completed—departed without being admitted or referred to another hospital;
- Non-admitted patient emergency department service episode completed—referred to another hospital for admission;
- Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed;
- Died in emergency department as a non-admitted patient;
- Dead on arrival, emergency department clinician certified the death of the patient.

Employee expenses

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Organisation—employee related expenses, total Australian currency NNNNN.N

METeOR identifier: 359947

Registration status: Health, Standard 05/12/2007

Definition: Expenses of an organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, and workers compensation premiums and payouts, in Australian currency.

Data Element Concept: Organisation—employee related expenses

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: NNNNN.N

Maximum character length: 6

Unit of measure: Australian currency (AU$)

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use: Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.

Employee related expenses are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).

Includes:

- Salaries, wages and supplements for all employees of the organisation (including contract staff employed by an agency, provided staffing data is also available). This is to include all paid leave (recreation, sick and long-service) and salary and wage payments relating to workers compensation leave.
- Superannuation employer contributions paid or, for an emerging cost scheme, that should be paid (as determined by an actuary) on behalf of establishment employees either by the establishment or a central administration such as a state health authority, to a superannuation fund providing retirement and related benefits to establishment employees, for a financial year.
- Workers compensation premiums and payments

Collection methods:

Employee related expenses are to be reported for the *Health industry relevant organisation type* and *Type of health and health related functions* data elements.

Health industry relevant organisation type

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments:

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Origin:

Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.aasb.com.au>

Relational attributes

Related metadata references: Is used in the formation of Organisation—expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007

Implementation in Data Set Specifications: Government health expenditure organisation expenditure data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure employee related data element cluster Health, Standard 01/04/2009

Employment status (admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—labour force status, acute hospital and private psychiatric hospital admission code N
METeOR identifier:	269948
Registration status:	Health, Standard 01/03/2005
Definition:	Self-reported employment status of a person, immediately prior to **admission** to an acute or private psychiatric hospital, as represented by a code.
Context:	The Australian Health Ministers' Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be: employment status, income, occupation and education.
Data Element Concept:	Person—labour force status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Unemployed / pensioner
2	Other

Data element attributes

Collection and usage attributes

Collection methods: In practice, this metadata item and current or last occupation could probably be collected with a single question, as is done in Western Australia:

Occupation?

For example:

- housewife or home duties
- pensioner miner
- tree feller
- retired electrician
- unemployed trades assistant
- child
- student
- accountant

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

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Employment status - acute hospital and private psychiatric hospital admissions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Implementation in Data Set Specifications: Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Employment status—health professional

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—labour force status, registered health professional code N
METeOR identifier:	383389
Registration status:	Health, Standard 10/12/2009
Definition:	An indicator of whether a registered health professional is in paid employment, and if so whether the employment is within their registered profession.
Data Element Concept:	Registered health professional—labour force status

Value domain attributes

Representational attributes

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

	Value	Meaning
Permissible values:	1	Employed in the registered profession
	2	Employed outside the registered profession
	3	Not employed
Supplementary values:	9	Unknown/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 EMPLOYED IN THE REGISTERED PROFESSION

Health professionals employed in the registered profession may be working in Australia or they may be working overseas.

CODE 2 EMPLOYED OUTSIDE OF THE REGISTERED PROFESSION

Health professionals who are employed in Australia or overseas, but not in the registered profession.

CODE 3 NOT EMPLOYED

Health professionals in this category may be unemployed (not employed and seeking work) or not in the labour force (not employed and not seeking work). This is consistent with the ABS Labour Force standard which allows the aggregation of 'Unemployed' and 'Not in the labour force' to form the category 'Not employed'.

FURTHER DEFINITIONS

The term 'employed' includes employees, employers, own account workers and contributing family workers.

The definitions of employed and unemployed in this data element differ slightly from Australian Bureau of Statistics (ABS) definitions. The main differences are:

- The labour force collection includes health professionals working in the Defence Forces. ABS does not, with the exception of the population census.
- ABS uses a tightly defined reference period for employment and unemployment; the labour force collection reference period is self-defined by the respondent as his/her usual status during the week before registration.
- The scope of the labour force collection is all health professionals listed by the Australian Health Practitioner Regulation Agency, regardless of their residential status in Australia. The scope of the ABS Labour Force Survey is usual residents of Australia. That is, those persons who will be living in Australia for at least 12 months.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: Data is self-reported based on the health professional's status in the registered profession in the week before registration.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Australian Bureau of Statistics 1996 Standards for Labour

Force Statistics Cat.no. 1288.0 Canberra: ABS

Relational attributes

Related metadata references: Supersedes Health professional—labour force status, code N{.N} Health, Superseded 10/12/2009

Implementation in Data Set Specifications: Labour force status cluster Health, Standard 10/12/2009

Employment status—public psychiatric hospital admissions

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—labour force status, public psychiatric hospital admission code N

METeOR identifier: 269955

Registration status: Health, Standard 01/03/2005

Definition: Self-reported employment status of a person, immediately prior to **admission** to a public psychiatric hospital, as represented by a code.

Context: The Australian Health Ministers' Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be: employment status, income, occupation and education.

Data Element Concept: Person—labour force status

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Child not at school
2	Student
3	Employed
4	Unemployed
5	Home duties
6	Other

Data element attributes

Collection and usage attributes

Collection methods: In practice, this data item and current or last occupation could probably be collected with a single question, as is done in Western Australia:

Occupation?

For example:

- housewife or home duties
- pensioner miner
- tree feller
- retired electrician
- unemployed trades assistant
- child
- student
- accountant

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

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Employment status - public psychiatric hospital admissions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.6 KB)

Implementation in Data Set Specifications: Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Environmental factor

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—environmental factor, code (ICF 2001) AN[NNN]
METeOR identifier:	320207
Registration status:	Community Services, Standard 16/10/2006 Health, Standard 29/11/2006
Definition:	The physical, social and attitudinal environment in which people live and conduct their lives, as represented by a code.
Context:	The environment in which a person functions or experiences disability.
Data Element Concept:	Person—environmental factor

Value domain attributes

Representational attributes

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

Collection and usage attributes

Guide for use:

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

Environmental factors represent the circumstances in which the individual lives. These factors are conceived as immediate (e.g. physical features of the environment, social environment) and societal (formal and informal social structures, services and systems). Different environments may have a very different impact on the same individual with a given health condition.

Facilitators are features of the environment that have a positive effect on **disability**. Barriers are features of the environment that have a negative effect on disability.

Data can be collected at the three digit level in one chapter and at the chapter level in another. However it is only possible to collect data at a single level of the hierarchy in a single chapter to maintain mutual exclusivity. For example, it is not permitted to collect both ‘Attitudes’ (chapter level) and ‘Social, norms, practices and ideology’ (3 digit level) as the former includes the latter.

The value domain below refers to the highest hierarchical level (ICF chapter level). Data collected at this level, in association with *Extent of environmental factor influence code [X]N* will use the codes as indicated. The full range of the permissible values together with definitions can be found in the *Environmental Factors* component of the ICF.

CODE e1   Products and technology
CODE e2   Natural environment and human-made changes to environment
CODE e3   Support and relationships
CODE e4   Attitudes
CODE e5   Services, systems and policies

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

An example of a value domain at the 3 digit level from the Environmental factors component may include:

CODE e225   Climate
CODE e240   Light
CODE e250   Sound
CODE e255   Vibration
CODE e260   Air quality

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

CODE e1151   Assistive products and technology for personal use in daily life
CODE e1201   Assistive products and technology for personal indoor and outdoor mobility and transportation
CODE e2151   Assistive products and technology for communication
CODE e1301   Assistive products and technology for education
CODE e1351   Assistive products and technology for employment
CODE e1401   Assistive products and technology for culture, recreation and sport
CODE e1451   Assistive products and technology for the

practice of religion and spirituality

The prefix ***e*** denotes the domains within the component of *Environmental Factors*.

Source and reference attributes

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

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

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

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

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

Data element attributes

Collection and usage attributes

Guide for use: This data element is a neutral list of environmental factors. It may be used, in conjunction with Person—extent of environmental factor influence, code (ICF 2001) [X]N, in health, community services and other disability-related data collections to record the environmental factors that facilitate or inhibit optimum functioning at the body, person or societal level. Identification of environmental factors may assist in determining appropriate interventions to support the person to achieve optimum functioning.

Source and reference attributes

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

Relational attributes

Related metadata references: See also Person—extent of environmental factor influence, code (ICF 2001) [X]N Community Services, Standard 16/10/2006, Health, Standard 29/11/2006

Implementation in Data Set Environmental factors cluster Community Services,

Specifications:	Standard 16/10/2006 Health, Standard 29/11/2006

Episode of residential care end date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of residential care—episode end date, DDMMYYYY

METeOR identifier: 417650

Registration status: Health, Standard 07/12/2011

Definition: Date on which a **resident** formally or statistically **ends an episode of residential care,** expressed as DDMMYYYY.

Data Element Concept: Episode of residential care—episode end date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Relational attributes

Related metadata references: Supersedes Episode of residential care—episode end date, DDMMYYYY Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Episode of residential care end mode

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode end mode, code N
METeOR identifier:	417529
Registration status:	Health, Standard 07/12/2011
Definition:	The reason for **ending an episode of residential care**, as represented by a code.
Data Element Concept:	Episode of residential care—episode end mode

Value domain attributes

Representational attributes

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

	Value	Meaning
Permissible values:	1	Died
	2	Left against clinical advice / at own risk
	3	Did not return from leave
	4	Formal discharge from residential care at this establishment
	5	End of reference period
Supplementary values:	9	Unknown/not stated/inadequately described

Collection and usage attributes

Guide for use:

CODES 1 - 4 These codes refer to the formal end of a residential care episode.

CODE 5 refers to the statistical end of a residential care episode.

Data element attributes

Relational attributes

Related metadata references: Supersedes Episode of residential care—episode end mode, code N Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Episode of residential care start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode start date, DDMMYYYY
METeOR identifier:	417636
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which the **resident** formally or statistically **starts an episode of residential care,** expressed as DDMMYYYY.
Data Element Concept:	Episode of residential care—episode start date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

Related metadata references:	Supersedes Episode of residential care—episode start date, DDMMYYYY Health, Superseded 07/12/2011
Implementation in Data Set Specifications:	Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Episode of residential care start mode

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode start mode, code N
METeOR identifier:	417521
Registration status:	Health, Standard 07/12/2011
Definition:	The reason for **starting an episode of residential care**, as represented by a code.
Data Element Concept:	Episode of residential care—episode start mode

Value domain attributes

Representational attributes

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

Permissible values:	Value	Meaning
	2	Start of a new residential stay
	3	Start of a new reference period
Supplementary values:	9	Unknown/not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 2 refers to the formal start of a residential care episode.

CODE 3 refers to the statistical start of a residential care episode.

Data element attributes

Relational attributes

Related metadata references: Supersedes Episode of residential care—episode start mode, code N Health, Superseded 07/12/2011

Implementation in Data Set Residential mental health care NMDS 2012-2013 Health,

Specifications: Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Erectile dysfunction

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person (male)—erectile dysfunction, code N

METeOR identifier: 270132

Registration status: Health, Standard 01/03/2005

Definition: Whether a male individual has a history of erection failure or has received treatment to achieve erection sufficient for penetration in the last 12 months and prior, as represented by a code.

Data Element Concept: Person (male)—erectile dysfunction

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Erectile dysfunction- developed in the last 12 months
	2	Erectile dysfunction- developed prior to the last 12 months
	3	No erectile dysfunction
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: Determine whether this developed within or prior to the last 12 months.

Collection methods: Ask the individual if he has a history of treatment or failure to achieve or maintain erection sufficient for penetration.

Data element attributes

Collection and usage attributes

Guide for use: Record for male patients only.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

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

Relational attributes

Related metadata references: Supersedes Erectile dysfunction, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

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

Establishment identifier

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—organisation identifier (Australian), NNX[X]NNNNN

METeOR identifier: 269973

Registration status: Health, Standard 01/03/2005

Definition: The identifier for the establishment in which episode or event occurred. Each separately administered health care establishment to have a unique identifier at the national level.

Data Element Concept: Establishment—organisation identifier

Value domain attributes

Representational attributes

Representation class: Identifier

Data type: String

Format: NNX[X]NNNNN

Maximum character length: 9

Data element attributes

Collection and usage attributes

Guide for use: Concatenation of:

Australian state/territory identifier (character position 1);

Sector (character position 2);

Region identifier (character positions 3-4); and

Organisation identifier (state/territory), (character positions 5-9).

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

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Establishment identifier, version 4, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.0 KB)

Is formed using Establishment—Australian state/territory identifier, code N Health, Standard 01/03/2005

Is formed using Establishment—organisation identifier (state/territory), NNNNN Health, Standard 01/03/2005

Is formed using Establishment—region identifier, X[X] Health, Standard 01/03/2005

Is formed using Establishment—sector, code N Health, Standard 01/03/2005

See also Hospital—hospital identifier, XXXXX Health, Standard 07/12/2011

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Elective surgery waiting times (census data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 30/09/2012

Elective surgery waiting times (removals data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 01/07/2012

Elective surgery waiting times cluster Health, Standard 07/12/2011

Conditional obligation:

This is the establishment identifier of the contracting hospital and is reported for contracted patients only.

Health care client identification DSS Health, Standard 03/12/2008

Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishment address details DSS Health, Standard 07/12/2011

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Establishment number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—organisation identifier (state/territory), NNNNN
METeOR identifier:	269975
Registration status:	Health, Standard 01/03/2005
Definition:	An identifier for an establishment, unique within the state or territory.
Data Element Concept:	Establishment—organisation identifier (state/territory)

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	NNNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Comments:

Identifier should be a unique code for the health care establishment used in that state/territory.

Relational attributes

Related metadata references:

Supersedes Establishment number, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (14.6 KB)

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

See also Hospital—hospital identifier, XXXXX Health, Standard 07/12/2011

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Cancer (clinical) DSS Health, Standard 07/12/2011

Health care client identification DSS Health, Standard 03/12/2008

Establishment sector

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—sector, code N

METeOR identifier: 269977

Registration status: Health, Standard 01/03/2005

Definition: A section of the health care industry with which a health care establishment can identify, as represented by a code.

Data Element Concept: Establishment—sector

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Public
2	Private

Data element attributes

Collection and usage attributes

Guide for use: This data element is used to differentiate between establishments run by the government sector (code 1) and establishments that receive some government funding but are run by the non-government sector (code 2).

CODE 1 is to be used when the establishment:

- operates from the public accounts of a Commonwealth, state or territory government or is part of the executive, judicial or legislative arms of government,

- is part of the general government sector or is controlled by some part of the general government sector,
- provides government services free of charge or at nominal prices, and
- is financed mainly from taxation.

CODE 2 is to be used only when the establishment:

- is not controlled by government,
- is directed by a group of officers, an executive committee or a similar body
- elected by a majority of members, and
- may be an income tax exempt charity.

Relational attributes

Related metadata references:

Supersedes Establishment sector, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

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

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Health care client identification DSS Health, Standard 03/12/2008

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Establishment type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—establishment type, sector and services provided code AN.N{.N}
METeOR identifier:	269971
Registration status:	Health, Standard 01/03/2005
Definition:	Type of establishment (defined in terms of legislative approval, service provided and patients treated) for each separately administered establishment, as represented by a code.
Data Element Concept:	Establishment—establishment type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AN.N{.N}
Maximum character length:	6

Permissible values:

Value	Meaning
R1.1	Public acute care hospital
R1.2	Private acute care hospital
R1.3.1	Veterans Affairs hospital
R1.3.2	Defence force hospital
R1.3.3	Other Commonwealth hospital
R2.1	Public psychiatric hospital
R2.2	Private psychiatric hospital
R3.1	Private charitable nursing home for the aged
R3.2	Private profit nursing home for the aged
R3.3	Government nursing home for the aged
R3.4	Private charitable nursing home for young disabled

R3.5	Private profit nursing home for young disabled
R3.6	Government nursing home for young disabled
R5.2	State government hostel for the aged
R4.1	Public alcohol and drug treatment centre
R4.2	Private alcohol and drug treatment centre
R5.1	Charitable hostels for the aged
R5.3	Local government hostel for the aged
R5.4	Other charitable hostel
R5.5	Other State government hostel
R5.6	Other Local government hostel
R6.1	Public hospice
R6.2	Private hospice
N7.1	Public day centre/hospital
N7.2	Public freestanding day surgery centre
N7.3	Private day centre/hospital
N7.4	Private freestanding day surgery centre
N8.1.1	Public community health centre
N8.1.2	Private (non-profit) community health centre
N8.2.1	Public domiciliary nursing service
N8.2.2	Private (non-profit) domiciliary nursing service
N8.2.3	Private (profit) domiciliary nursing service

Collection and usage attributes

Guide for use:

Establishments are classified into 10 major types subdivided into major groups:

- residential establishments (R)
- non-residential establishments (N)

CODE R1 Acute care hospitals

Establishments which provide at least minimal medical, surgical or obstetric services for inpatient treatment and/or care, and which provide round-the-clock comprehensive qualified nursing service as well as other necessary professional services. They must be licensed by the state health department, or controlled by government departments. Most of the patients have acute conditions or temporary ailments and the average stay per admission is relatively short.

Hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical care are included in this category. Hospices (establishments providing palliative care to terminally ill patients) that are freestanding and do not provide any other form of acute care are classified to R6.

CODE R2 Psychiatric hospitals

Establishments devoted primarily to the treatment and care of inpatients with psychiatric, mental, or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the Health Insurance Act 1973 (Cwlth) (now licensed/approved by each state health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Centres for the non-acute treatment of drug dependence, developmental and intellectual disability are not included here (see below). This code also excludes institutions mainly providing living quarters or day care.

CODE R3 Nursing homes

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

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

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

Government nursing homes are nursing homes either operated by or on behalf of a state or territory Government.

CODE R4 Alcohol and drug treatment centres

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

CODE R5 Hostels and residential services

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

CODE R6 Hospices

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

CODE N7 Same-day establishments

This code includes both the traditional day centre/hospital and also freestanding day surgery centres.

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

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

CODE N8 Non-residential health services

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

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

CODE N8.1 Community health centres

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

CODE N8.2 Domiciliary nursing service

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

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

Data element attributes

Collection and usage attributes

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

This metadata item is currently under review by the Establishments Framework Working Group of the Health Data Standards Committee. Recommendations will provide a comprehensive coverage of the health service delivery sector.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

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

Supersedes Establishment type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (31.2 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Estimated glomerular filtration rate (eGFR) recorded indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—estimated glomerular filtration rate (eGFR) recorded indicator, yes/no code N
Synonymous names:	eGFR recorded indicator
METeOR identifier:	464961
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a person has had an estimated glomerular filtration rate (eGFR) recorded, as represented by a code.
Data Element Concept:	Person—estimated glomerular filtration rate (eGFR) recorded indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A person has had an estimated glomerular filtration rate (eGFR) recorded.

CODE 2 No

A person has not had an estimated glomerular filtration rate (eGFR) recorded.

The estimated glomerular filtration rate (eGFR) is a measure of the amount of fluid that passes through the kidneys per unit time.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications:	Indigenous primary health care DSS Health, Standard 07/12/2011

Ever been pregnant indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—ever been pregnant indicator, yes/no/not stated/inadequately described code N
METeOR identifier:	399559
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether a female person has ever been pregnant, as represented by a code.
Data Element Concept:	Female—ever been pregnant indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

Pregnancy includes babies who were carried full term, abortions and miscarriages.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Female—age at first pregnancy, total years N[N] Community Services, Standard 06/02/2012, Health, Standard 25/08/2011

Implementation in Data Set Specifications:

Pregnancy status cluster Health, Standard 25/08/2011

Ever smoked a full cigarette indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—ever smoked a full cigarette indicator, yes/no/not stated/inadequately described code N
METeOR identifier:	399275
Registration status:	Health, Standard 25/08/2011
Definition:	A self-reported indicator of whether a person has ever smoked a full cigarette, as represented by a code.
Data Element Concept:	Person—ever smoked a full cigarette indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: In this data collection, cigarette includes manufactured cigarettes, roll-your-own cigarettes, cigars, pipes and other tobacco products.

Collection methods: If the person indicates that they never smoked a full cigarette but provided details on the age of first smoking and current smoking status then the person should be counted as having smoked a full cigarette.

Comments: This question has been included because it exactly matches a question in the 2007 National Drug Strategy Household Survey—"Have you ever smoked a full cigarette?"—thus enabling comparisons with the general community.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Australian Institute of Health and Welfare 2008. 2007 National Drug Strategy Household Survey: first results. Drug Statistics Series number 20.Cat. no. PHE 98. Canberra: AIHW

Relational attributes

Implementation in Data Set Specifications: Smoking status cluster Health, Standard 25/08/2011

Extended leave status in registered profession

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—extended leave status in registered profession, code N
METeOR identifier:	383415
Registration status:	Health, Standard 10/12/2009
Definition:	Whether a registered health professional is on extended leave (3 months or more) from their registered profession, as represented by a code.
Data Element Concept:	Registered health professional—extended leave status in registered profession

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	On extended leave (3 months or more)
	2	Not on extended leave
Supplementary values:	9	Unknown/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 ON EXTENDED LEAVE (3 MONTHS OR MORE)

The person is on a period of leave from their place of employment for three months or more. The person may be starting their extended leave or they may be part-way through their extended leave.

CODE 2 NOT ON EXTENDED LEAVE

The person is not on a period of leave for three months or more. They may be working or they may be on short-term leave of less than three months.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	This data element is applicable to registered health professionals who are employed in the registered profession.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Labour force status cluster Health, Standard 10/12/2009

Extended wait patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—extended wait patient indicator, code N
METeOR identifier:	269964
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a patient is an extended wait patient, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—extended wait patient indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Extended wait patient
2	Other patient

Data element attributes

Collection and usage attributes

Guide for use: A patient is classified as an extended wait patient if the patient is in clinical urgency category 3 at the time of admission or at a census time and has been waiting for the elective surgery for more than one year.

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

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Is formed using Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Superseded 13/12/2011 Is formed using Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Superseded 13/12/2011 Supersedes Extended wait patient, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.8 KB)
Implementation in Data Set Specifications:	Elective surgery waiting times cluster Health, Standard 07/12/2011

Extent of harm from a health-care incident

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—extent of harm from a health-care incident, code N[N]
Synonymous names:	Severity of loss from a health-care incident
METeOR identifier:	421931
Registration status:	Health, Standard 07/12/2011
Definition:	The extent of overall harm, in terms of impairment, activity limitation or participation restriction, to the patient from a health-care incident, as represented by a code.
Data Element Concept:	Patient—extent of harm from a health-care incident

Value domain attributes

Representational attributes

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

	Value	Meaning
Permissible values:	4	Death
	7	Mild injury
	8	Moderate injury
	9	Severe injury
Supplementary values:	97	Not applicable (no body function or structure affected)
	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 7 Mild injury

'Mild injury' includes situations where the harm results in a mild variation (up to 25%) from accepted population standards in the status of the affected body function or structures.

'Mild' refers to an intensity that a person can tolerate, and is unlikely to be permanent. This category could include, for example, the situation where a patient has suffered mild psychological harm as a result of a misdiagnosis by a general practitioner.

CODE 8 Moderate injury

'Moderate injury' includes situations where the harm results in a moderate variation (between 25–50%) from accepted population standards in the status of the affected body function or structures.

'Moderate' refers to a problem with an intensity which interferes with the person's day to day life, and which may be permanent. This may include, for example, a situation where a patient is administered a medication that was clearly contraindicated, which results in a moderate impairment of hepatic function.

CODE 9 Severe injury

'Severe injury' includes situations where the harm results in a severe variation (more than 50%) from accepted population standards in the status of the affected body function or structures.

'Severe' refers to a problem that has an intensity that partially or completely disrupts the person's day to day life, and which is likely to be permanent. This could include, for example, a situation where an accidental cut, puncture or perforation which occurred during surgery leads to a severe permanent impairment of lower limb function.

In cases where the patient has pre-existing impairments, activity limitations and/or participation restrictions, the coding category chosen should reflect only the additional harm or disability due to the incident, over and above any pre-existing conditions.

CODE 97 Not applicable (no body function or structure affected)

'Not applicable (no body function or structure affected)' includes cases where there is no consequent harm to body functions or structures; for example, failed sterilisation procedure or awareness during a procedure due to anaesthetic failure.

CODE 99 Not stated/inadequately described

'Not stated/inadequately described' should be used when the information is not currently available. This code should also be used where the medical indemnity claim is for fetal distress and the outcome for the child will not be known until some future time.

Comments: The coding categories were developed with reference to the WHO (2003) 'Activity Limitations and Participation Restriction' definitions (ICF Version 2.1a) for 'Mild difficulty', 'Moderate difficulty', 'Severe difficulty' and 'Complete difficulty'.

The categories in this value domain align with the categories in the Australian Prudential Regulation Authority (2006) National Claims and Policies Database data item 17 'Severity of loss'.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: APRA (Australian Prudential Regulation Authority) 2006. Data Specifications National Claims and Policies Database document number 3.1. Canberra: APRA

WHO (World Health Organization) 2003. International Classification of Functioning, Disability and Health. Geneva: WHO

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Extent of participation

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—extent of participation in a life area, code (ICF 2001) N

METeOR identifier: 320219

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Definition: The degree of participation by an individual in a specified life area, as represented by a code.

Context: Human functioning and disability

Data Element Concept: Person—extent of participation in a life area

Value domain attributes

Representational attributes

Classification scheme: International Classification of Functioning, Disability and Health 2001

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	0	Full participation
	1	Mild participation restriction
	2	Moderate participation restriction
	3	Severe participation restriction
	4	Complete participation restriction
Supplementary values:	8	Not specified
	9	Not applicable

Collection and usage attributes

Guide for use: This metadata item contributes to the definition of the concept ‘**Disability**’ and gives an indication of the experience of disability for a person.

In the context of health, participation is involvement in a life situation. Participation restrictions are problems an individual may experience in involvement of life situations.

This metadata item may be used to describe the extent of **participation** in life situations for an individual with a health condition. The standard or norm to which an individual's participation is compared is that of an individual without a similar health condition in that particular society. The participation restriction records the discordance between the experienced participation and the expected participation of an individual without a health condition. The definition of 'particular society' is not specified and will inevitably give rise to different interpretations. If limiting the interpretation, it will be necessary to state the factors which are taken into account, for example, age, gender, ethnicity, religion, education, locality (town, state, rural, remote, urban).

The user will select the code that most closely summarises, in terms of duration, frequency, manner or outcome, the level of participation of the person for whom the data is recorded.

CODE 0 Full participation

Used when the person participates in this life area in the same way in terms of duration, frequency, manner or outcome as other individuals without a similar health condition in that particular society

CODE 1 Mild participation restriction

Used for example, when the person is restricted in their participation less than 25% of the time, and/or with a low alteration in functioning which may happen occasionally over the last 30 days

CODE 2 Moderate participation restriction

Used for example, when the person is restricted in their participation between 26% and 50% of the time with a significant, and/or with a moderate effect on functioning (Up to half the total scale of performance) which may happen regularly over the last 30 days

CODE 3 Severe participation restriction

Used for example, when participation in this life area can be achieved, but only rarely and/or with an extreme effect on functioning which may happen often over the last 30 days

CODE 4 Complete participation restriction

Used when the person can not participate in this life area. This scale has a margin of error of 5%

CODE 8 Not specified

Used when a person's participation in a life area is restricted but there is insufficient information to use codes 0-4

CODE 9 Not applicable

Used when participation in a life area is not relevant, such as employment for an infant.

Source and reference attributes

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

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

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

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

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

Data element attributes

Collection and usage attributes

Guide for use: Extent of participation is always associated with a health condition. For example, a restriction in participation in 'community, social and civic life' may be recorded when the person has had a stroke, but not when the restriction is associated only with personal preferences, without a related health condition. A value is attached to restriction of participation (i.e. a participation restriction is a disadvantage). The value is dependent on cultural norms, so that an individual may be disadvantaged in one group or location and not in another place.

This data element is used in conjunction with a specified

Activities and participation life area (ICF 2001) AN[NNN]. For example, a 'mild restriction in participation in exchange of information'.

Source and reference attributes

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

Relational attributes

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

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

External cause

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Injury event—external cause, code (ICD-10-AM 7th edn) ANN{.N[N]}

METeOR identifier: 391330

Registration status: Health, Standard 22/12/2009

Definition: The environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect, as represented by a code.

Data Element Concept: Injury event—external cause

Value domain attributes

Representational attributes

Classification scheme: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition

Representation class: Code

Data type: String

Format: ANN{.N[N]}

Maximum character length: 6

Data element attributes

Collection and usage attributes

Guide for use: This code must be used in conjunction with an injury or poisoning code and can be used with other disease codes. The external cause 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 V00 to Y84 must be accompanied by a place of occurrence code.

External cause codes V00 to Y34 must be accompanied by an activity code.

Comments: Enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research. It is also used as a quality of care indicator of adverse patient outcomes.

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

Source and reference attributes

Origin: National Centre for Classification in Health

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: Supersedes Injury event—external cause, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Implementation in Data Set Specifications: Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Injury surveillance DSS Health, Standard 14/12/2009

External cause (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—external cause, non-admitted patient code NN
METeOR identifier:	269988
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	Environmental event, circumstance or condition as the cause of injury, poisoning or other adverse effect to a non-admitted patient.
Context:	Injury surveillance: Enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.
Data Element Concept:	Injury event—external cause

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Motor vehicle - driver
02	Motor vehicle - passenger or unspecified occupant
03	Motorcycle - driver
04	Motorcycle - passenger or unspecified
05	Pedal cyclist or pedal cycle passenger
06	Pedestrian
07	Other or unspecified transport-related

	circumstance
08	Horse-related (includes fall from, struck or bitten by)
09	Fall - low (on same level or
10	Fall - high (drop of 1 metre or more)
11	Drowning, submersion - swimming pool
12	Drowning, submersion - other than swimming pool (excludes drowning associated with water craft)
13	Other threat to breathing (including strangling and asphyxiation)
14	Fire, flames, smoke
15	Hot drink, food, water, other fluid, steam, gas or vapour
16	Hot object or substance, not otherwise specified
17	Poisoning - drugs or medicinal substance
18	Poisoning - other substance
19	Firearm
20	Cutting, piercing object
21	Dog-related
22	Animal-related (excluding Horse and Dog)
23	(deleted)
24	Machinery in operation
25	Electricity
26	Hot conditions (natural origin) sunlight
27	Cold conditions (natural origins)
28	Other specified external cause
29	Unspecified external cause
30	Struck by or collision with person
31	Struck by or collision with object

Collection and usage attributes

Comments: This code list has been derived from the ICD-10-AM external cause classification.

Source and reference attributes

Reference documents: International Classification of Diseases - Tenth Revision - Australian Modification (3rd edition 2002)

Data element attributes

Collection and usage attributes

Guide for use: This metadata item is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. Non-admitted patients in emergency departments). Select the item which best characterises the circumstances of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate select the one that comes first in the code list. The external cause - non-admitted patient group must always be accompanied by an external cause - human intent code (see metadata item Injury event—external cause, non-admitted patient human intent code NN).

Comments: This metadata item has been developed to cater for the information requirements of the wide range of settings where injury surveillance is undertaken and do not have the capability of recording the complete ICD-10-AM external cause codes.
Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Source and reference attributes

Origin: National Centre for Classification in Health

National Data Standards for Injury Surveillance Advisory Group

National Health Data Committee

Reference documents: International Classification of Diseases - Tenth Revision - Australian Modification (3rd Edition 2002) National Centre for Classification in Health, Sydney

Relational attributes

Related metadata references: Supersedes External cause - non-admitted patient, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.0 KB)

External cause—human intent

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—human intent of injury, code NN
METeOR identifier:	268944
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The clinician's assessment identifying the most likely role of human intent in the occurrence of the injury or poisoning, as represented by a code.
Data Element Concept:	Injury event—human intent of injury

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Accident - injury not intended
02	Intentional self-harm
03	Sexual assault
04	Maltreatment by parent
05	Maltreatment by spouse or partner
06	Other and unspecified assault
07	Event of undetermined intent
08	Legal intervention (including police) or operations of war
09	Adverse effect or complications of medical and surgical care
10	Other specified intent

11	Intent not specified

Collection and usage attributes

Guide for use:

Select the code which best characterises the role of intent in the occurrence of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. This metadata item must always be accompanied by an Injury event—external cause, non-admitted patient human intent code NN code.

This Value domain is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. non-admitted patients in emergency departments).

Data element attributes

Collection and usage attributes

Comments:

Enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Source and reference attributes

Submitting organisation: National Data Standards for Injury Surveillance Advisory Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes External cause - human intent, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.4 KB)

Implementation in Data Set Specifications: Injury surveillance DSS Health, Standard 14/12/2009

Family name

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person (name)—family name, text X[X(39)]

Synonymous names: Surname; Last name

METeOR identifier: 286953

Registration status:
Community Services, Superseded 06/02/2012
Housing assistance, Standard 20/06/2005
Health, Standard 04/05/2005
Tasmanian Health, Proposed 28/09/2011

Definition: That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names, as represented by text.

Data Element Concept: Person (name)—family name

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: X[X(39)]

Maximum character length: 40

Data element attributes

Collection and usage attributes

Guide for use: The agency or establishment should record the person's full **family** name on their information systems.

National Community Services Data Dictionary specific:

In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. Or, where proof of identity is required, as the name that is recorded on a majority of the higher point scoring documents that are produced as proof of identity.

Collection methods:

This metadata item should be recorded for all persons who receive services from or are of interest to an organisation. For the purposes of positive identification, it may also be recorded for providers of those services who are individuals.

Mixed case should be used.

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

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

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

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

What is your family name?

____

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

____

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

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

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

Hyphenated family names:

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

Punctuation:

If special characters form part of the family name they should be included, e.g. hyphenated names should be entered with a hyphen.

Examples:

- hyphen, e.g. Wilson-Phillips

Do not leave a space before or after a hyphen, i.e. between the last letter of ‘Wilson’ and the hyphen, nor a space between the hyphen and the first letter of ‘Phillips’.

- apostrophe, e.g. O’Brien, D’Agostino

Do not leave a space before or after the apostrophe, i.e. between the ‘O’ and the apostrophe, or a space between the apostrophe and ‘Brien’.

- full stop, e.g. St. John, St. George

Do not leave a space before a full stop, i.e. between ‘St’ and the full stop. Do leave a space between the full stop and ‘John’.

- space, e.g. van der Humm, Le Brun, Mc Donald

If the health care client has recorded their family name as more than one word, displaying spaces in between the words, record their family name in the same way leaving one space between each word.

Registered unnamed newborn babies:

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

Persons with only one name:

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

Registering an unidentified person:

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

Registering health care clients from disaster sites:

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

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

If the family name needs to be shortened:

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

Use of incomplete names or fictitious names:

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

Baby for **adoption**:

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

Prefixes:

Where a family name contains a prefix, such as one to indicate that the person is a widow, this must be entered as part of the 'Family name' field. When widowed, some Hungarian women add 'Ozvegy' (abbreviation is 'Ozy') before their married family name, e.g. 'Mrs Szabo' would become 'Mrs Ozy Szabo'. That is, 'Mrs Szabo' becomes an alias name and 'Mrs Ozy Szabo' becomes the preferred name.

Ethnic Names:

The Centrelink publication, Naming Systems for Ethnic Groups, provides the correct coding for ethnic names.

Misspelled family name:

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

Comments:

Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between MacIntosh and McIntosh - can make record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) 'Given name' and 'Family name'. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred names that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family name or surname separately. These should then be recorded as 'Given name' and 'Family name' as appropriate, regardless of the order in which they may be traditionally given.

National Community Services Data Dictionary specific:

Selected letters of the family name in combination with selected letters of the given name, date of birth and sex, may be used for record linkage for statistical purposes only.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Standards Australia

Origin:

National Health Data Committee

National Community Services Data Committee

Commonwealth Department of Health and Family Services 1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Reference documents:

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

Relational attributes

Related metadata references:

Supersedes Person (name)—family name, text X[X(39)] Community Services, Superseded 25/08/2005, Health, Superseded 04/05/2005

See also Person (name)—given name, text [X(40)] Community Services, Superseded 06/02/2012, Housing assistance, Standard 20/06/2005, Health, Standard 04/05/2005, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Person—letters of family name, text XXX Community Services, Standard 27/03/2007, Housing assistance, Standard 23/08/2010, Health, Standard 07/12/2011, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Is used in the formation of Person—letters of given and family name, text XXXXX Community Services, Standard 14/09/2009

Is used in the formation of Person—letters of given name, text XX Community Services, Standard 27/03/2007, Housing assistance, Standard 23/08/2010, Health, Standard 07/12/2011, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Standard 07/12/2011

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Fasting status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—fasting indicator, code N
METeOR identifier:	302941
Registration status:	Health, Standard 21/09/2005
Definition:	Whether the patient was fasting at the time of an examination, test, investigation or procedure, as represented by a code.
Data Element Concept:	Health service event—fasting indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes: Record if the patient is fasting at the time of an examination, test, investigation or procedure.

CODE 2 No: Record if the patient is not fasting at the time of an examination, test, investigation or procedure.

Comments:

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

Source and reference attributes

Submitting organisation:

National Diabetes Data Working Group

Cardiovascular Data Working Group

Relational attributes

Related metadata references:

Supersedes Health service event—fasting status, code N Health, Superseded 21/09/2005

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Standard 01/10/2008

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

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

Feedback collection indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—feedback collection indicator, yes/no code N
METeOR identifier:	290438
Registration status:	Health, Standard 05/12/2007
Definition:	Whether feedback relating to services and service delivery is actively and routinely collected from clients and staff within a service provider organisation, as represented by a code.
Data Element Concept:	Service provider organisation—feedback collection indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

The active and routine collection of feedback from clients and/or staff means that, as a matter of routine, the agency initiates and implements feedback mechanisms and does not rely on mechanisms such as ad hoc comments, ad hoc questionnaires, informal debriefing sessions, or similar casual arrangements.

Active mechanisms include the use of periodic questionnaires that are implemented through either face-to-face interviews, by telephone or by mail, focus groups aimed at collecting feedback from the participants, established debriefing sessions, or other routine procedures the agency has in place to collect feedback.

CODE 1 Yes
The service provider organisation actively and routinely collects feedback relating to services and service delivery from clients and staff within the service provider organisation. If feedback is actively and routinely collected from clients only or staff only, this should be recorded as 'No' (Code 2).

CODE 2 No
The service provider organisation does not actively and routinely collect feedback relating to services and service delivery from clients and staff within the service provider organisation.

Collection methods: Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

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

Feedback collection method

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—feedback collection method, code N
METeOR identifier:	290476
Registration status:	Health, Standard 05/12/2007
Definition:	The method the service provider organisation employs to actively and routinely collect feedback on services and service delivery, as represented by a code.
Data Element Concept:	Service provider organisation—feedback collection method

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Questionnaire - periodic face-to-face interview
2	Questionnaire - face-to-face interview on exit
3	Questionnaire - periodic telephone interview
4	Questionnaire - telephone interview on exit
5	Questionnaire - periodic written survey
6	Questionnaire - written survey on exit
7	Feedback focus group
8	Other

Data element attributes

Collection and usage attributes

Guide for use: The active and routine collection of feedback means that, as a matter of routine, the agency initiates and implements feedback methods and does not rely on mechanisms such as ad hoc comments, ad hoc questionnaires, informal debriefing sessions, or similar casual arrangements.

Active methods include the use of periodic questionnaires that are implemented through either face-to-face interviews, by telephone or by mail, focus groups aimed at collecting feedback from the participants, established debriefing sessions, or other routine procedures the agency has in place to collect feedback.

The aim of the method used must be to collect feedback on services and service delivery.

'Periodic' may mean at set intervals or at (a) specified points in time during the service episode.

'On exit' refers to the closure of the service episode (for clients or related people), or (for staff) the time at which the staff member ceases to be employed by the agency.

CODE 7 Feedback focus group

An in-depth qualitative interview with a small number of persons, held specifically to collect feedback from the participants.

Collection methods: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

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

Conditional obligation:
Recorded when the data element *Service provider organisation—feedback collection indicator, yes/no code N* value is 'yes' (code 1).

Fibrinolytic drug used

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—fibrinolytic drug administered, code N
METeOR identifier:	356870
Registration status:	Health, Standard 01/10/2008
Definition:	The type of fibrinolytic drug administered to a person, as represented by a code.
Data Element Concept:	Person—fibrinolytic drug administered

Value domain attributes

Representational attributes

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

Permissible values:	Value	Meaning
	1	Streptokinase
	2	t-PA (Tissue Plasminogen Activator) (Alteplase)
	3	r-PA (Reteplase)
	4	TNK t-PA (Tenecteplase)
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—fibrinolytic drug administered, code N Health, Superseded 01/10/2008
Implementation in Data Set	Acute coronary syndrome pharmacotherapy data cluster

Specifications:	Health, Standard 01/10/2008 *Conditional obligation:* If prescribed, provide the fibrinolytic drug administered.

Fibrinolytic therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—fibrinolytic therapy status, code NN
METeOR identifier:	285087
Registration status:	Health, Standard 04/06/2004
Definition:	The person's fibrinolytic therapy status, as represented by a code.
Data Element Concept:	Person—fibrinolytic therapy status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
10	Given
21	Not given - therapy not indicated
22	Not given - patient refusal
23	Not given - previous haemorrhagic stroke at any time; other strokes or cerebrovascular events within 1 year
24	Not given - known intracranial neoplasm
25	Not given - active or recent (within 2 to 4 weeks) internal bleeding (does not include menses)

	26	Not given - suspected aortic dissection
	27	Not given - severe uncontrolled hypertension on presentation (blood pressure >180 mmHg systolic and/or 110 mmHg diastolic). Note: This could be an absolute contraindication in low-risk patients with MI.
	28	Not given - history of prior cerebrovascular accident or known intracerebral pathology not covered in 2.3 & 2.4 contraindications
	29	Not given - current use of anticoagulants in therapeutic doses (INR greater than or equal to 2); known bleeding diathesis
	30	Not given - recent trauma (within 2 to 4 weeks), including head trauma, traumatic or prolonged (greater than 10 minutes) CPR, or major surgery (less than 3 weeks)
	31	Not given - pregnancy
	32	Not given - other
Supplementary values:	90	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: CODES 23, 24, 25, 26, 27, 28, 29, 30 and 31

More than one code may be recorded for the following codes: 23, 24, 25, 26, 27, 28, 29, 30 and 31.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

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

Relational attributes

Related metadata references: Supersedes Fibrinolytic therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.0 KB)

Field of medicine—medical practitioner

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—principal field of medicine, medical practitioner code N
METeOR identifier:	377809
Registration status:	Health, Standard 10/12/2009
Definition:	The field of medicine in which a medical practitioner spent the most hours in the week before registration, as represented by a code.
Data Element Concept:	Registered health professional—principal field of medicine

Value domain attributes

Representational attributes

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

Permissible values:	Value	Meaning
	1	General practitioner (GP)
	2	Hospital non-specialist (salaried)
	3	Specialist
	4	Specialist-in-training
	5	Other clinician
	6	Non-clinician
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 GENERAL PRACTITIONER

A medical practitioner who works in general practice and has membership with the Royal Australian College of General Practice (RACGP) or who holds a training position supervised by a member of the college. It includes medical practitioners who are currently:

- Vocationally registered
- a RACGP fellow
- a RACGP fellowship trainee
- a GP registrar

CODE 2 HOSPITAL NON-SPECIALIST (SALARIED)

A medical practitioner mainly employed in a salaried position in a hospital who is not in training to gain a recognised specialist qualification. They include interns, Resident Medical Officers (RMOs), and Hospital Medical Officers (HMOs).

CODE 3 SPECIALIST

A medical practitioner with a qualification awarded by, or which equates to that awarded by, the relevant specialist professional college in Australia and works in that speciality area.

CODE 4 SPECIALIST-IN-TRAINING

A medical practitioner who has been accepted by a specialist medical college into a training position supervised by a member of the college and is working in that position.

CODE 5 OTHER CLINICIAN

A medical practitioner that has mainly undertaken clinical work in the week before registration, but who does not fall into any of the above categories.

CODE 6 NON-CLINICIAN

Includes all medical practitioners that have not mainly undertaken clinical work in the week prior to registration.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Registered medical professional labour force DSS Health, Standard 10/12/2009

First day of the last menstrual period

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy—first day of the last menstrual period, date DDMMYYYY
METeOR identifier:	270038
Registration status:	Health, Standard 01/03/2005
Definition:	Date of the first day of the mother's last menstrual period (LMP).
Data Element Concept:	Pregnancy—first day of the last menstrual period

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	If the first day is unknown, it is unnecessary to record the month and year (i.e. record 99999999).
Comments:	The first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Is used in the formation of Female (pregnant)—estimated gestational age, total weeks NN Health, Superseded

02/12/2009

Supersedes First day of the last menstrual period, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.6 KB)

First health service contact date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—first service contact date, DDMMYYYY
METeOR identifier:	447930
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which first contact is made between a health care provider and one or more persons for assessment, care, consultation and/or treatment, expressed as DDMMYYYY.
Data Element Concept:	Health service event—first service contact date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

Related metadata references:

See also Health service event—service request received date, DDMMYYYY Health, Standard 07/12/2011

Implementation in Data Set Specifications:

Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Conditional obligation:
Every record must contain either this item or Patient—radiotherapy start date, DDMMYYYY.

First language spoken

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—first language spoken, code (ASCL 2011) NN{NN}
METeOR identifier:	460120
Registration status:	Community Services, Standard 13/10/2011 Housing assistance, Standard 13/10/2011 Health, Standard 13/10/2011 Homelessness, Standard 13/10/2011
Definition:	The language the person identifies as being the first language that they could understand to the extent of being able to conduct a conversation, as represented by a code.
Data Element Concept:	Person—first language spoken

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Languages 2011
Representation class:	Code
Data type:	Number
Format:	NN{NN}
Maximum character length:	4

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Languages (ASCL) has a three-level hierarchical structure. The most detailed level of the classification consists of base units (languages) which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow group level), identified by the first two digits. The most general level of the classification consists of broad groups of languages (the Broad group level) and is identified by the first digit. The classification includes Australian Indigenous languages and sign languages.

For example, the Lithuanian language has a code of 3102. In this case 3 denotes that it is an Eastern European language, while 31 denotes that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denotes that it is an Australian Indigenous language and 87 denotes that the language is a Western Desert language.

Language data may be output at the Broad group level, Narrow group level or base level of the classification. If necessary, significant languages within a Narrow group can be presented separately while the remaining languages in the Narrow group are aggregated. The same principle can be adopted to highlight significant Narrow groups within a Broad group.

Data element attributes

Collection and usage attributes

Collection methods: Data should be captured, classified and stored at the base level of the classification wherever possible as this allows the greatest flexibility for output.

Recommended question:

Which language did you/the person/name first speak as a child?

English
Italian
Greek
Cantonese
Arabic
Mandarin
Vietnamese
Spanish
German
Hindu
Other (please specify)

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, this standard should be used wherever practically possible.

Comments: Persons whose first language is not English have been identified by service providers as a population group that may experience disadvantage when seeking to obtain equal access to government and community programs and services in Australia. Data relating to ‘First language spoken’ may thus provide a surrogate indicator of disadvantage potentially associated with a lack of English competence or with other factors associated with cultural background.

Source and reference attributes

Origin:

Australian Bureau of Statistics 2011. Australian Standard Classification of Languages (ASCL) 2011. Cat. no. 1267.0. Canberra: ABS.

Relational attributes

Related metadata references:

See also Person—country of birth, code (SACC 1998) NNNN Community Services, Superseded 02/06/2008, Housing assistance, Superseded 24/11/2008, Health, Superseded 01/10/2008

Supersedes Person—first language spoken, code (ASCL 2005) NN{NN} Community Services, Superseded 13/10/2011, Housing assistance, Standard 10/02/2006, Health, Superseded 13/10/2011

See also Person—main language other than English spoken at home, code (ASCL 2005) NN{NN} Community Services, Superseded 13/10/2011, Housing assistance, Standard 10/02/2006, Health, Superseded 13/10/2011

See also Person—main language other than English spoken at home, code (ASCL 2011) NN{NN} Community Services, Standard 13/10/2011, Housing assistance, Standard 13/10/2011, Health, Standard 13/10/2011, Homelessness, Standard 13/10/2011

See also Person—proficiency in spoken English, code N Community Services, Standard 01/03/2005, Housing assistance, Standard 10/02/2006, Health, Standard 01/03/2005

First time in prison or juvenile detention indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Prison entrant—first time in prison or juvenile detention indicator, yes/no code N

Synonymous names: First time imprisoned indicator; first time incarcerated indicator

METeOR identifier: 415745

Registration status: Health, Standard 25/08/2011

Definition: An indicator of whether the current imprisonment is a prison entrant's first time in prison or juvenile detention, as represented by a code.

Data Element Concept: Prison entrant—first time in prison or juvenile detention indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Incarceration history cluster Health, Standard 25/08/2011

Implementation in Data Set Specifications: Prison entrants DSS Health, Standard 25/08/2011

Floor/level type (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—floor/level type, code A[A]
Synonymous names:	Australian level type
METeOR identifier:	270024
Registration status:	Community Services, Superseded 06/02/2012 Health, Standard 01/03/2005
Definition:	The type of floor/level where a person can be located, as represented by a code.
Data Element Concept:	Person (address)—floor/level type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
B	Basement
FL	Floor
G	Ground
L	Level
LG	Lower Ground
M	Mezzanine
UG	Upper Ground

Data element attributes

Collection and usage attributes

Guide for use: Some floor/level identification may require the Floor/level type plus a Floor/level number to be recorded.

Collection methods: To be collected in conjunction with Floor/level number where applicable. Some Floor/level type entries will often have no corresponding number e.g. Basement, Ground, Lower ground, Mezzanine and Upper ground.

Source and reference attributes

Origin: Health Data Standards Committee

Australia Post Address Presentation Standard

Reference documents: AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references: Supersedes Floor/level type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)

Is used in the formation of Person (address)—address line, text [X(180)] Community Services, Standard 30/09/2005, Health, Standard 04/05/2005

Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Floor/level type (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—floor/level type, code A[A]
METeOR identifier:	290245
Registration status:	Community Services, Superseded 06/02/2012 Health, Standard 04/05/2005
Definition:	The type of floor/level where an organisation can be located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—floor/level type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
B	Basement
FL	Floor
G	Ground
L	Level
LG	Lower Ground
M	Mezzanine
UG	Upper Ground

Data element attributes

Collection and usage attributes

Collection methods: To be collected in conjunction with Floor/level number where applicable. Some Floor/level type entries will often have no corresponding number e.g. Basement, Ground,

	Lower ground, Mezzanine and Upper ground.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Community Services, Standard 30/09/2005, Housing assistance, Recorded 13/10/2011, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Standard 03/12/2008

Foot deformity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot deformity indicator, code N
METeOR identifier:	302449
Registration status:	Health, Standard 21/09/2005
Definition:	Whether a deformity is present on either foot, as represented by a code.
Data Element Concept:	Person—foot deformity indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes

	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes: Record if a foot deformity is present on either foot.

CODE 2 No: Record if no foot deformity is present on either foot.

Common deformities include claw toes, pes cavus, hallux valgus, hallux rigidus, hammer toe, Charcot foot and nail deformity.

Collection methods: Both feet to be examined for the presence of foot deformity.

Comments: Foot deformities are associated with high mechanical pressure on the overlying skin that lead to ulceration in the absence of protective pain sensation and when shoes are unsuitable. Limited joint mobility is often present, with displaced plantar fat pad and more prominent metatarsal heads.

Source and reference attributes

Submitting organisation: National diabetes data working group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

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

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

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

Most RS, Sinnock P. The epidemiology of lower limb extremity amputations in diabetic individuals. Diabetes

	Care 1983; 6: 87 - 91. Therapeutic Guidelines Limited (05.04.2002) Management plan for diabetes.

Relational attributes

Related metadata references:	Supersedes Person—foot deformity status, code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Foot lesion (active)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot lesion indicator (active), code N
METeOR identifier:	302437
Registration status:	Health, Standard 21/09/2005
Definition:	Whether an individual has an active foot lesion, other than an ulcer, on either foot, as represented by a code.
Data Element Concept:	Person—foot lesion indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes: Record if current active foot lesion other than ulceration is present on either foot.

CODE 2 No: Record if no current active foot lesion other than ulceration is present on either foot.

The following entities would be included: fissures, infections, inter-digital maceration, corns, calluses and nail dystrophy.

Collection methods: Assess whether the individual has an active foot lesion on either foot.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

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

Relational attributes

Related metadata references: Supersedes Person—foot lesion status (active), code N Health, Superseded 21/09/2005

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

Foot ulcer (history)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot ulcer indicator (history), code N
METeOR identifier:	302819
Registration status:	Health, Standard 21/09/2005
Definition:	Whether person has a previous history of ulceration on either foot, as represented by a code.
Data Element Concept:	Person—foot ulcer indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes: Record if person has a previous history of ulceration on either foot.

CODE 2 No: Record if person has no previous history of ulceration on either foot.

Collection methods:

Ask the individual if he/she a previous history of foot ulceration. Alternatively obtain this information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Person—foot ulcer history status, code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Foot ulcer (current)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot ulcer indicator (current), code N
METeOR identifier:	302445
Registration status:	Health, Standard 21/09/2005
Definition:	Whether an individual has a current foot ulcer on either foot, as represented by a code.
Data Element Concept:	Person—foot ulcer indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes: Record if a foot ulcer is currently present on either foot.

CODE 2 No: Record if a foot ulcer is not currently present on either foot.

Collection methods: Access whether the individual has a current foot ulcer on either foot.

Assessment

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

Comments: Foot ulcer is usually situated on the edge of the foot or toes because blood supply is the poorest at these sites. In a purely vascular ulcer, nerve function is normal and sensation is intact, hence vascular ulcers are usually painful.

Foot ulcers require urgent care from an interdisciplinary team, which may include a general practitioner, podiatrist, endocrinologist physician, nurse or surgeon.

Source and reference attributes

Submitting organisation: National diabetes data working group

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

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

Relational attributes

Related metadata references: Supersedes Person—foot ulcer status (current), code N Health, Superseded 21/09/2005

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

Formal community support access status

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—formal community support access indicator (current), code N

METeOR identifier: 270169

Registration status: Health, Standard 01/03/2005

Definition: Whether a person is currently accessing a formal community support service or services, as represented by a code.

Data Element Concept: Person—formal community support access indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Currently accessing
	2	Currently not accessing
Supplementary values:	9	Not known/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: CODE 1:

The person is currently accessing at least one paid community support service (i.e. meals on wheels, home help, in-home respite, service packages, district nursing services, etc).

CODE 2:

The person is not currently accessing any paid community support service or services.

CODE 9:

The person's current status with regards to accessing community support services is not known or inadequately described for more specific coding.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references: Supersedes Formal community support access status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Frequency consumed 6 or more standard drinks on one occasion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—consumption of 6 or more standard drinks on one occasion, AUDIT consumption of 6 or more standard drinks code N
METeOR identifier:	403107
Registration status:	Health, Standard 25/08/2011
Definition:	A person's self-reported frequency of consuming six or more standard drinks on one occasion, as represented by a code.
Data Element Concept:	Person—consumption of 6 or more standard drinks on one occasion

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
0	Never
1	Less than monthly
2	Monthly
3	Weekly
4	Daily or almost daily

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Department of Health and Ageing 2009. The Australian Standard Drink. Canberra: Department of Health and Ageing.

Babor T, Higgins-Biddle JC, Saunders JB, Monteiro MG

2001.The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care. 2nd edn. Switzerland: World Health Organization.

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data elements: *Person—alcohol consumption frequency, AUDIT alcohol consumption frequency code N* and *Person—alcohol consumption amount (self-reported), total standard drinks NN* to obtain a score on the Alcohol Use Disorders Identification Test (AUDIT) and consequently obtain a risk of alcohol-related harm.

Comments: The AUDIT is an alcohol screen that can help identify patients who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Department of Health and Ageing 2009. The Australian Standard Drink. Canberra: Department of Health and Ageing.

Babor T, Higgins-Biddle JC, Saunders JB, Monteiro MG 2001. The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care. 2nd edn. Switzerland: World Health Organization.

Relational attributes

Related metadata references: See also Person—alcohol consumption amount (self-reported), total standard drinks NN Health, Standard 01/03/2005

See also Person—alcohol consumption frequency, AUDIT alcohol consumption frequency code N Health, Standard 25/08/2011

Implementation in Data Set Specifications: AUDIT score of risky alcohol consumption cluster Health, Standard 25/08/2011

Conditional obligation:
Conditional on the person having had an alcoholic drink in the last 12 months.

Full-time equivalent staff (mental health)—all staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}]
METeOR identifier:	296553
Registration status:	Health, Standard 08/12/2004
Definition:	The aggregate full-time equivalent staff units paid for all staffing categories within a mental health establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:

The total is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

Full-time equivalent staff units are the on-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary-time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are to be excluded.

Contract staff employed through an agency are included where the contract is for the supply of labour (e.g. nursing) rather than of products (e.g. photocopier maintenance). In the former case, the contract would normally specify the amount of labour supplied and could be reported as full-time equivalent units.

Collection methods:

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one hospital (for Public hospitals NMDS) or service unit (for Mental health establishments NMDS), full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments:

This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Establishment—full-time equivalent staff (paid) (administrative and clerical staff), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (carer consultants), average N[NNN{.N}] Health, Standard 08/12/2004

Is formed using Establishment—full-time equivalent staff (paid) (consumer consultants), average N[NNN{.N}] Health, Standard 08/12/2004

Is formed using Establishment—full-time equivalent staff (paid) (diagnostic and health professionals), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (domestic and other staff), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (enrolled nurses), average N[NNN{.N}] Health,

Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (other personal care staff), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (registered nurses), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (salaried medical officers), average N[NNN{.N}] Health, Standard 01/03/2005

Full-time equivalent staff—administrative and clerical staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (administrative and clerical staff), average N[NNN{.N}]
METeOR identifier:	270496
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **administrative and clerical staff** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (administrative and clerical staff)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Staff engaged in administrative and clerical duties. Medical staff and nursing staff, diagnostic and health professionals and any domestic staff primarily or partly engaged in administrative and clerical duties are excluded. Civil engineers and computing staff are included in this metadata item.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—average

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid), average N[NNN{.N}]
METeOR identifier:	270543
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all staffing categories within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Calculated by adding the full-time equivalents for each staffing category listed below:

C1.1 Salaried medical officers

C1.2 Registered nurses

C1.3 Enrolled nurses

C1.4 Student nurses

C1.5 Trainee/pupil nurses

C1.6 Other personal care staff

C1.7 Diagnostic and health professionals

C1.8 Administrative and clerical staff

C1.9 Domestic and other staff

The average is to be calculated from pay period figures.

The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Full-time equivalent staff units are the on-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary-time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are to be excluded.

Contract staff employed through an agency are included where the contract is for the supply of labour (e.g. nursing) rather than of products (e.g. photocopier maintenance). In the former case, the contract would normally specify the amount of labour supplied and could be reported as full-time equivalent units.

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Full-time equivalent staff—carer consultants

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (carer consultants), average N[NNN{.N}]
METeOR identifier:	296498
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **carer consultants** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (carer consultants)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Carer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of carers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the carer only received reimbursements of expenses or occasional sitting fees for attendance at meetings.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—consultant psychiatrists and psychiatrists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists), average N[NNN{.N}]
METeOR identifier:	287509
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **consultant psychiatrists and psychiatrists** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Medical officers who are registered to practice psychiatry under the relevant state or territory Medical Registration Board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure metadata items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—consumer consultants

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—full-time equivalent staff (paid) (consumer consultants), average N[NNN{.N}]

METeOR identifier: 296496

Registration status: Health, Standard 08/12/2004

Definition: The average number of full-time equivalent staff units paid for all **consumer consultants** within an establishment.

Data Element Concept: Establishment—full-time equivalent staff (paid) (consumer consultants)

Value domain attributes

Representational attributes

Representation class: Average

Data type: Number

Format: N[NNN{.N}]

Maximum character length: 5

Unit of measure: Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use: Consumer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of consumers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the consumer only received reimbursements of expenses or occasional sitting fees for attendance at meetings.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:
If specialised mental health service organisation-consumer participation arrangements status (consumer consultants employed) METeOR 288866 = 1, this data element must be completed.

Full-time equivalent staff—diagnostic and health professionals

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—full-time equivalent staff (paid) (diagnostic and health professionals), average N[NNN{.N}]

METeOR identifier: 270495

Registration status: Health, Standard 01/03/2005

Definition: The average number of full-time equivalent staff units paid for all **diagnostic and health professionals** within an establishment.

Data Element Concept: Establishment—full-time equivalent staff (paid) (diagnostic and health professionals)

Value domain attributes

Representational attributes

Representation class: Average

Data type: Number

Format: N[NNN{.N}]

Maximum character length: 5

Unit of measure: Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use: Qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature (but also including diagnostic and health professionals whose duties are primarily or partly of an administrative nature). This metadata item includes all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff). This metadata item includes full-time equivalent staff units of occupational therapists, social workers, psychologists, and other diagnostic and health professionals.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—domestic and other staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (domestic and other staff), average N[NNN{.N}]
METeOR identifier:	270498
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **domestic and other staff** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (domestic and other staff)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Domestic staff are staff engaged in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.

This metadata item also includes all staff not elsewhere included (primarily maintenance staff, trades people and gardening staff).

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—enrolled nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (enrolled nurses), average N[NNN{.N}]
METeOR identifier:	270497
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **enrolled nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (enrolled nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Enrolled nurses are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states).

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—nurses

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—full-time equivalent staff (paid) (nurses), average NNNN.NN

METeOR identifier: 426703

Registration status: Health, Standard 07/12/2011

Definition: The average number of full-time equivalent staff units paid for all nurses within an establishment.

Data Element Concept: Establishment—full-time equivalent staff (paid) (nurses)

Value domain attributes

Representational attributes

Representation class: Average

Data type: Number

Format: NNNN.NN

Maximum character length: 6

Unit of measure: Full-time equivalent (FTE) staff

Unit of measure precision: 2

Data element attributes

Collection and usage attributes

Guide for use: Includes registered and enrolled nurses employed by the organisation on a full-time or part-time salaried basis. Excludes trainee/pupil and student nurses.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Enrolled nurse Health, Standard 01/03/2005

See also Registered nurse Health, Standard 01/03/2005

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—occupational therapists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (occupational therapists), average N[NNN{.N}]
METeOR identifier:	287603
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **occupational therapists** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (occupational therapists)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Occupational Therapists.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—other diagnostic and health professionals

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals), average N[NNN{.N}]

METeOR identifier: 287611

Registration status: Health, Standard 08/12/2004

Definition: The average number of full-time equivalent staff units paid for all **other diagnostic and health professionals** within an establishment.

Data Element Concept: Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals)

Value domain attributes

Representational attributes

Representation class: Average

Data type: Number

Format: N[NNN{.N}]

Maximum character length: 5

Unit of measure: Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use: Includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature. This metadata item covers all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff).

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—other medical officers

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—full-time equivalent staff (paid) (other medical officers), average N[NNN{.N}]

METeOR identifier: 287531

Registration status: Health, Standard 08/12/2004

Definition: The average number of full-time equivalent staff units paid for all **other medical officers** within an establishment.

Data Element Concept: Establishment—full-time equivalent staff (paid) (other medical officers)

Value domain attributes

Representational attributes

Representation class: Average

Data type: Number

Format: N[NNN{.N}]

Maximum character length: 5

Unit of measure: Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use: Medical officers employed or engaged by the organisation who are neither registered as psychiatrists within the state or territory nor formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure metadata items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—other personal care staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (other personal care staff), average N[NNN{.N}]
METeOR identifier:	270171
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **other personal care staff** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (other personal care staff)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item includes attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Steward: Australian Bureau of Statistics (ABS)

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—psychiatry registrars and trainees

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees), average N[NNN{.N}]

METeOR identifier: 287529

Registration status: Health, Standard 08/12/2004

Definition: The average number of full-time equivalent staff units paid for all **psychiatry registrars and trainees** within an establishment.

Data Element Concept: Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees)

Value domain attributes

Representational attributes

Representation class: Average

Data type: Number

Format: N[NNN{.N}]

Maximum character length: 5

Unit of measure: Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use: Medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—psychologists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (psychologists), average N[NNN{.N}]
METeOR identifier:	287609
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **psychologists** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (psychologists)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Persons who are registered as psychologists with the relevant state and territory registration board.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments:

This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—registered nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (registered nurses), average N[NNN{.N}]
METeOR identifier:	270500
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **registered nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (registered nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—salaried medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (salaried medical officers), average N[NNN{.N}]
METeOR identifier:	270494
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **salaried medical officers** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (salaried medical officers)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Medical officers employed by the hospital on a full time or part time salaried basis. This excludes visiting medical officers engaged on an honorary, sessional or fee for service basis.

This metadata item includes salaried medical officers who are engaged in administrative duties regardless of the extent of that engagement (for example, clinical superintendent and medical superintendent).

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Comments:

This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Relational attributes

Related metadata references:

Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—social workers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (social workers), average N[NNN{.N}]
METeOR identifier:	287607
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **social workers** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (social workers)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—student nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (student nurses), average N[NNN{.N}]
METeOR identifier:	270499
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **student nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (student nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Full-time equivalent staff—trainee/pupil nurses

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—full-time equivalent staff (paid) (trainee/pupil nurses), average N[NNN{.N}]

METeOR identifier: 270493

Registration status: Health, Standard 01/03/2005

Definition: The average number of full-time equivalent staff units paid for all **trainee/pupil nurses** within an establishment.

Data Element Concept: Establishment—full-time equivalent staff (paid) (trainee/pupil nurses)

Value domain attributes

Representational attributes

Representation class: Average

Data type: Number

Format: N[NNN{.N}]

Maximum character length: 5

Unit of measure: Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use: The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Fully immunised recorded indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Child—fully immunised recorded indicator, yes/no code N
METeOR identifier:	457664
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a child has been recorded as fully immunised, as represented by a code.
Data Element Concept:	Child—recorded as fully immunised indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes

A child is recorded as fully immunised.

CODE 2 No

A child is not recorded as fully immunised.

Comments: 'Fully immunised' status is determined in accordance with the National Immunisation Program Schedule. The childhood vaccinations essential to be considered 'fully immunised' include:

- DTPa (diphtheria, tetanus, pertussis)
- HiB (haemophilus influenzae type B)
- Polio
- Hep B (hepatitis B)
- MMR (measles, mumps, rubella).

A child is considered 'fully immunised' if they have received the following vaccinations by the specified age milestones:

- At 12 months: 3 doses DTPa; 3 doses Polio; 2 or 3 doses HiB; 2 or 3 doses Hep B
- At 24 months: 3 doses DTPa; 3 doses Polio; 3 or 4 doses HiB; 3 doses Hep B; 1 dose MMR
- At 60 months: 4 doses DTPa; 4 doses Polio; 2 doses MMR.

(Department of Health and Ageing 2011)

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Reference documents: Department of Health and Ageing 2011. National Immunisation Program Schedule, Immunise Australia Program. Department of Health and Ageing, Canberra. Viewed 25 July 2011:

http://www.health.gov.au/internet/immunise/publishing.nsf/content/nips2

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Functional stress ischaemic and perfusion outcome result

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Functional stress test—ischaemic and perfusion outcome result, code N
Synonymous names:	Functional stress test result
METeOR identifier:	349703
Registration status:	Health, Standard 01/10/2008
Definition:	The result of the person's functional stress test in terms of ischaemic and perfusion outcomes, as represented by a code.
Data Element Concept:	Functional stress test—ischaemic and perfusion outcome result

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	No abnormal outcome
	2	Ischaemic discomfort and/or ST shift
	3	Fixed perfusion or wall motion defects only
	4	Reversible perfusion or wall motion defects only
	5	Fixed and reversible perfusion and wall motion defects
	6	Equivocal
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Depending on the method used for the stress test, and therefore the way the results are viewed, some of these codes will not be applicable. For example where an ECG was used for the stress test codes 3, 4 and 5 will not be applicable.

CODE 1   No abnormal outcome

Use this code when the stress test result identifies no evidence of ischaemia (i.e. no typical angina pain and no ST shifts).

CODE 2   Ischaemic discomfort and/or ST shift

Use this code when the stress test result identifies either:

- Both ischaemic discomfort and ST shift greater than or equal to 1 mm (0.1 mV) (horizontal or downsloping); or
- new ST shift greater than or equal to 2 mm (0.2 mV) (horizontal or down-sloping) believed to represent ischaemia even in the absence of ischaemic discomfort.

This code only applies to stress tests where no imaging component was performed.

CODE 3   Fixed perfusion or wall motion defects only

Use this code when the stress test result identifies fixed perfusion defects only. This means the presence of non-viable myocardium with no areas of inducible ischaemia during functional stress testing.

This code only applies to stress tests where an imaging component was performed.

CODE 4   Reversible perfusion or wall motion defects only

Use this code when the stress test result identifies reversible perfusion defects only. This means the presence of inducible defects in myocardial perfusion with underlying viable myocardium in all areas.

This code only applies to stress tests where an imaging component was performed.

CODE 5   Fixed and reversible perfusion or wall motion defects

Use this code when the stress test result identifies reversible and fixed perfusion defects. This means the presence of non-viable myocardial areas, together with areas of inducible defects in reperfusion.

This code only applies to stress tests where an imaging component was performed.

CODE 6   Equivocal

Use this code when the stress test result identifies either:

- Typical ischaemic pain but no ST shift greater than or equal to 1 mm (0.1 mV) (horizontal or downsloping); OR ST shift of 1 mm (0.1 mV) (horizontal or downsloping) but no ischaemic discomfort.
- Defect on myocardial imaging of uncertain nature or significance.

Data element attributes

Relational attributes

Related metadata references: Supersedes Person—functional stress test ischaemic result, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Functional stress test cluster Health, Standard 01/10/2008

Conditional obligation:
To be provided when a functional stress test is performed.

Functional stress test assessment of cardiac perfusion

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Functional stress test—assessment of cardiac perfusion, code N[N]

Synonymous names: Functional stress test method

METeOR identifier: 344432

Registration status: Health, Standard 01/10/2008

Definition: The method of functional assessment of cardiac perfusion undertaken in a person's stress test, as represented by a code.

Data Element Concept: Functional stress test—assessment of cardiac perfusion

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Exercise tolerance
	2	Pharmacological
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Exercise tolerance

Use this code when a treadmill, bicycle or arm-exercise was used to increase the cardiac work.

CODE 2 Pharmacological

Use this code when any form of pharmacologic augmentation was used to increase cardiac work. For example, dobutamine, atropine or persantin.

CODE 9 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Relational attributes

Implementation in Data Set Specifications:

Functional stress test cluster Health, Standard 01/10/2008

Conditional obligation:
To be provided when a functional stress test is performed.

Functional stress test element

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Functional stress test—stress test element, code N
METeOR identifier:	356883
Registration status:	Health, Standard 01/10/2008
Definition:	The element included in a person's functional stress test, as represented by a code.
Data Element Concept:	Functional stress test—functional stress test element

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	ECG monitoring
	2	Echocardiography
	3	Radionuclide (perfusion) imaging (e.g. Thallium, Sestamibi)
	4	Positron Emission Tomography (PET)
	5	Magnetic Resonance Imaging (MRI)
Supplementary values:	9	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: More than one code may be recorded (code 9 is excluded from multiple coding).

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Related metadata references: Supersedes Person—functional stress test element, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Functional stress test cluster Health, Standard 01/10/2008

Conditional obligation:
To be provided when a functional stress test is performed.

Functional stress test intensity

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Functional stress test— stress test intensity, code N

METeOR identifier: 344443

Registration status: Health, Standard 01/10/2008

Definition: The intensity of the functional stress test performed on a person, as represented by a code.

Data Element Concept: Functional stress test—stress test intensity

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Maximal (symptom limited)
	2	Submaximal
	3	Rest / distribution study
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 1 Maximal (symptom limited)

Use this code when the intensity of the stress test is to increase the person's heart rate with the exercise to 85-90% of their predicted maximum heart rate.

CODE 2 Submaximal

Use this code when the intensity of the stress test is limited to increasing the person's heart rate with the exercise to 120 beats per minute or 70% of their predicted maximum heart rate.

CODE 3 Rest/distribution study

Use this code when a Thallium (nuclear) study has been undertaken for the assessment of viability, where no exercise or pharmacologic stress component has been undertaken

CODE 9 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Collection and usage attributes

Collection methods: The intensity is determined and recorded by the clinicians performing the test.

Comments: The stress test intensity has implications for the interpretation of the test results.

Relational attributes

Implementation in Data Set Specifications: Functional stress test cluster Health, Standard 01/10/2008

Conditional obligation:
To be provided when a functional stress test is performed.

Functional stress test performed indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—functional stress test performed indicator, yes/no code N

METeOR identifier: 347697

Registration status: Health, Standard 01/10/2008

Definition: An indicator of whether a functional stress test was performed on a person, as represented by a code.

Data Element Concept: Person—functional stress test performed indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: Code 1 Yes

Record if a functional stress test was performed.

Code 2 No

Record if no functional stress test was performed.

Relational attributes

Implementation in Data Set Specifications:	Functional stress test cluster Health, Standard 01/10/2008

Funding source for hospital patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—principal source of funding, hospital code NN
METeOR identifier:	339080
Registration status:	Health, Standard 29/11/2006
Definition:	The principal source of funds for an admitted patient episode or non-admitted patient service event, as represented by a code.
Context:	Admitted patient care. Hospital non-admitted patient care.
Data Element Concept:	Episode of care—principal source of funding

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Australian Health Care Agreements
02	Private health insurance
03	Self-funded
04	Worker’s compensation
05	Motor vehicle third party personal claim
06	Other compensation (e.g. public liability, common law, medical negligence)

	07	Department of Veterans' Affairs
	08	Department of Defence
	09	Correctional facility
	10	Other hospital or public authority (contracted care)
	11	Reciprocal health care agreements (with other countries)
	12	Other
	13	No charge raised
Supplementary values:	99	Not known

Collection and usage attributes

Guide for use:

CODE 01 Australian Health Care Agreements

Australian Health Care Agreements should be recorded as the funding source for Medicare eligible admitted patients who elect to be treated as public patients and Medicare eligible emergency department patients and Medicare eligible patients presenting at a public hospital outpatient department for whom there is not a third party arrangement.

Includes: Public admitted patients in private hospitals funded by state or territory health authorities (at the state or regional level).

Excludes: Inter-hospital contracted patients and overseas visitors who are covered by Reciprocal health care agreements and elect to be treated as public admitted patients.

CODE 02 Private health insurance

Excludes: overseas visitors for whom travel insurance is the major funding source.

CODE 03 Self-funded

This code includes funded by the patient, by the patient's family or friends, or by other benefactors.

CODE 10 Other hospital or public authority

Includes: Patients receiving treatment under contracted care arrangements (Inter-hospital contracted patient).

CODE 11 Reciprocal health care agreements (with other countries)

Australia has Reciprocal Health Care Agreements with the

United Kingdom, the Netherlands, Italy, Malta, Sweden, Finland, Norway, New Zealand and Ireland. The Agreements provide for free accommodation and treatment as public hospital services, but do not cover treatment as a private patient in any kind of hospital.

– The Agreements with Finland, Italy, Malta, the Netherlands, Norway, Sweden and the United Kingdom provide free care as a public patient in public hospitals, subsidised out-of-hospital medical treatment under Medicare, and subsidised medicines under the Pharmaceutical Benefits Scheme.

– The Agreements with New Zealand and Ireland provide free care as a public patient in public hospitals and subsidised medicines under the Pharmaceutical Benefits Scheme, but do not cover out-of-hospital medical treatment.

– Visitors from Italy and Malta are covered for a period of six months from the date of arrival in Australia only.

Excludes: Overseas visitors who elect to be treated as private patients.

CODE 12 Other funding source

Includes: Overseas visitors for whom travel insurance is the major funding source.

CODE 13 No charge

Includes: Admitted patients who are Medicare ineligible and receive public hospital services free of charge at the discretion of the hospital or the state/territory. Also includes patients who receive private hospital services for whom no accommodation or facility charge is raised (for example, when the only charges are for medical services bulk-billed to Medicare), and patients for whom a charge is raised but is subsequently waived.

Excludes: Admitted public patients (Medicare eligible) whose funding source should be recorded as Australian Health Care Agreements or Reciprocal Health Care Agreements. Also excludes Medicare eligible non-admitted patients, presenting to a public hospital emergency department and Medicare eligible patients (for whom there is not a third party payment arrangement) presenting at a public hospital outpatient department, whose funding source should be recorded as Australian Health Care Agreements.

Also excludes patients presenting to an outpatient department who have chosen to be treated as a private patient and have been referred to a named medical specialist who is exercising a right of private practice. These patients are not considered to be patients of the hospital (see Guide for use).

Data element attributes

Collection and usage attributes

Guide for use:

If there is an expected funding source followed by a finalised actual funding source (for example, in relation to compensation claims), then the actual funding source known at the end of the reporting period should be recorded.

The expected funding source should be reported if the fee has not been paid but is not to be waived.

If a charge is raised for accommodation or facility fees for the episode/service event, the intent of this data element is to collect information on who is expected to pay, provided that the charge would cover most of the expenditure that would be estimated for the episode/service event. If the charge raised would cover less than half of the expenditure, then the funding source that represents the majority of the expenditure should be reported.

The major source of funding should be reported for nursing-home type patients.

Relational attributes

Related metadata references:

Supersedes Episode of care—expected principal source of funding, hospital code NN Health, Superseded 29/11/2006

See also Non-admitted patient service event—principal source of funding Health, Standard 01/12/2010

See also Non-admitted patient service event—principal source of funding, code NN Health, Standard 01/12/2010

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Funding source for hospital patient

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of care—source of funding, patient funding source code NN

METeOR identifier: 472033

Registration status: Health, Standard 11/04/2012

Definition: The source of funds for an admitted patient episode or non-admitted patient service event, as represented by a code.

Context: Admitted patient care.

Hospital non-admitted patient care.

Data Element Concept: Episode of care—source of funding

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: NN

Maximum character length: 2

Permissible values:

Value	Meaning
01	Health service budget (not covered elsewhere)
02	Health service budget (due to eligibility for Reciprocal Health Care Agreement)
03	Health service budget (no charge raised due to hospital decision)
04	Department of Veterans' Affairs
05	Department of Defence
06	Correctional facility
07	Medicare Benefits Scheme
08	Other hospital or public authority (contracted care)

	09	Private health insurance
	10	Worker’s compensation
	11	Motor vehicle third party personal claim
	12	Other compensation (e.g. public liability, common law, medical negligence)
	13	Self-funded
	88	Other funding source
Supplementary values:	98	Not known

Collection and usage attributes

Guide for use:

CODE 01 Health service budget (not covered elsewhere)

Health service budget (not covered elsewhere) should be recorded as the funding source for Medicare eligible patients for whom there is no other funding arrangement.

CODE 02 Health service budget (due to eligibility for Reciprocal Health Care Agreement)

Patients who are overseas visitors from countries covered by Reciprocal Health Care Agreements.

Australia has Reciprocal Health Care Agreements with the United Kingdom, the Netherlands, Italy, Malta, Sweden, Finland, Norway, Belgium, Slovenia, New Zealand and Ireland. The Agreements provide for free accommodation and treatment as public hospital services, but do not cover treatment as a private patient in any kind of hospital.

The Agreements with Finland, Italy, Malta, the Netherlands, Norway, Sweden, Belgium, Slovenia and the United Kingdom provide free care as a public patient in public hospitals, subsidised out-of-hospital medical treatment under Medicare, and subsidised medicines under the Pharmaceutical Benefits Scheme.

The Agreements with New Zealand and Ireland provide free care as a public patient in public hospitals and subsidised medicines under the Pharmaceutical Benefits Scheme, but do not cover out-of-hospital medical treatment.

Visitors from Italy and Malta are covered for a period of six months from the date of arrival in Australia only.

Visitors from Belgium, the Netherlands and Slovenia require their European Health Insurance card to enrol in Medicare. They are eligible for treatment in public hospitals until the expiry date indicated on the card, or to the length of their authorised stay in Australia if earlier.

Excludes: Overseas visitors who elect to be treated as private patients or under travel insurance.

CODE 03 Health service budget (no charge raised due to hospital decision)

Patients who are Medicare ineligible and receive public hospital services free of charge at the discretion of the hospital or the state/territory. Also includes patients who receive private hospital services for whom no accommodation or facility charge is raised (for example, when the only charges are for medical services bulk-billed to Medicare) and patients for whom a charge is raised but is subsequently waived.

CODE 07 Medicare Benefits Scheme

Medicare eligible patients presenting at a public hospital for whom services are billed to Medicare. Includes both bulk-billed patients and patients with out-of-pocket expenses. This value is not applicable for admitted patients.

CODE 08 Other hospital or public authority (contracted care)

Patients receiving treatment under contracted arrangements with another hospital (inter-hospital contracted patient) or a public authority (e.g. a state or territory government).

CODE 09 Private health insurance

Patients who are funded by private health insurance, including travel insurance for Medicare eligible patients. If patients receive any funding from private health insurance, choose Code 09, regardless of whether it is the majority source of funds.

Excludes: Overseas visitors for whom travel insurance is the major funding source.

CODE 13 Self-funded

This code includes funded by the patient, by the patient's family or friends, or by other benefactors.

CODE 88 Other funding source

This code includes overseas visitors for whom travel insurance is the major funding source.

Data element attributes

Collection and usage attributes

Guide for use:

The source of funding should be assigned based on a best estimate of where the majority of funds come from, except for private health insurance, which should be assigned wherever there is a private health insurance contribution to the cost. This data element is not designed to capture information on out-of-pocket expenses to patients (for example, fees only partly covered by the Medicare Benefits Schedule).

If a charge is raised for accommodation or facility fees for the episode/service event, the intent of this data element is to collect information on who is expected to pay, provided that the charge would cover most of the expenditure that would be estimated for the episode/service event. If the charge raised would cover less than half of the expenditure, then the funding source that represents the majority of the expenditure should be reported.

If there is an expected funding source followed by a finalised actual funding source (for example, in relation to compensation claims), then the actual funding source known at the end of the reporting period should be recorded.

The expected funding source should be reported if the fee has not been paid but is not to be waived.

The major source of funding should be reported for nursing-home type patients.

Relational attributes

Related metadata references:

See also Non-admitted patient service event—principal source of funding, code NN Health, Standard 01/12/2010

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Geographic remoteness—admitted patient care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—geographic remoteness, admitted patient care remoteness classification (ASGC-RA) N
Synonymous names:	Geographic remoteness of establishment
METeOR identifier:	461473
Registration status:	Health, Standard 07/12/2011
Definition:	The remoteness of an establishment providing admitted patient care, based on the physical road distance to the nearest urban centre and its population size, as represented by a code.
Data Element Concept:	Establishment—geographic remoteness

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Geographical Classification 2010
Representation class:	Code
Data type:	String
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	Major cities of Australia
1	Inner regional Australia
2	Outer regional Australia
3	Remote Australia
4	Very remote Australia

	5	Migratory
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

This value domain is intended exclusively for use when collecting data relating to admitted patient care.

CODE 0 Major cities of Australia

'Major cities of Australia' includes Census Collection Districts (CDs) with an average Accessibility/Remoteness Index of Australia (ARIA+) index value of 0 to 0.2.

CODE 1 Inner regional Australia

'Inner regional Australia' includes CDs with an average ARIA+ index value greater than 0.2 and less than or equal to 2.4.

CODE 2 Outer regional Australia

'Outer regional Australia' includes CDs with an average ARIA+ index value greater than 2.4 and less than or equal to 5.92.

CODE 3 Remote Australia

'Remote Australia' includes CDs with an average ARIA+ index value greater than 5.92 and less than or equal to 10.53.

CODE 4 Very remote Australia

'Very remote Australia' includes CDs with an average ARIA+ index value greater than 10.53.

CODE 5 Migratory

'Migratory' is composed of off-shore, shipping and migratory CDs.

This value domain allows for the allocation of remoteness codes in accordance with those used by the Australian Bureau of Statistics (ABS) remoteness structure. It is intended exclusively for use in the collection of admitted patient care data, where historically data has been remoteness coded to the value range 0-5. The similarly structured value domain, using the value range 1-6 for remoteness, should be used wherever possible (see the 'Related metadata references' section below).

Collection methods:

In this value domain, physical distance is defined in terms of ARIA+ codes, rather than a simple linear distance between points.

The list of permissible values for this value domain, i.e. codes 0 to 5, is the same as that used by the ABS to describe remoteness areas, i.e. codes 0 to 5, and is directly to mappable to the code range used 1-6 in the related value domain linked below (see the 'Related metadata references' section).

Comments:

In its initial form, as developed by GISCA and the then Department of

Health and Aged Care in 1999, ARIA scores ranged from 0 to 12 and were based on proximity to 4 points of reference.

A new version, ARIA+, was introduced in 2003, with ARIA+ scores now based on proximity to 5 points of reference. Also, changes were made to allow for more accurate estimation of the cost of travelling from Tasmania to the mainland, and to increase accuracy for locations at the urban fringe.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Information relating to remoteness is available from the Geography portal on the ABS website:

Australian Bureau of Statistics 2011. ABS Geography. Viewed 14 November 2011,

<http://www.abs.gov.au/websitedbs/D3310114.nsf/home/Geography>

Information relating to the development of the ARIA and ARIA+ scores by the National Centre for Social Applications of Geographic Information Systems (GISCA) is available from the GISCA website:

National Centre for Social Applications of Geographic Information Systems 2011. ARIA - Accessibility/Remoteness Index of Australia. Viewed 14 November 2011,
<http://gisca.adelaide.edu.au/projects/aria_project.html>

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Geographic remoteness

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health-care incident—geographic remoteness, remoteness classification (ASGC-RA) N
Synonymous names:	Geographic remoteness of health-care incident
METeOR identifier:	466881
Registration status:	Health, Standard 07/12/2011
Definition:	The remoteness of the location at which a health-care incident took place, based on the physical road distance to the nearest urban centre and its population size, as represented by a code.
Data Element Concept:	Health-care incident—geographic remoteness

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Geographical Classification 2010
Representation class:	Code
Data type:	String
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Major cities of Australia
2	Inner regional Australia
3	Outer regional Australia
4	Remote Australia

	5	Very remote Australia
	6	Migratory
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 1 Major cities of Australia

'Major cities of Australia' includes Census Collection Districts (CDs) with an average Accessibility/Remoteness Index of Australia (ARIA+) index value of 0 to 0.2.

CODE 2 Inner regional Australia

'Inner regional Australia' includes CDs with an average ARIA+ index value greater than 0.2 and less than or equal to 2.4.

CODE 3 Outer regional Australia

'Outer regional Australia' includes CDs with an average ARIA+ index value greater than 2.4 and less than or equal to 5.92.

CODE 4 Remote Australia

'Remote Australia' includes CDs with an average ARIA+ index value greater than 5.92 and less than or equal to 10.53.

CODE 5 Very remote Australia

'Very remote Australia' includes CDs with an average ARIA+ index value greater than 10.53.

CODE 6 Migratory

'Migratory' is composed of off-shore, shipping and migratory CDs.

Collection methods: In this value domain, physical distance is defined in terms of ARIA+ codes, rather than a simple linear distance between points.

The list of permissible values for this value domain, i.e. codes 1 to 6, is intended to be directly mappable to the values used by the ABS to describe remoteness areas, i.e. codes 0 to 5.

Comments: In its initial form, as developed by GISCA and the then Department of Health and Aged Care in 1999, ARIA scores ranged from 0 to 12 and were based on proximity to 4 points of reference.

A new version, ARIA+, was introduced in 2003, with ARIA+ scores now based on proximity to 5 points of reference. Also, changes were made to allow for more accurate estimation of the cost of travelling from Tasmania to the mainland, and to increase accuracy for locations at the urban fringe.

Source and reference attributes

Submitting Australian Institute of Health and Welfare *organisation:*

Origin: Information relating to remoteness is available from the Geography portal on the ABS website:

Australian Bureau of Statistics 2011. ABS Geography. Viewed 14 November 2011,

<http://www.abs.gov.au/websitedbs/D3310114.nsf/home/Geography>

Information relating to the development of the ARIA and ARIA+ scores by the National Centre for Social Applications of Geographic Information Systems (GISCA) is available from the GISCA website:

National Centre for Social Applications of Geographic Information Systems 2011. ARIA - Accessibility/Remoteness Index of Australia. Viewed 14 November 2011,
<http://gisca.adelaide.edu.au/projects/aria_project.html>

Data element attributes

Collection and usage attributes

Guide for use: The remoteness classification of an entity can be derived using characteristics of its physical location, e.g. its postcode or other address details.

The remoteness classification (RA1 to RA5) can be found by entering the postcode or other address details of the hospital or other health service provider at which the health-care incident occurred into the Department of Health and Ageing's Remoteness area locator, available on the DoctorConnect website. The website can be accessed via the following link:

<http://www.doctorconnect.gov.au/internet/otd/Publishing.nsf/Content/locator>

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Department of Health and Ageing 2012. DoctorConnect. Viewed 23 February 2012.

<http://www.doctorconnect.gov.au/internet/otd/Publishing.nsf/Content/locator>

Relational attributes

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Geographical location of establishment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—geographical location, code (ASGC 2011) NNNNN
METeOR identifier:	455521
Registration status:	Health, Standard 07/12/2011
Definition:	The geographical location of the main administrative centre of an establishment, as represented by a code.
Data Element Concept:	Establishment—geographic location

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Geographical Classification 2011
Representation class:	Code
Data type:	Number
Format:	NNNNN
Maximum character length:	5

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

The geographical location is reported using a five digit numerical code to indicate the Statistical Local Area (SLA) within the reporting state or territory, as defined in the Australian Standard Geographical Classification (ASGC) (Australian Bureau of Statistics (ABS), catalogue number 1216.0). It is a composite of state/territory identifier and SLA (first digit = state/territory identifier, next four digits = SLA).

The Australian Standard Geographical Classification (ASGC) is updated by the ABS on an annual basis, with a date of effect of 1 July each year.

Up until 2007, the ABS's National Localities Index (NLI) (catalogue number 1252.0.55.001) was available as a coding tool designed to assist users assign the ASGC Main Structure codes to street address information. However, the NLI is no longer produced by the ABS. To replace the Localities file of the NLI, the ABS has created a Locality to SLA correspondence file for 2011. This file is available on request by contacting ABS Geography at geography@abs.gov.au.

Source and reference attributes

Origin: Australian Standard Geographical Classification (Australian Bureau of Statistics catalogue number 1216.0)

Relational attributes

Related metadata references: Is formed using Establishment—Australian state/territory identifier, code N Health, Standard 01/03/2005

Supersedes Establishment—geographical location, code (ASGC 2010) NNNNN Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Geographical location of service delivery outlet

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Service delivery outlet—geographic location, code (ASGC 2011) NNNNN

METeOR identifier: 455547

Registration status: Health, Standard 07/12/2011

Definition: Geographical location of a site from which a health/community service is delivered, as represented by a code.

Data Element Concept: Service delivery outlet—geographic location

Value domain attributes

Representational attributes

Classification scheme: Australian Standard Geographical Classification 2011

Representation class: Code

Data type: Number

Format: NNNNN

Maximum character length: 5

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: The geographical location is reported using a five digit numerical code to indicate the Statistical Local Area (SLA) within the reporting state or territory, as defined in the Australian Standard Geographical Classification (ASGC) (Australian Bureau of Statistics (ABS), catalogue number 1216.0). It is a composite of state/territory identifier and SLA (first digit = state/territory identifier, next four digits = SLA).

The Australian Standard Geographical Classification (ASGC) is updated by the ABS on an annual basis, with a date of effect of 1 July each year.

Up until 2007, the ABS's National Localities Index (NLI) (catalogue number 1252.0.55.001) was available as a coding tool designed to assist users assign the ASGC Main Structure codes to street address information. However, the NLI is no longer produced by the ABS. To replace the Localities file of the NLI, the ABS has created a Locality to SLA correspondence file for 2011. This file is available on request by contacting ABS Geography at geography@abs.gov.au.

Comments: To enable the analysis of the accessibility of service provision in relation to demographic and other characteristics of the population of a geographic area.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Origin: Australian Standard Geographical Classification (ABS catalogue number 1216.0)

Relational attributes

Related metadata references: Is formed using Establishment—Australian state/territory identifier, code N Health, Standard 01/03/2005

Supersedes Service delivery outlet—geographic location, code (ASGC 2010) NNNNN Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Gestational age

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Product of conception—gestational age, completed weeks N[N]
METeOR identifier:	298105
Registration status:	Health, Standard 02/12/2009
Definition:	The age of a product of conception in completed weeks.
Data Element Concept:	Product of conception—gestational age

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Not stated/unknown

Unit of measure: Completed weeks

Data element attributes

Collection and usage attributes

Guide for use:

Gestational age is the best clinical estimate of the duration of pregnancy at a specific point in time, based on the first day of the last menstrual period, ultrasound or physical examination of the baby.

Gestational age is conventionally expressed in completed weeks. When gestational age is calculated using the first day of the last normal menstrual period, the first day is counted as day zero and not day one. Therefore, a 25 week, 5 day fetus is considered a 25 week fetus (25+0, 25+1, 25+2, 25+3, 25+4, 25+5, 25+6).

When ultrasound is used to date a pregnancy, the earliest ultrasound examination should be used and should preferably be between 6 and 10 weeks gestation. Scans performed beyond 24 weeks gestation are unlikely to be reliable in estimating gestational age and should not be used for this purpose.

The duration of gestation can be determined from the first day of the last normal menstrual period, from ultrasound or clinical assessment. For the purpose of the national collection, gestational age is expressed in completed weeks.

The World Health Organisation identifies the following categories:

- pre-term: less than 37 completed weeks (less than 259 days) of gestation;
- term: from 37 completed weeks to less than 42 completed weeks (259 to 293 days) of gestation; and
- post-term: 42 completed weeks or more (294 days or more) of gestation.

Comments: Gestational age is a key marker in pregnancy and an important risk factor for neonatal outcomes.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Origin: International Classification of Diseases and Related Health Problems, 10 Revision, WHO, 1992

Reference documents: American Academy of Pediatrics (2004) ‘ Policy statement - Age terminology during the perinatal period’.

Relational attributes

Related metadata references: Supersedes Female (pregnant)—estimated gestational age, total weeks NN Health, Superseded 02/12/2009

See also Pregnancy—estimated duration (at the first visit for antenatal care), completed weeks N[N] Health, Standard 02/12/2009

Implementation in Data Set Specifications: Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Given name sequence number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—given name sequence number, code N
METeOR identifier:	287595
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	The numerical order of the given names or initials of a person, as represented by a code.
Data Element Concept:	Person (name)—given name sequence number

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	First given name
2	Second given name
3	Third given name
4	Fourth given name
5	Fifth given name
6	Sixth given name
7	Seventh given name
8	Eighth given name
9	Ninth and subsequent given name

Data element attributes

Collection and usage attributes

Guide for use: To be used in conjunction with Given name.
Example: Mary Georgina Smith

In the example above 'Mary' would have a given name sequence number of 1 and 'Georgina' would have a given name sequence number of 2.

Example: Jean Claude Marcel Moreaux

If the person has recorded a single given name as more than one word, displaying spaces in between the words(e.g. Jean Claude), their given names are recorded in data collection systems in the same way (i.e. Jean Claude is one given name and Marcel is another given name). 'Jean Claude' would have a Given name sequence number of '1' and 'Marcel' would have a Given name sequence number of '2'.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Given name(s)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person (name)—given name, text [X(40)]

METeOR identifier: 287035

Registration status: Community Services, Superseded 06/02/2012
Housing assistance, Standard 20/06/2005
Health, Standard 04/05/2005
Tasmanian Health, Proposed 28/09/2011

Definition: The person's identifying name within the family group or by which the person is socially identified, as represented by text.

Data Element Concept: Person (name)—given name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:

A person may have more than one Given name. All given names should be recorded.

The agency or establishment should record the person's full given name(s) on their information systems.

National Community Services Data Dictionary specific:

In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. In situations where proof of identity is required, the name is that recorded on a majority of the higher point scoring documents that are produced as proof of identity.

National Health Data Dictionary specific:

Each individual Given name should have a Given name sequence number associated with it.

Health care establishments may record given names (first and other given names) in one field or several fields. This metadata item definition applies regardless of the format of data recording.

A full history of names is to be retained.

Collection methods:

This metadata item should be recorded for all clients.

Given name(s) should be recorded in the format preferred by the person. The format should be the same as that indicated by the person (for example written on a form) or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.

It is acknowledged that some people use more than one given name (for example 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 only change his or her name under the Change of Name Act.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The person's preferred name may in fact be their legal (or Medicare card) name. The Person name type metadata item (see Comments) can be used to distinguish between the different types of names that may be used by the person.

The following format may assist with data collection:

What is the given name you would like to be known by?

____

Are you known by any other given names that you would like recorded?

If so, what are they

____

Please indicate the 'type' of given name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by).

Whenever a person informs the agency or establishment of a change of given name (for example prefers to be know by their middle name), the former name should be recorded according to the appropriate name type. Do not delete or overwrite a previous given name. For example 'Mary Georgina Smith' informs the hospital that she prefers to be known as 'Georgina'. Record 'Georgina' as her preferred given name and record 'Mary' as the Medicare card given name.

Similarly the establishment is informed that 'Baby of Louise Jones' has been named 'Mary Jones'. Retain 'Baby of Louise' as the newborn name and also record 'Mary' as the preferred 'Given name'.

Registering an unidentified health care client:

If the person is a health care client and her/his given name is not known record unknown in the 'Given name' field and use alias Name type. When the person's name becomes known, add the actual name as preferred Name type (or other as appropriate). Do not delete or overwrite the alias name of unknown.

Use of first initial:

If the person's given name is not known, but the first letter (initial) of the given name is known, record the first letter in the preferred 'Given name' field. Do not record a full stop following the initial.

Persons with only one name:

Some people do not have a **family** name and a given name: they have only one name by which they are known. If the person has only one name, record it in the 'Family name' field and leave the 'Given name' blank.

Record complete information:

All of the person's given names should be recorded.

Shortened or alternate first given name:

If the person uses a shortened version or an alternate version of their first given name, record their preferred name, the actual name as their Medicare card name and any alternative versions as alias names as appropriate.

Example - The person's given name is Jennifer but she prefers to be called Jenny. Record 'Jenny' as the preferred 'Given name' and 'Jennifer' as her Medicare card name.

Example - The person's given name is 'Giovanni' but he prefers to be called 'John'.

Record 'John' as the preferred 'Given name' and 'Giovanni' as the Medicare card name.

Punctuation:

If special characters form part of the given names they shall be included, e.g. hyphenated names shall be entered with the hyphen.

- Hyphen, for example Anne-Maree, Mary-Jane

Do not leave a space before or after the hyphen, that is between last letter of 'Anne' and the hyphen, nor a space between the hyphen and the first letter of 'Maree'.

- spaces, for example Jean Claude Marcel Moreaux

If the person has recorded their given name as more than one word, displaying spaces in between the words, record their given names in data collection systems in the same way (that is Jean Claude is one given name and Marcel is another given name).

Names not for continued use:

For cultural reasons, a person such as an Aboriginal or Torres Strait Islander may advise that they are no longer using the given name they previously used and are now using an alternative current name. Record their current name as their preferred given name and record their previously used name as an alias name (with a Name conditional use flag of 'not for continued use').

Composite name:

If a person identifies their first name as being a composite word,

both parts should be recorded under the first Given Name (rather than the first and second Given Name).
If ʻAnne Marie Walker' notes her preferred Given Name to be ʻAnne Marie', then ʻAnne Marie' is recoded as (first) Given Name, and (second) Given Name is left blank.

Registering an unnamed newborn baby:

An unnamed (newborn) baby is to be registered using the mother's given name in conjunction with the prefix 'Baby of'. For example, if the baby's mother's given name is Fiona, then record 'Baby of Fiona' in the preferred 'Given name' field for the baby. This name is recorded under the newborn Name type. If a name is subsequently given, record the new name as the preferred given name and retain the newborn name.

Registering unnamed multiple births:

An unnamed (newborn) baby from a multiple birth should use their mother's given name plus a reference to the multiple births. For example, if the baby's mother's given name is 'Fiona' and a set of twins is to be registered, then record 'Twin 1 of Fiona' in the Given name field for the first born baby, and 'Twin 2 of Fiona' in the 'Given name' field of the second born baby. Arabic numbers (1, 2, 3 ...) are used, not Roman Numerals (I, II, III ......).

In the case of triplets or other multiple births the same logic applies. The following terms should be use for recording multiple births:

- Twin:

use Twin, that is Twin 1 of Fiona

- Triplet:

use Trip, that is Trip 1 of Fiona

- Quadruplet:

use Quad, that is Quad 1 of Fiona

- Quintuplet:

use Quin, that is Quin 1 of Fiona

- Sextuplet:

use Sext, that is Sext 1 of Fiona

- Septuplet:

use Sept, that is Sept 1 of Fiona.

These names should be recorded under the newborn Person name type. When the babies are named, the actual names should be recorded as the preferred name. The newborn name is retained.

Ethnic Names:

The Centrelink Naming Systems for Ethnic Groups publication provides the correct coding for ethnic names. Refer to Ethnic Names

Condensed Guide for summary information.

Misspelled given names:

If the person's given name has been misspelled in error, update the Given name field with the correct spelling and record the misspelled given name as an Alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the client's name. Discretion should be used regarding the degree of recording that is maintained.

Comments: Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between Thomas and Tom - can make Record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) Given name and Family name. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred name that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family or surname separately. These should then be recorded as Given name and Family name as appropriate, regardless of the order in which they may be traditionally given.

National Community Services Data Dictionary specific:

Selected letters of the given name in combination with selected letters of the family name, date of birth and sex may be used for **record linkage** for statistical purposes only.

National Health Data Dictionary specific:

Health care provider identification DSS and Health care client identification DSS
For the purpose of positive identification or contact, agencies or establishments that collect Given name should also collect Given name sequence number. Given name sequence number is also a metadata item in Australian Standard AS4846-2004 Health care provider identification and is proposed for inclusion in the review of Australian Standard AS5017-2002 Health care client identification. AS5017 and AS4846 use alternative alphabetic codes for Given name sequence number. Refer to the current standards for more details.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Standards Australia

Origin: National Health Data Committee

National Community Services Data Committee

Commonwealth Department of Health and Family Services 1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references: See also Person (name)—family name, text X[X(39)] Community Services, Superseded 06/02/2012, Housing assistance, Standard 20/06/2005, Health, Standard 04/05/2005, Tasmanian Health, Proposed 28/09/2011

Supersedes Person (name)—given name, text [X(40)] Community Services, Superseded 25/08/2005, Health, Superseded 04/05/2005

Is used in the formation of Person—letters of given and family name, text XXXXX Community Services, Standard 14/09/2009

Is used in the formation of Person—letters of given name, text XX Community Services, Standard 27/03/2007, Housing assistance, Standard 23/08/2010, Health, Standard 07/12/2011, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Glycoprotein IIb/IIIa receptor antagonist (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—glycoprotein IIb/IIIa receptor antagonist status, code NN
METeOR identifier:	285115
Registration status:	Health, Standard 04/06/2004
Definition:	The person's glycoprotein IIb/IIIa receptor antagonist therapy status, as represented by a code.
Data Element Concept:	Person—glycoprotein IIb/IIIa receptor antagonist status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - therapy not indicated
22	Not given - patient refusal
23	Not given - known intracranial neoplasm
24	Not given - active or recent (within 2 to 4 weeks) internal bleeding (does not include menses). Suspected aortic dissection
25	Not given - history of prior cerebrovascular accident or known intracerebral pathology not covered in contraindications
26	Not given - recent trauma (within 2 to 4 weeks), including head trauma, traumatic or prolonged (greater than 10 minutes) CPR, or major surgery (less than 3 weeks)
27	Not given - pregnancy

	28	Not given - other
Supplementary values:	90	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: This metadata item pertains to the administering of Glycoprotein IIb/IIIa receptor antagonist drugs at any time point during this current event.

CODES 21 - 28 Not given

If recording `Not given', record the principal reason if more than one code applies.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Glycoprotein IIb/IIIa receptor antagonist status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Glycosylated haemoglobin level

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—glycosylated haemoglobin level, code N
Synonymous names:	HbA1c level
METeOR identifier:	443631
Registration status:	Health, Standard 07/12/2011
Definition:	A person's glycosylated haemoglobin (HbA1c) level, as represented by a code.
Data Element Concept:	Person—glycosylated haemoglobin level

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	N

Permissible values:

Value	Meaning
1	Less than or equal to 7%
2	Greater than 7% but less than or equal to 8%
3	Greater than 8% but less than 10%
4	Greater than or equal to 10%

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Data element attributes

Collection and usage attributes

Comments: Glycosylated haemoglobin (HbA1c) is an index of average blood glucose level for the previous 2 to 3 months and is used to monitor blood sugar control in people with diabetes.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Conditional obligation:

Conditional on having had a glycosylated haemoglobin measurement result recorded within the previous 6 months or within the previous 12 months.

This item is only collected for persons who have Type II diabetes.

Glycosylated haemoglobin level (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—glycosylated haemoglobin level (measured), percentage N[N].N
METeOR identifier:	270325
Registration status:	Health, Standard 01/03/2005
Definition:	A person's glycosylated haemoglobin (HbA1c) level, measured as percentage.
Data Element Concept:	Person—glycosylated haemoglobin level

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

HbA1c results vary between laboratories; use the same laboratory for repeated testing.

When reporting, record absolute result of the most recent HbA1c level in the last 12 months.

Record the absolute result of the test (%).

Collection methods:

Test is performed in accredited laboratories:

- A single blood sample is sufficient and no preparation of the patient is required.
- Measure HbA1c ideally using High Performance Liquid Chromatography (HPLC).

Source and reference attributes

Submitting organisation: National diabetes data working group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Reference documents: Koening, R. J. Peterson, CM and Kilo, C et al. Hemoglobin A1c as an indicator of the degree of glucose intolerance in diabetes. Diabetes 259 (1976): 230-232. Nathan, D.M., Singer, D.E, Hurxthal, K, and Goodson, J.D. The clinical information value of the glycosylated hemoglobin assay. N. Eng. J. Med. 310 (1984): 341-346.

Relational attributes

Related metadata references: Supersedes Glycosylated Haemoglobin (HbA1c) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.0 KB)

See also Laboratory standard—upper limit of normal range of glycosylated haemoglobin, percentage N[N].N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Diabetes (clinical) DSS Health, Standard 21/09/2005

Glycosylated haemoglobin measurement result recorded indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—glycosylated haemoglobin measurement result recorded indicator, yes/no code N
Synonymous names:	HbA1c measurement result recorded indicator; Blood sugar level recorded indicator
METeOR identifier:	441495
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a person has had a glycosylated haemoglobin (HbA1c) measurement result recorded, as represented by a code.
Data Element Concept:	Person—glycosylated haemoglobin measurement result recorded indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A person has had a glycosylated haemoglobin measurement result recorded.

CODE 2 No

A person has not had a

glycosylated haemoglobin measurement result recorded.

Comments: Glycosylated haemoglobin (HbA1c) is an index of average blood glucose level for the previous 2 to 3 months and is used to monitor blood sugar control in people with diabetes.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Conditional obligation:
This item is only collected for persons who have Type II diabetes.

Glycosylated haemoglobin—upper limit of normal range (percentage)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Laboratory standard—upper limit of normal range of glycosylated haemoglobin, percentage N[N].N

METeOR identifier: 270333

Registration status: Health, Standard 01/03/2005

Definition: Laboratory standard for the value of glycosylated haemoglobin (HbA1c) measured as a percentage that is the upper boundary of the normal range.

Data Element Concept: Laboratory standard—upper limit of normal range of glycosylated haemoglobin

Value domain attributes

Representational attributes

Representation class: Percentage

Data type: Number

Format: N[N].N

Maximum character length: 3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of the HbA1c normal reference range from the laboratory result.

Collection methods: This value is usually notified in patient laboratory results and may vary for different laboratories.

Comments: HbA1c results vary between laboratories; use the same laboratory for repeated testing.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Glycosylated Haemoglobin (HbA1c) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.9 KB)

See also Person—glycosylated haemoglobin level (measured), percentage N[N].N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Diabetes (clinical) DSS Health, Standard 21/09/2005

Goal of care

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Community nursing service episode—goal of care, code NN

METeOR identifier: 270225

Registration status: Health, Standard 01/03/2005

Definition: The goal or expected outcome of a plan of care, negotiated by the service provider and recipient, as represented by a code.

Data Element Concept: Community nursing service episode—goal of care

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: NN

Maximum character length: 2

Permissible values:

Value	Meaning
01	Well person for preventative/maintenance/health promotion program
02	Person will make a complete recovery
03	Person will not make a complete recovery; but will rehabilitate to a state where formal on-going service is no longer required
04	Person has a long-term care need and the goal is aimed at on-going support to maintain at home
05	Person in end-stage of illness the goal is aimed at support to stay at home in comfort and dignity and facilitation of choice of where to die
06	Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and

appropriate time

07 For assessment only/not applicable

Collection and usage attributes

Guide for use:

CODE 01 Well person for preventative/maintenance/health promotion program

Service recipients are those making contact with the health service primarily as a part of a preventative/maintenance health promotion program. This means they are well and do not require care for established health problems. They include well antenatal persons attending or being seen by the service for screening or health education purposes.

CODE 02 Person will make a complete recovery

Describes those persons whose condition is self-limiting and from which complete recovery is anticipated, or those with established or long-term health problems who are normally independent in their management.

Goal 2 service recipient includes:

- post-surgical or acute medical service recipients whose care at home is to facilitate convalescence. Such admissions to home care occur as a result of early discharge from hospital; post-surgical complication such as wound infection; or because the person is at risk during the recovery phase and requires surveillance for a limited period;
- persons recovering from an acute illness and referred from the general practitioner or other community-based facility;
- persons with **disability** or established health problem normally independent of health services, and currently recovering from an acute condition or illness as above.

CODE 03 Person will not make a complete recovery; but will rehabilitate to a state where formal on-going service is no longer required

Refers to those service recipients whose care plan is aimed at returning them to independent functioning at home either through self-care or with informal assistance, such that formal services will be discontinued. The distinguishing characteristic of this group is that complete recovery is not expected but some functional gain may be possible. Further, the condition is not expected to deteriorate rapidly or otherwise cause the client to be at risk without contact or surveillance from the community service.

CODE 04 Person has a long-term care need and the goal is aimed at on-going support to maintain at home

Refers to those service recipients whose health problem/condition is not expected to resolve and who will require ongoing maintenance care from the nursing service. Such clients are distinguished from those in Goal 3 in that their condition is of an unknown or long-term nature and not expected to cause death in the foreseeable future. They may require therapy for restoration of function initially and intermittently, and may also have intermittent admissions for respite. However, the major part of their care is planned to be at home.

CODE 05 Person in end-stage of illness the goal is aimed at support to stay at home in comfort and dignity and facilitation of choice of where to die

Refers to persons whose focus of care is palliation of symptoms and facilitation of the choice to die at home.

CODE 06 Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time

Includes persons who have a limited ability to remain at home because of their intensive care requirements and the inability of formal and informal services to meet these needs. Admission to institutional care is therefore a part of the care planning process and the timing dependent upon the capacity and/or wish to remain at home. The distinguishing feature of this group is that the admission is not planned to be an intermittent event to boost the capacity for home care but is expected to be of a more permanent (or indeterminate) nature.

- Excluded from this group are persons with established health problems or permanent disability, if the contact is related to the condition. For example, persons with diabetes and in a diabetes program would be included in Goal 3; however, such persons would be included in Goal 6 if the contact with the service is not related to an established health problem but is primarily for preventative/maintenance care as described above.

CODE 07 For assessment only/not applicable

Service recipients are those for whom the reason for the visit is to undertake an assessment. This may include clients in receipt of a Domiciliary Nursing Care Benefit (DNCB) for whom the purpose of the visit is to determine ongoing DNCB eligibility and requirements for care. Implicit in this visit is review of the person's health status and circumstances, to ensure that their ongoing support does not place them or their carer at avoidable risk.

Data element attributes

Collection and usage attributes

Guide for use: Only one option is permissible and where Code 07 is selected, Code 9 must be used in the metadata item Community nursing service episode—nursing interventions, code N.

Collection methods: At time of formal review of the client, the original goal of care should be retained and not over-written by the system. The goal of care relates to the episode bounded by the date of first contact with community nursing service and date of last contact and in this format provides a focussing effect at the time of planning for care.

Comments: Agencies who had previously implemented this metadata item should note changes to the code set in the Value domain.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Goal of care, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (23.1 KB)

GP Management Plan indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—GP Management Plan (MBS Item 721) indicator, yes/no code N

Synonymous names: GPMP indicator

METeOR identifier: 441514

Registration status: Health, Standard 07/12/2011

Definition: An indicator of whether a person has received a GP Management Plan (MBS Item 721), as represented by a code.

Data Element Concept: Person—GP Management Plan (MBS Item 721) indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A person has received a GP Management Plan.

CODE 2 No

A person has not received a GP Management Plan.

Comments:

The Chronic Disease Management Medicare items on the Medicare Benefits Schedule enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions. This item is designed for patients who require a structured approach to their care. To be eligible for a GP Management Plan (GPMP) a patient must have a chronic (or terminal) medical condition; one that has been or is likely to be present for 6 months or longer, including, but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus and musculoskeletal conditions (Department of Health and Ageing 2011a).

A GPMP is required by legislation to be a comprehensive written plan that describes:

- the patient's health care needs, health problems and relevant conditions
- management goals with which the patient agrees
- actions to be taken by the patient
- treatment and services the patient is likely to need
- arrangements for providing these treatment and services

- a date to review these matters (Department of Health and Ageing 2011b).

This chronic disease management service is for a patient who has at least one medical condition that:

(a) has been (or is likely to be) present for at least six months; or

(b) is terminal (Department of Health and Ageing 2011c).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Origin: Department of Health and Ageing 2011a. Department of Health and Ageing, Canberra. Viewed 27 May 2011, <http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement>

Department of Health and Ageing 2011b. GP Management Plans (Medicare item 721). Department of Health and Ageing, Canberra. Viewed 27 May 2011, <http://www.health.gov.au/internet/main/publishing.nsf/Content/81BB2DB118217838CA2576710015F3B3/$File/Important%20Reminders%20About%20GPMPs%20Nov%2009.pdf

Department of Health and Ageing 2011c. Medicare Benefits Schedule – Item 721. Department of Health and Ageing, Canberra. Viewed 27 May 2011, <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=721>

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Conditional obligation:
This item is only collected for persons who have Type II diabetes.

Grants to non-government organisations—accommodation services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—accommodation services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	398477
Registration status:	Health, Standard 01/12/2010
Definition:	The value of grants made to non-government organisations for the provision of accommodation services, defined as housing services that are linked to support services for people affected by a mental health issue, in Australian dollars.
Data Element Concept:	Specialised mental health service organisation—accommodation services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Where the exact dollar amount, for accommodations services as a whole, is unable to be provided an estimate should be derived from available local information.

Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under the *Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total*

Australian currency N[N(8)] data element.

Accommodation services are subcategorised into 5 subtypes:

1. *Crisis/interim accommodation* - Short-term accommodation which may be staffed up to 24 hours a day, seven days a week for people affected by a mental health issue. Accommodation is residential/facility based with an average of 4-8 beds. Length of stay is generally limited to a maximum of three months.
2. *Transitional supported accommodation* - Short to medium-term accommodation (3-12 months) that is provided in a residential/facility based setting.
3. *Headleasing* - Provides a supportive landlord service that assists tenants to access and maintain suitable accommodation and maintains their tenancies and which is linked to support.
4. *Residential rehabilitation* - Short to long-term residential/facility based accommodation provided to people with high needs. Staff support is provided.
5. *Long-term supported accommodation* - Secure/tenured long-term accommodation with staff support as necessary or desired.

Note: If any of the above accommodation services are staffed by mental health trained staff for at least 50 hours per week with at least 6 hours staffing on any single day, the accommodation services and their associated expenditure should be reported as a residential mental health care service. For information on what constitutes a residential service setting, please refer to the glossary item for **Residential mental health care service**.

Collection methods: Grants for accommodation services are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Specialised mental health service organisation—accommodation services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 01/12/2010

See also Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 07/12/2005

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Grants to non-government organisations—advocacy services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—advocacy services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	286911
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of advocacy services, defined as services that provide assistance to people affected by a mental health issue to access their human and legal rights and promote reform.
Data Element Concept:	Specialised mental health service organisation—advocacy services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Where the exact dollar amount for advocacy services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.

Advocacy services are subcategorised into 2 subtypes, however data are not expected to be reported at this level:

1. *Systemic* - The representation and promotion of the rights, views and responsibilities of people affected by mental health issues in the community, public and private sectors at both domestic and international levels.
2. *Individual* - The representation and promotion of the rights and views of the individual affected by a mental health issue.

Collection methods: Grants for advocacy services are to be reported at the lowest statistical unit level which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references: See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Grants to non-government organisations—community awareness/health promotion services

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations (financial year), total Australian currency N[N(8)]

METeOR identifier: 287011

Registration status: Health, Standard 08/12/2004

Definition: Grants made to non-government organisations for community awareness/health promotion services, defined as services aimed at raising awareness about mental health/illness and those affected by mental health issues through the provision of information and/or education to the community, in order to enhance the community's capacity to support people affected by a mental health issue.

Data Element Concept: Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Where the exact dollar amount for community awareness/health promotion services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.

Collection methods:

Grants for community awareness/health promotion services are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Grants to non-government organisations—counselling services

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service organisation—counselling services grants to non-government organisations, total Australian currency N[N(8)]

METeOR identifier: 287021

Registration status: Health, Standard 08/12/2004

Definition: Grants made to non-government organisations for counselling services provided by professionals and non-professionals that provide emotional support, psychological support, assistance with achieving goals and the strengthening of community and social networks for people affected by a mental health issue.

Data Element Concept: Specialised mental health service organisation—counselling services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Where the exact dollar amount for counselling services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.

Collection methods: Grants for counselling services are to be reported only at the level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Grants to non-government organisations—independent living skills support services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—independent living skills support services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296480
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for services that provide encouragement and support of people living with a mental health issue to participate actively in their day to day living in a community.
Data Element Concept:	Specialised mental health service organisation—independent living skills support services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for independent living skills support services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for independent living skills support services are to be reported at the lowest statistical unit level at which the

expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Grants to non-government organisations—other and unspecified mental health services

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)]

METeOR identifier: 306250

Registration status: Health, Standard 07/12/2005

Definition: Grants made to non-government organisations for provision of mental health services not elsewhere classified and grants not allocatable to specific service types.

Data Element Concept: Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Where the exact dollar amount for other and unspecified mental health services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific mental health service types, the value of grants not allocatable to specific mental health service types should be included.

Grants for mental health services classified elsewhere are listed below under Relational metadata attributes.

Collection methods: Grants to non-government organisations for mental health services not elsewhere classified are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—accommodation services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 01/12/2010

See also Specialised mental health service organisation—accommodation services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 01/12/2010

See also Specialised mental health service organisation—advocacy services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—counselling services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—independent living skills support services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

Supersedes Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

See also Specialised mental health service organisation—pre-vocational training services grants for non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—psychosocial support services grants for non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—recreation services grants to non-government organisations, total Australian currency N[N(8)] Health,

Standard 08/12/2004

See also Specialised mental health service organisation—respite services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—self-help support groups services grants for non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Grants to non-government organisations—pre-vocational training services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—pre-vocational training services grants for non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296484
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for pre-vocational training services, defined as the provision of training and skill development to individuals affected by a mental health issue to facilitate their progress into employment of their choice.
Data Element Concept:	Specialised mental health service organisation—pre-vocational training services grants for non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for pre-vocational training services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for pre-vocational training expenditure are to be

reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references: See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Grants to non-government organisations—psychosocial support services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—psychosocial support services grants for non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296486
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for psychosocial support services, defined as services that work in partnership with the individual affected by a mental health issue and their carers to provide a range of support and skill development options addressing key issues in attainment of mental health and social competence goals.
Data Element Concept:	Specialised mental health service organisation—psychosocial support services grants for non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for recreation services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-

government organisations.

Collection methods:

Grants for recreation expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Grants to non-government organisations—recreation services

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service organisation—recreation services grants to non-government organisations, total Australian currency N[N(8)]

METeOR identifier: 296488

Registration status: Health, Standard 08/12/2004

Definition: Grants made to non-government organisations for recreation services, defined as services that provide and/or facilitate a range of leisure and social opportunities to people affected by a mental health issue to enhance their social competence.

Data Element Concept: Specialised mental health service organisation—recreation services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Where the exact dollar amount for recreation services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.

Collection methods: Grants for recreation expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references: See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Grants to non-government organisations—respite services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—respite services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296490
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for respite services, defined as the provision of services that allow a planned break from the usual caring environment.
Data Element Concept:	Specialised mental health service organisation—respite services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for respite services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for respite expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references: See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Grants to non-government organisations—self-help support group services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—self-help support groups services grants for non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296492
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for self-help groups support services, defined as the provision of opportunities for people affected by a mental health issue to learn from and support each other.
Data Element Concept:	Specialised mental health service organisation—self-help support groups services grants for non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for self-help support groups services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for self-help support group expenditure are to be reported at the lowest statistical unit level at which the

expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Gross capital expenditure (accrual accounting)—buildings and building services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (buildings and building services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270521
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of buildings and building services (including plant).
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (buildings and building services)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
Implementation in Data Set	Public hospital establishments NMDS 2012-2013 Health,

Specifications: Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Gross capital expenditure (accrual accounting)—constructions

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—gross capital expenditure (accrual accounting) (constructions) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270526

Registration status: Health, Standard 01/03/2005

Definition: Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of constructions (other than buildings).

Data Element Concept: Establishment—gross capital expenditure (accrual accounting) (constructions)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Round to the nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Gross capital expenditure (accrual accounting)—equipment

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—gross capital expenditure (accrual accounting) (equipment) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270525

Registration status: Health, Standard 01/03/2005

Definition: Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of equipment.

Data Element Concept: Establishment—gross capital expenditure (accrual accounting) (equipment)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Round to the nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Gross capital expenditure (accrual accounting)—information technology

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—gross capital expenditure (accrual accounting) (information technology) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270527

Registration status: Health, Standard 01/03/2005

Definition: Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of information technology.

Data Element Concept: Establishment—gross capital expenditure (accrual accounting) (information technology)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Round to the nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Gross capital expenditure (accrual accounting)—intangible assets

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—gross capital expenditure (accrual accounting) (intangible assets) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270522

Registration status: Health, Standard 01/03/2005

Definition: Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of intangible assets.

Data Element Concept: Establishment—gross capital expenditure (accrual accounting) (intangible assets)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Round to the nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Gross capital expenditure (accrual accounting)—land

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—gross capital expenditure (accrual accounting) (land) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270528

Registration status: Health, Standard 01/03/2005

Definition: Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of land.

Data Element Concept: Establishment—gross capital expenditure (accrual accounting) (land)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Gross capital expenditure (accrual accounting)—major medical equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (major medical equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	269968
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of major medical equipment.

Data Element Concept: Establishment—gross capital expenditure (accrual accounting) (major medical equipment)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Round to the nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Gross capital expenditure (accrual accounting)—other equipment

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—gross capital expenditure (accrual accounting) (other equipment) (financial year), total Australian currency N[N(8)]

METeOR identifier:	270523
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of other equipment, such as furniture, art objects, professional instruments and containers.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (other equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Gross capital expenditure (accrual accounting)—transport

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (transport) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270524
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of transport.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (transport)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Gross capital expenditure—computer equipment/installations

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (computer equipment/installations) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270520
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, on computer equipment/installations.
Data Element Concept:	Establishment—gross capital expenditure (computer equipment/installations)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Round to the nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Gross capital expenditure—intangible assets

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (intangible assets) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270517
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, in relation to intangible assets.
Data Element Concept:	Establishment—gross capital expenditure (intangible assets)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Gross capital expenditure—land and buildings

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (land and buildings) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270519
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, on land and buildings.
Data Element Concept:	Establishment—gross capital expenditure (land and buildings)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Gross capital expenditure—major medical equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (major medical equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	269966
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, on major medical equipment.
Data Element Concept:	Establishment—gross capital expenditure (major medical equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012

Implementation end date: 30/06/2013

Gross capital expenditure—other

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—gross capital expenditure (other capital expenditure) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270516

Registration status: Health, Standard 01/03/2005

Definition: Other gross capital expenditure, measured in Australian dollars, which are not included elsewhere.

Data Element Concept: Establishment—gross capital expenditure (other capital expenditure)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Round to the nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Gross capital expenditure—plant and other equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (plant and other equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270518
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, on plant and other equipment.
Data Element Concept:	Establishment—gross capital expenditure (plant and other equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012

Implementation end date: 30/06/2013

Group session indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Non-admitted patient service event—group session indicator, yes/no code N

Synonymous names: Group service event flag

METeOR identifier: 400662

Registration status: Health, Standard 06/10/2010

Definition: An indicator of whether a non-admitted patient service event was delivered in a group, as represented by a code.

Data Element Concept: Non-admitted patient service event—group session status

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: **Yes - Group service event**

'Yes' indicates care that has been provided to two or more patients by the same healthcare provider(s) at the same time.

A group must have two or more persons attending in the capacity of patients in their own right.

One service event is recorded for each patient who attends a group session.

Spouses, parents or carers attending the session are counted for the group session only if they are also participating in the service as a patient (see definition of a service event).

A group session may be delivered by more than one provider. This may be multidisciplinary care within one clinic appointment as part of a group, e.g. a group session jointly delivered by a physiotherapist and an occupational therapist.

In practice, this should be interpreted to mean that patients are receiving precisely the same services. For example:

- Patients may be part of a movement or hydrotherapy class where all participants are following the same intervention at the same time.
- Patients attending education sessions at chemotherapy or dialysis clinics are group sessions, if two or more people are receiving the same services at the same time.

No - Individual service event

‘No’ indicates that care was delivered to the patient as an individual. An individual service event is provided to one person by one or more healthcare providers. For example:

- Where a clinician works one-on-one with several different patients in the same space over a period of time but each patient is following their own personalised program (for example, where several patients are scheduled to use the physiotherapy gym at once).
- Where multiple persons, such as several family members and carers, meet with a clinician to discuss one patient only.
- Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services.

Relational attributes

Implementation in Data Set Specifications:

Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions (public psychiatric, alcohol and drug hospital)—emergency and outpatient

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment (public psychiatric or alcohol and drug hospital)—number of group session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN]

Synonymous names: Type of non-admitted patient care (public psychiatric, alcohol & drug) - emergency and outpatient group sessions

METeOR identifier: 270217

Registration status: Health, Standard 01/03/2005

Definition: The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the emergency and outpatient functional unit of a public psychiatric hospital or an alcohol and drug hospital.

Data Element Concept: Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNNN]

Maximum character length: 7

Unit of measure: Occasion of service

Data element attributes

Collection and usage attributes

Guide for use: Emergency patients and outpatients are persons who receive non-admitted care. Group session non-admitted care is care provided to persons who receive direct care within the **emergency department** or other designated clinics within the hospital and who are not formally admitted at the time when the care is provided. A person who first contacts the hospital and receives non-admitted care, for example through the emergency department, and is subsequently admitted should have both components of care enumerated separately.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care (public psychiatric, alcohol & drug), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions (public psychiatric, alcohol and drug hospital)—outreach and community

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment (public psychiatric or alcohol and drug hospital)—number of group session occasions of service for non-admitted patients (outreach and community), total N[NNNNNN]

Synonymous names: Type of non-admitted patient care (public psychiatric, alcohol & drug) - outreach and community group sessions

METeOR identifier: 270219

Registration status: Health, Standard 01/03/2005

Definition: The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the outreach and community functional unit of a public psychiatric hospital or an alcohol and drug hospital.

Data Element Concept: Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNNN]

Maximum character length: 7

Unit of measure: Occasion of service

Data element attributes

Collection and usage attributes

Guide for use: For outreach/community patients, care is delivered by hospital employees to the patient in the home, place of work or other non-hospital site.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Type of non-admitted patient care (public psychiatric, alcohol & drug), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.1 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Group sessions—alcohol and other drug

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—number of group session occasions of service for non-admitted patients (alcohol and drug), total N[NNNNN]

Synonymous names: Type of non-admitted patient care - alcohol and other drug group sessions

METeOR identifier: 270479

Registration status: Health, Standard 01/03/2005

Definition: The total number of occasions of examination, consultation, treatment or other services provided as group session to non-admitted patients in the alcohol and drug functional unit of an establishment.

Data Element Concept: Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNN]

Maximum character length: 6

Unit of measure: Group session

Data element attributes

Collection and usage attributes

Guide for use: Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Comments:

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions—allied health services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (allied health services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - allied health services group sessions
METeOR identifier:	270480
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in allied health services functional units or clinics of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

Allied health services include units primarily concerned with physiotherapy, family planning, dietary advice, optometry, occupational therapy, and so on.

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are

provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods:

At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients. This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary.

For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions—community health services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (community health services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - community health services group sessions
METeOR identifier:	270491
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the community health services functional unit of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

Community health services include units primarily concerned with baby clinics, immunisation clinics, aged care assessment teams, and so on.

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods: At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments: Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients. This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary.

For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions—dental

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (dental), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - dental group sessions
METeOR identifier:	270488
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group session to non-admitted patients in the dental unit of an establishment
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods: At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments: This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions—dialysis

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—number of group session occasions of service for non-admitted patients (dialysis), total N[NNNNN]

Synonymous names: Type of non-admitted patient care - dialysis group sessions

METeOR identifier: 270368

Registration status: Health, Standard 01/03/2005

Definition: The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the dialysis unit of an establishment.

Data Element Concept: Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNN]

Maximum character length: 6

Unit of measure: Group session

Data element attributes

Collection and usage attributes

Guide for use: Where patients receive treatment in a ward or clinic classified elsewhere (for example Emergency Department), they are to be counted as dialysis patients and are to be excluded from other categories. All forms of dialysis that are undertaken as a treatment necessary for renal failure are to be included.

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods:

At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments:

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions—district nursing services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (district nursing services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - district nursing services group sessions
METeOR identifier:	270482
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients by the district nursing service of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

District nursing services:

- are for medical/nursing/psychiatric care
- are provided by a nurse, paramedic or medical officer
- involve travel by the service provider
- exclude care provided by staff from a unit classified in the community health category.

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods: At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments: Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients. This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary.

For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions—emergency services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (emergency services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - emergency services group sessions
METeOR identifier:	270485
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the designated emergency department of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods:

At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments:

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions—endoscopy and related procedures

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—number of group session occasions of service for non-admitted patients (endoscopy and related procedures), total N[NNNNN]

Synonymous names: Type of non-admitted patient care - endoscopy and related procedures group sessions

METeOR identifier: 270484

Registration status: Health, Standard 01/03/2005

Definition: The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the endoscopy and related procedures functional unit of an establishment.

Data Element Concept: Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNN]

Maximum character length: 6

Unit of measure: Group session

Data element attributes

Collection and usage attributes

Guide for use: For all occasions of endoscopy and related procedures provided as group sessions to non-admitted patients.

Endoscopy and related procedures include:

- cystoscopy
- gastroscopy
- oesophagoscopy
- duodenoscopy
- colonoscopy

- bronchoscopy
- laryngoscopy.

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods: At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments: This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE,

NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions—mental health

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (mental health), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - mental health group sessions
METeOR identifier:	270490
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in designated psychiatric or mental health units of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods: At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments: This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions—other medical/surgical/diagnostic

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (other medical/surgical/diagnostic), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - other medical/surgical/diagnostic group sessions
METeOR identifier:	270487
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the medical/surgical/diagnostic functional unit of an establishment not defined elsewhere.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

Includes ECG, obstetrics, nuclear medicine, general surgery, fertility, and so on.

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are

provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods: At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments: This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions—other outreach services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (other outreach services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - other outreach services group sessions
METeOR identifier:	270489
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients as outreach services not classified in allied health or community health services.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

Includes units primarily concerned with physiotherapy, speech therapy, family planning, dietary advice, optometry, occupational therapy, and so on.

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods: At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments: This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions—pathology

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—number of group session occasions of service for non-admitted patients (pathology), total N[NNNNN]

Synonymous names: Type of non-admitted patient care - pathology group sessions

METeOR identifier: 270481

Registration status: Health, Standard 01/03/2005

Definition: The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in designated pathology laboratories of an establishment.

Data Element Concept: Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNN]

Maximum character length: 6

Unit of measure: Group session

Data element attributes

Collection and usage attributes

Guide for use: Occasions of pathology services to all patients from other establishments should be counted separately.

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods: At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments: This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions—pharmacy

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—number of group session occasions of service for non-admitted patients (pharmacy), total N[NNNNN]

Synonymous names: Type of non-admitted patient care - pharmacy group sessions

METeOR identifier: 270486

Registration status: Health, Standard 01/03/2005

Definition: The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the pharmacy unit of an establishment.

Data Element Concept: Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNN]

Maximum character length: 6

Unit of measure: Group session

Data element attributes

Collection and usage attributes

Guide for use: Those drugs dispensed/administered in other departments such as the emergency or outpatient are to be counted by the respective department.

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are

provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods: At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments: This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Group sessions—radiology and organ imaging

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (radiology and organ imaging), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - radiology and organ imaging group sessions
METeOR identifier:	270483
Registration status:	Health, Standard 01/03/2005
Definition:	A count of groups of patients/clients receiving radiology and organ imaging services in a health service establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

Includes x-ray department as well as specialised organ imaging clinics carrying out ultrasound, computerised tomography and magnetic resonance imaging.

Each group is to be counted once, irrespective of size or the number of staff providing services.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are

provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods: At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments: This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Health industry relevant organisation type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health industry relevant organisation—main activity type, code NNN
METeOR identifier:	372264
Registration status:	Health, Standard 01/04/2009
Definition:	Describes a health industry relevant organisation based on its main activity, as represented by a code.
Data Element Concept:	Health industry relevant organisation—main activity type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NNN
Maximum character length:	3

Permissible values:

Value	Meaning
	Main Health Care Services organisation
101	Hospital – public
102	Hospital – private (excluding private free-standing day hospital facility)
103	Hospital – private free-standing day hospital facility (excluding private non free-standing day hospital facility)
104	Residential facility – mental health care
105	Residential facility – other
106	Provider of ambulance service
107	Medical and diagnostic laboratory
108	Clinical practices – medical – general
109	Clinical practices – medical – specialist
110	Clinical practices – medical – other

111	Clinical practices – dental
112	Clinical practices – other
113	Community health facility – substance abuse
114	Community health facility – mental
115	Community health facility – other
116	Blood and organ bank
117	Retail sale/supplier of medical goods – optical glasses and other vision products
118	Retail sale/supplier of medical goods – hearing aids
119	Retail sale/supplier of medical goods – dispensing community pharmacist
120	Retail sale/supplier of medical goods – other
121	Public health program service provider
122	General health administration service provider
123	Private health insurance
188	Other Main Health Care Service providers
198	Regional health service not further defined
199	State/territory health authority not further defined
	Secondary/non-Health Care Services organisation
201	Pharmaceutical industry
202	University
203	Non-health related insurance
204	Residential aged care facility
288	Other Secondary/non-Health Care Services organisation

Collection and usage attributes

Guide for use: **Main Health Care Service organisation**

CODE 101 Hospital – public

An organisation comprised of a health care facility or group of health care facilities established under Commonwealth, state or territory legislation as a hospital or free-standing day hospital facility and authorised to provide treatment and/or care to patients. Comprises all health care facilities that are reported as public hospitals to the Public Hospital Establishments National Minimum Data Set (PHE NMDS). This includes organisations such as rehabilitation hospitals; psychiatric hospitals; mothercraft hospitals; and hospices and multi-purpose services defined as hospitals. The list of public hospitals reported to the PHE NMDS is available at www.aihw.gov.au/publications/index.cfm in the Australian Hospital Statistics annual report.

NOTE 1: Excludes providers of services where those services are not captured in the hospital financial statements. For example, the provider of a pathology or pharmacy service may be co-located within the hospital, but as a private service, and will pay the hospital for use of the site. The provider of this pathology or pharmacy service would be recorded under codes 106 to 112.

CODE 102 Hospital – private (excluding private free-standing day hospital facilities)

An organisation comprised of a health care facility or a group of health care facilities established under Commonwealth, state or territory legislation as a hospital and authorised to provide treatment and/or care to patients.

Comprises hospitals that are NOT reporting to the PHE NMDS.

NOTE: State and territory data providers are to refer to the GHE NMDS Collection Guidelines for instructions on how to report expenditure for this category.

Excludes private free-standing day hospital facilities reported under code 103.

CODE 103 Hospital - private free-standing day facility (excluding private non free-standing day hospital facilities)

An organisation comprised of one or more private free-standing day hospital facilities which provide investigation and treatment for acute conditions on a day-only basis and is approved by the Commonwealth as a hospital for the purposes of private health insurance benefits. The four main types of private free-standing day hospitals are specialist endoscopy, ophthalmic, plastic/cosmetic and general. Excludes private non free-standing day hospital facilities reported under code 102.

CODE 104 Residential facility – mental health care

An organisation comprised of one or more specialised mental health facilities primarily engaged in providing residential care to persons requiring mental health diagnosis and treatment combined with either nursing, supervisory or other types of care as required (including medical) by the residents.

Excludes residential care facilities primarily providing aged care or care for persons requiring treatment for alcohol or other substance abuse or persons with a disability.

CODE 105 Residential facility – other

Includes all government-funded facilities primarily engaged in providing residential care to persons requiring diagnosis and treatment for alcohol and other substance abuse combined with either nursing, supervisory or other types of care as required (including medical) by the residents. Includes hospices that are not defined as hospitals and respite and transitional care services.

Excludes facilities primarily providing services to aged persons or persons requiring mental health diagnosis and treatment.

Also excludes residential care facilities that report under the Commonwealth, State and Territory Disability Agreement where the primary purpose is care for persons with a disability.

CODE 106 Provider of ambulance service

Organisations primarily engaged in providing transportation of patients by ground or air, along with health (or medical) care. These services are often provided during a medical emergency but are not restricted to emergencies. The vehicles are equipped with lifesaving equipment operated by medically trained personnel. Includes organisations providing public ambulance services or flying doctor services such as Royal Flying Doctor Service and Care Flight, and support programs to assist isolated patients with travel to obtain specialised health care.

NOTE 2: Excludes providers of services where those services are captured in public or private hospital financial statements. For example, the provider of an ambulance, medical or diagnostic laboratory, general practice, specialist medical, dental or other health practitioner service may be located within a hospital set of accounts and its expenditure recorded on the hospital financial statement. The provider of the ambulance or other service would then be recorded under code 101.

CODE 107 Medical and diagnostic laboratory

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in providing analytic or diagnostic services, including body fluid analysis and diagnostic imaging, generally to the medical profession or the patient on referral from a health practitioner. Includes diagnostic imaging centres; dental or medical X-ray laboratories ultrasound services; medical testing laboratories; medical pathology laboratories; medical forensic laboratories; and X-ray clinic services. Includes public and private medical and diagnostic laboratories.

See NOTE 2 under code 106.

CODE 108 Clinical practices – medical – general

Organisations of registered medical practitioners holding the degree of a Doctor of medicine or a qualification at a corresponding level primarily engaged in the independent practice of general medicine. These practitioners operate private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals or medical centres.

See NOTE 2 under code 106.

This item is not currently required to be reported by state and territory health authorities.

CODE 109 Clinical practices – medical – specialist

This item is not currently required to be reported by state and territory health authorities.

Organisations of health practitioners holding the degree of a Doctor of medicine or a qualification at a corresponding level primarily engaged in the independent practice of specialist medicine or surgery, other than pathology and diagnostic imaging services. These practitioners operate a wide range of specialities in private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals or health maintenance type medical centres. Includes for example:

- Anaesthetist service
- Dermatology service
- Ear, nose and throat specialist service
- Gynaecology service
- Neurology service
- Obstetrics service
- Paediatric service

- Psychiatry service
- Specialist medical clinic service
- Specialist surgical service
  See NOTE 2 under code 106.

CODE 110 Clinical practices – medical – other

This item is not currently required to be reported by state and territory health authorities.

Includes organisations of physicians not able to be allocated to Codes 108 or 109

CODE 111 Clinical practices – dental

Organisations of registered health practitioners holding the degree of Doctor of dental medicine or a qualification at a corresponding level primarily engaged in the independent practice of general or specialised dentistry or dental surgery. These practitioners operate private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals, medical centres or community health facilities. They can provide either comprehensive preventive, cosmetic, or emergency care, or specialise in a single field of dentistry. Also included are dental hospitals providing ambulatory services only. Includes for example:

- Cleft lip and palate services
- Community dental service
- Dental assessment and treatment
- Dental hospital (out-patient)
- Dental practice service
- Dental practitioner service
- Dental surgery service
- Endodontic service
- Oral and maxillofacial services
- Oral pathology service
- Oral surgery service
- Orthodontic service
- Pedodontic service
- Periodontic service

See NOTE 2 under code 106.

CODE 112 Clinical practices – other

This item is not currently required to be reported by state and territory health authorities.

Organisations of independent health practitioners (other than physicians and dentists), such as chiropractors, optometrists, mental health specialists, physical, occupational, and speech therapists and audiologists organisations primarily engaged in providing **ambulatory** health care. These practitioners operate private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals or medical centres. Includes for example:

- Acupuncture service
- Aromatherapy service
- Audiology service
- Chiropractic service
- Clinical psychology service
- Dental hygiene service
- Dietician service
- Hearing aid dispensing
- Homoeopathic service
- Midwifery service
- Naturopathic service
- Nursing service
- Occupational therapy service
- Optometrist
- Osteopathic service
- Podiatry service
- Speech pathology service
- Therapeutic massage service

See NOTE 2 under code 106.

CODE 113 Community health facility – substance abuse

Organisations with health staff primarily engaged in providing ambulatory services related to the diagnosis and treatment of alcohol and other substance abuse. These are community-based organisations that treat patients who do not require admitted patient treatment. They may provide counselling staff and information regarding a wide range of substance abuse issues and/or refer patients to more extensive treatment programmes, if necessary. Includes for example:

- Community based alcoholism treatment centres and clinics (other than hospitals or residential care facilities);
- Community based detoxification centre and clinics (other than hospitals or residential care facilities);
- Community based drug addiction treatment centres and clinics (other than hospitals or residential care

facilities);

- Community based substance abuse treatment centres and clinics (other than hospitals or residential care facilities).

CODE 114 Community health facility – mental

An organisation comprised of one or more specialised mental health services or facilities with health staff primarily engaged in providing ambulatory services related to the diagnosis and treatment of mental health disorders. These specialised mental health services generally treat patients who do not require admitted patient treatment. However, these services do include consultation/liaison services provided to admitted patients by community mental health services. They may provide counselling staff and information regarding a wide range of mental health issues and/or refer patients to more extensive treatment programmes, if necessary. They may also provide treatment both on and off site, for example through mobile units. Includes only government-funded specialised mental health services, such as community mental health centres and clinics.

Includes expenditure on government-managed community specialised mental health services, plus the cost of the grants to non-government organisations that provide community specialised mental health services, not the total expenditure by these non-government organisations.

Excludes mental health clinics in hospitals and residential mental health care facilities.

CODE 115 Community health facility – other

Organisations with health staff primarily engaged in providing general or specialised ambulatory care. Centres or clinics of health practitioners with the same degree or with different degrees from more than one speciality practising within the same establishment i.e., physician and dentist) are included in this item. Includes only government-funded community health facilities such as:

- Community centres and clinics;
- General practitioner plus centres;
- Multi-speciality community clinics.

Excludes clinical practices that provide exclusively medical services or exclusively health services, ambulatory mental health and substance abuse centres, and free-standing ambulatory surgical centres (reported under codes 108 to 114) and kidney dialysis centres and clinics (reported under codes 101 to 103 if part of a hospital or code 109 if they are free-standing ambulatory centres).

CODE 116 Blood and organ bank

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in collecting, storing and distributing blood and blood products and storing and distributing body organs.

CODE 117 Retail sale/supplier of medical goods – optical glasses and other vision products

This item is not currently required to be reported by state and territory health authorities.
Organisations primarily engaged in the retail sale of optical glasses and other vision products to the general public for personal or household consumption or utilisation. This includes the fitting and repair provided in combination with sales of optical glasses and other vision products.

Excludes organisations primarily engaged in providing optometric services.

CODE 118 Retail sale/supplier of medical goods – hearing aids

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in the sale of hearing aids to the general public for personal or household consumption or utilisation. This includes the fitting and repair provided in combination with the sale of hearing aids.

Excludes organisations primarily engaged in hearing testing where that also includes a component of hearing aid dispensing and fitting.

CODE 119 Retail sale/supplier of medical goods – dispensing community pharmacist

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in the retail sale of pharmaceuticals to the general public for personal or household consumption or utilisation. Instances when the processing of medicine may be involved should be only incidental to selling. This includes both medicines with and without prescription.

Excludes organisations listed under code 201.

CODE 120 Retail sale/supplier of medical goods – other

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in the sale of medical appliances other than optical goods and hearing aids to the general public with or without prescription for personal or household consumption or utilisation. Included are:

- Organisations primarily engaged in the manufacture of medical appliances but where the fitting and repair is usually done in combination with manufacture of medical appliances.
- Organisations engaged in the retail sale of other miscellaneous medical goods to the general public for personal or household consumption or utilisation (included are sales other than by shops, such as electronic shopping and mail-order houses).
Illustrative examples
- sale of fluids (e.g. for home dialysis);
- all other miscellaneous health and personal care stores;
- all other sale of pharmaceuticals and medical goods;
- electronic shopping and mail-order houses specialised in medical goods.

CODE 121 Provision and administration of public health program

Organisations engaged in government or private administration and provision of public health programs such as health promotion, organised screening, immunisation and health protection programs.

CODE 122 General health administration

Organisations primarily engaged in the regulation of activities of agencies that provide health care, overall administration of health policy, and health insurance. This item comprises government administration (excluding social security) primarily engaged in the formulation and administration of government policy in health and in the setting and enforcement of standards for medical and paramedical personnel and for hospitals, clinics, etc., including the regulation and licensing of providers of health services. For example:

- Department of Health;
- Agencies for the regulation of safety in the workplace.

Excludes organisations primarily engaged in the provision and administration of public health programs which is reported under code 121.

CODE 123 Private health insurance provider

This item is not currently required to be reported by state and territory health authorities.

- Organisations engaged in insurance of health (other than social security funds and other social insurance funds) that provide insurance cover for hospital, medical, dental, pharmaceutical or funeral expenses. This includes organisations primarily engaged in activities involved in or closely related to the management of private health insurance (activities of insurance agents, average and loss adjusters and actuaries.

CODE 188 Main Health Care Service organisation - other

Organisations mainly engaged in providing health care services that are not reported under codes 101 to 123. Includes health or health-related call centres or e-health sites such as Poisons Information Centre and centres that provide information on alcohol and other drugs, mental health or other health issues.

CODE 198 Regional health service (not further defined)

Organisations at an area health service or regional level could be a combination of categories 101 to 188 but which could not be further disaggregated.

CODE 199 State/territory health authority (not further defined)

Organisations at the state or territory health authority level that could be a combination of categories 101 to 188 but which could not be further disaggregated.

Secondary/non-Health Care Service organisation

This item is not currently required to be reported by state and territory health authorities.

CODE 201 Pharmaceutical industry

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in wholesaling human pharmaceuticals, medicines, cosmetics, perfumes and toiletries. Also included are units mainly engaged in wholesaling veterinary drugs or medicines

Excludes organisations listed under code 119.
CODE 202 University

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in providing undergraduate or postgraduate teaching but which also undertake health research activities. Also includes organisations primarily engaged in undertaking research in the agricultural, biological, physical or social sciences. Units may undertake the research for themselves or others.

Includes:

- Postgraduate school, university operation
- Research school, university operation
- Specialist institute or college
- Undergraduate school, university operation
- University operation

For reporting purposes includes only the health or health related research component or other health services component of these organisations' activities.

CODE 203 Non-health related insurance

This item is not currently required to be reported by state and territory health authorities.

Units mainly engaged in providing general insurance cover (except life and health insurance).

Includes:

- Motor vehicle third party insurance provision
- Worker's compensation insurance provision

CODE 204 Residential aged care facility

This item is not currently required to be reported by state and territory health authorities.

An organisation comprised of one or more government-funded facilities primarily engaged in providing residential care to aged persons and in receipt of funding under the Aged Care Act and subject to Commonwealth reporting requirements (i.e. report to the System for the payment of Aged Residential Care (SPARC) collection.

Excludes facilities primarily providing services to persons requiring mental health diagnosis and treatment. Also excludes residential care facilities that report under the Commonwealth, State and Territory Disability Agreement where the primary purpose is care for persons with a disability.

CODE 288 Secondary/non-Health Care Service organisation – other

This item is not currently required to be reported by state and territory health authorities.

This item comprises organisations that are not reported under codes 201 to 203 which provide health care as secondary providers or other providers. Included are providers of occupational health care and home care provided by private households.

Includes:

Occupational health care services not provided in separate health care organisations (all industries);

- Military health services not provided in separate health care organisations
- Prison health services not provided in separate health care organisations
- School health services
- Other providers n.e.c.

Other providers of services which support the health care industry such as laundry or catering services.

Other providers of services unrelated to the health care industry such as the building or automotive industry.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents: Organisation for Economic Cooperation and Development 2000. A System of Health Accounts. Version 1.0. Paris: OECD.

Australian Bureau of Statistics 2006. Australian and New Zealand Standard Industry Classification. Cat. no. 1292.0. Canberra: ABS.

RACGP 6 September 2005 <www.racgp.org.au/whatisgeneralpractice>

Data element attributes

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Relational attributes

Related metadata references: Supersedes Health industry relevant organisation—main activity type, code NNN Health, Superseded 01/04/2009

Implementation in Data Set Specifications: Government health expenditure organisation expenditure capital consumption data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure employee related data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure purchase of goods and services data element cluster Health, Standard 01/04/2009

Government health expenditure organisation revenue data element cluster Health, Standard 01/04/2009

Health professionals attended (diabetes mellitus)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—health professionals attended for diabetes mellitus (last 12 months), code N

METeOR identifier: 270287

Registration status: Health, Standard 01/03/2005

Definition: The health professionals that a person has attended in the last 12 months in relation to issues arising from diabetes mellitus, as represented by a code.

Data Element Concept: Person—health professionals attended for diabetes mellitus

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:	Value	Meaning
	1	Diabetes educator
	2	Dietician
	3	Ophthalmologist
	4	Optometrist
	5	Podiatrist
	8	None of the above
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: Record a code sequentially for each health professional attended.

A person may have attended several health professionals in the last 12 months; therefore more than one code can be recorded sequentially.

Example 1: If a person has attended a diabetes educator and a podiatrist in the last twelve months, the code recorded would be 15.

Example 2: If all have been seen, the code recorded would be 12345.
If the person answers 'NO' to all the health professionals specified, code 8 should be applied.

CODE 9 should only be used in situations where it is not practicable to ask the questions.

Collection methods: The person should be asked about each type of health professional in successive questions, as follows:

Have you attended any of the following health professionals in relation to diabetes mellitus in the last 12 months?

Diabetes educator ___Yes ___ No

Dietician ___Yes ___ No

Ophthalmologist ___Yes ___ No

Optometrist ___Yes ___ No

Podiatrist ___Yes ___ No

The appropriate code should be recorded for each health professional attended.

Comments: The health professional occupations are assigned the following codes at the occupation level of the Australian Standard Classification of Occupations, Second Edition, Australian Bureau of Statistics, 1997, Catalogue No. 1220.0

Diabetes educator 2512-13

Dietician 2393-11

Ophthalmologist 2312-19

Optometrist 2384-11

Podiatrist 2388-11

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Health professionals attended - diabetes mellitus, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.8 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Health service request received date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—service request received date, DDMMYYYY
METeOR identifier:	447938
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which a request for assessment, care, consultation and/or treatment is received by the health care provider, expressed as DDMMYYYY.
Data Element Concept:	Health service event—service request received date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Relational attributes

Related metadata references:

See also Health service event—first service contact date, DDMMYYYY Health, Standard 07/12/2011

Implementation in Data Set Specifications:

Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Conditional obligation:
This item must be completed if Health service event—first service contact date, DDMMYYYY exists.

Health service setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health-care incident—service delivery setting, health service setting code N[N]
METeOR identifier:	329836
Registration status:	Health, Standard 07/12/2011
Definition:	The service setting in which the health-care incident occurred, as represented by a code.
Data Element Concept:	Health-care incident—service delivery setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Public hospital or day surgery centre (includes public psychiatric hospital)
2	Private hospital or day surgery centre (includes private psychiatric hospital)
3	Public community health centre
4	Private community health centre
5	Public residential aged care service
6	Private residential aged care service
7	Private medical practitioner rooms or surgery
8	Other public health service provider setting
9	Other private health service provider setting
12	Patient's home
88	Other (including 'Medihotels')

Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

A health service provider setting is classified as 'public' if it is operated by or on behalf of a Commonwealth, state or territory or local government agency.

CODES 1 and 2 Hospital or day surgery centre

A 'hospital or day surgery centre' is an establishment that provides at least minimal medical, surgical or obstetric services and/or care, and provides comprehensive qualified nursing services as well as other necessary professional services. The centre must be licensed by a state, territory or Commonwealth health department, or controlled by a government department. These codes include psychiatric hospitals; hospitals that specialise in dental, ophthalmic aids, and other specialised medical or surgical care; and free-standing day surgery centres.

CODES 3 and 4 Community health centre

A 'community health centre' is an establishment that provides a range of non-residential health services, or which provides for the coordination of health services elsewhere in the community.

CODES 5 and 6 Residential aged care service

A 'residential aged care service' is an establishment that provides long-term residential care, involving regular basic nursing care, primarily to older people who are frail or have disabilities. The service must be approved by the Australian Government Department of Health and Ageing and/or licensed by the state, or controlled by a government department.

CODE 7 Private medical practitioner rooms or surgery

'Private medical practitioner rooms or surgery' provide investigation and treatment for acute conditions on a non-residential, day-only basis. This code includes 24-hour medical clinics and general practitioner surgeries.

CODES 8 and 9 Other health service provider setting

'Other health service provider setting' includes hospices, and alcohol and drug treatment centres.

CODE 12 Patient's home

'Patient's home' includes domiciliary nursing services.

CODE 88 Other (including 'Medihotels')

'Other (including 'Medihotels')' covers services in settings other than those listed above. ‘Medihotels’ provide supported accommodation to patients who require access to hospital services.

CODE 99 Not stated/inadequately described

‘Not stated/inadequately described’ should be used only when the information is not currently available, but is expected to become available.

Comments: This value domain maps to the Insurance Statistics Australia data item 14.3 ‘Venue where procedure performed’ (AIHW 2011).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: AIHW (Australian Institute of Health and Welfare) 2011. Public and private sector medical indemnity claims in Australia 2008–09. Safety and quality of health care series no. 10. Cat. no. HSE 112. Canberra: AIHW

Data element attributes

Collection and usage attributes

Guide for use: Where the health-care incident that gave rise to the medical indemnity claim involved a series of events that occurred in different health service settings, the code recorded should reflect the health service setting in which the primary incident occurred. Where a missed diagnosis was the main, dominant or primary cause giving rise to a medical indemnity claim, the code recorded should reflect the health service setting where the diagnosis should first have been made, but was not.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Heart rate

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—heart rate, total beats per minute N[NN]
METeOR identifier:	285123
Registration status:	Health, Standard 04/06/2004
Definition:	The person's heart rate measured in beats per minute.
Data Element Concept:	Person—heart rate

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3

Supplementary values:

Value	Meaning
997	Cardiac arrest
998	Not recorded
999	Not stated/inadequately described

Unit of measure:	Heart beats per minute

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Heart rate, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Heart rhythm type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram—heart rhythm type, code N[N]
METeOR identifier:	361626
Registration status:	Health, Standard 01/10/2008
Definition:	The type of rhythm associated with the beating of the heart as determined from the electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—heart rhythm type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	N[N]
Maximum character length:	2

	Value	Meaning
Permissible values:	Value	Meaning
	1	Sinus rhythm
	2	Atrial fibrillation
	3	Atrial flutter
	4	Second degree heart block
	5	Complete heart block
	6	Supraventricular tachycardia
	7	Idioventricular rhythm
	8	Ventricular tachycardia
	9	Ventricular fibrillation
	10	Paced
	11	Other rhythm
Supplementary values:	99	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Related metadata references: Supersedes Person—heart rhythm type, code N[N] Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Electrocardiogram cluster Health, Standard 01/10/2008

Height (measured)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—height (measured), total centimetres NN[N].N

METeOR identifier: 270361

Registration status: Health, Standard 01/03/2005

Definition: The height of a person measured in centimetres.

Context: Public health and health care

Data Element Concept: Person—height

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: NN[N].N

Maximum character length: 4

Supplementary values:

Value	Meaning
999.9	Not measured

Unit of measure: Centimetre (cm)

Data element attributes

Collection and usage attributes

Guide for use: In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.

Measurements of height should be assessed in relation to children and adolescents' age and pubertal status.

Collection methods: The measurement protocol described below are those recommended by the *International Society for the Advancement of Kinanthropometry as described by Norton et al. (1996), and the World Health Organization (WHO Expert Committee 1995), which was adapted from Lohman et al. (1988).*

Measurement protocol:

Height measurements can be based on recumbent length or standing height. In general, length measurements are recommended for children under 2 years of age and height measurements for others.

The measurement of height requires a vertical metric rule, a horizontal headboard, and a non-compressible flat even surface on which the subject stands. The equipment may be fixed or portable, and should be described and reported.

The graduations on the metric rule should be at 0.1 cm intervals, and the metric rule should have the capacity to measure up to at least 210 cm.

Measurement intervals and labels should be clearly readable under all conditions of use of the instrument.

Apparatus that allows height to be measured while the subject stands on a platform scale is not recommended.

Adults and children who can stand:

The subject should be measured without shoes (i.e. is barefoot or wears thin socks) and wears little clothing so that the positioning of the body can be seen. Anything that may affect or interfere with the measurement should be noted on the data collection form (e.g. hairstyles and accessories, or physical problems). The subject stands with weight distributed evenly on both feet, heels together, and the head positioned so that the line of vision is at right angles to the body. The correct position for the head is in the Frankfort horizontal plan (Norton et al. 1996). The arms hang freely by the sides. The head, back, buttocks and heels are positioned vertically so that the buttocks and the heels are in contact with the vertical board. To obtain a consistent measure, the subject is asked to inhale deeply and stretch to their fullest height. The measurer applies gentle upward pressure through the mastoid processes to maintain a fully erect position when the measurement is taken. Ensure that the head remains positioned so that the line of vision is at right angles to the body, and the heels remain in contact with the base board.

The movable headboard is brought onto the top of the head with sufficient pressure to compress the hair.

The measurement is recorded to the nearest 0.1 cm. Take a repeat measurement. If the two measurements disagree by more than 0.5 cm, then take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject’s measured height is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over reporting (Armitage & Berry 1994). For example, a mean value of 172.25 cm would be rounded to 172.2 cm, while a mean value of 172.35 cm would be rounded to 172.4 cm.

Infants:

For the measurement of supine length of children up to and including 2 years of age, two observers are required. One observer positions the head correctly while the other ensures the remaining position is correct and brings the measuring board in contact with the feet. The subject lies in a supine position on a recumbent length table or measuring board. The crown of the head must touch the stationary, vertical headboard. The subject's head is held with the line of vision aligned perpendicular to the plane of the measuring surface. The shoulders and buttocks must be flat against the table top, with the shoulders and hips aligned at right angles to the long axis of the body. The legs must be extended at the hips and knees and lie flat against the table top and the arms rest against the sides of the trunk. The measurer must ensure that the legs remain flat on the table and must shift the movable board against the heels. In infants care has to be taken to extend the legs gently. In some older children two observers may also be required.

In general, length or height is measured and reported to the nearest 0.1 cm. For any child, the length measurement is approximately 0.5 - 1.5 cm greater than the height measurement. It is therefore recommended that when a length measurement is applied to a height-based reference for children over 24 months of age (or over 85 cm if age is not known), 1.0 cm be subtracted before the length measurement is compared with the reference. It is also recommended that as a matter of procedure and data recording accuracy, the date be recorded when the change is made from supine to standing height measure.

Validation and quality control measures:

All equipment, whether fixed or portable should be checked prior to each measurement session to ensure that both the headboard and floor (or footboard) are at 90 degrees to the vertical rule. With some types of portable anthropometer it is necessary to check the correct alignment of the headboard, during each measurement, by means of a spirit level. Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement of height, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 5 mm and be less than 5 mm within observers.

Extreme values at the lower and upper end of the distribution of measured height should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference. Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Comments:

This metadata item applies to persons of all ages. It is recommended for use in population surveys and health care settings.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present height data in categories. It is recommended that 5 cm groupings are used for this purpose. Height data should not be rounded before categorisation. The following categories may be appropriate for describing the heights of Australian men, women, children and adolescents although the range will depend on the population:

Height

70 cm = Height

75 cm = Height

... in 5 cm categories

185 cm = Height

Height => 190 cm

Relational attributes

Related metadata references:

Is used in the formation of Adult—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Supersedes Height - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (28.7 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Diabetes (clinical) DSS Health, Standard 21/09/2005

Height (self-reported)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—height (self-reported), total centimetres NN[N]

METeOR identifier: 270365

Registration status: Health, Standard 01/03/2005

Definition: A person's self-reported height, measured in centimetres.

Data Element Concept: Person—height

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: NN[N]

Maximum character length: 3

Supplementary values:

Value	Meaning
888	Unknown
999	Not stated/inadequately described

Unit of measure: Centimetre (cm)

Data element attributes

Collection and usage attributes

Collection methods: The method of data collection, e.g. face to face interview, telephone interview or self-completion questionnaire, can affect survey estimates and should be reported.

The data collection form should include a question asking the respondent what their height is. For example, the Australian Bureau of Statistics National Health Survey 1995 included the question 'How tall are you without shoes?'. The data collection form should allow for both metric (to the nearest 1 cm) and imperial (to the nearest 0.5 inch) units to be recorded.

If practical, it is preferable to enter the raw data into the database before conversion of measures in imperial units to metric. However if this is not possible, height reported in imperial units can be converted to metric prior to data entry using a conversion factor of 2.54 cm to the inch.

Rounding to the nearest 1 cm will be required for measures converted to metric prior to data entry, and may be required for data reported in metric units to a greater level of precision than the nearest 1 cm. The following rounding conventions are desirable to reduce systematic over-reporting (Armitage & Berry 1994):

NNN.x where x

NNN.x where x > 5 - round up, e.g. 172.7 cm would be rounded to 173 cm.

NNN.x where x = 5 - round to the nearest even number, e.g. 172.5 cm would be rounded to 172 cm, while 173.5 cm would be rounded to 174 cm.

Comments:

This metadata item is recommended for persons aged 18 years or older. It is recommended for use in population surveys when it is not possible to measure height.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present height data in categories. It is recommended that 5 cm groupings are used for this purpose. Height data should not be rounded before categorisation. The following categories may be appropriate for describing the heights of

Australian men and women, although the range will depend on the population. The World Health Organization's range for height is 140-190 cm.

Height <140 cm

140 cm = Height < 145 cm

145 cm = Height < 150 cm

... in 5 cm categories

185 cm = Height < 190 cm

Height => 190 cm

On average, height tends to be overestimated when self-reported by respondents. Data for Australian men and women aged 20-69 years in 1989 indicated that men overestimated by an average of 1.1 cm (SEM* of 0.04 cm) and women by an average of 0.5 cm (SEM of 0.05 cm) (Waters 1993). The extent of overestimation varied with age.

*Note: SEM is the standard error of measurement.

Relational attributes

Related metadata references:

Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Supersedes Height - self-reported, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.0 KB)

Highest year of school completed

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—highest year of school completed, code N
Synonymous names:	Highest level of schooling completed
METeOR identifier:	375998
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	The highest level of schooling that a person has completed, as represented by a code.
Data Element Concept:	Person—highest year of school completed

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:	Value	Meaning
	1	Year 12
	2	Year 11
	3	Year 10
	4	Year 9
	5	Year 8 or below
	6	No schooling
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Highest level of schooling includes study at a secondary education level which might, for example, be undertaken at a Technical and Further Education (TAFE) institution (ABS, 2002).

Record the code for the highest year of schooling completed, regardless of the institution or location where that study took place. If a year of schooling had been commenced but not completed, the code for the year below should be used.

Only one option may be selected.

Comments: This metadata item maps to the Australian Bureau of Statistics standard ‘Highest year of school completed’.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Australian Bureau of Statistics 2002. Education variables. ABS cat. no. 1246.0. Canberra: ABS

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Australian Bureau of Statistics 2002. Education variables. ABS cat. no. 1246.0. Canberra: ABS

Relational attributes

Implementation in Data Set Specifications: Prison entrants DSS Health, Standard 25/08/2011

Hip circumference (measured)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—hip circumference (measured), total centimetres NN[N].N

METeOR identifier: 270366

Registration status: Health, Standard 01/03/2005

Definition: An adult's hip circumference at the level of maximum posterior extension of the buttocks measured in centimetres.

Data Element Concept: Person—hip circumference

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: NN[N].N

Maximum character length: 4

Supplementary values:

Value	Meaning
999.9	Not measured

Unit of measure: Centimetre (cm)

Data element attributes

Collection and usage attributes

Guide for use: As there are no cut-off points for waist-to-hip ratio for children and adolescents, it is not necessary to collect this metadata item for those aged under 18 years.

Collection methods: The measurement protocol described below is that recommended by the *World Health Organization (WHO Expert Committee 1995).*

Measurement protocol:

The data collection form should allow for up to three measurements of hip circumference to be recorded in centimetres to 1 decimal place. The data collection form should also have the capacity to record any reasons for the non-collection of hip circumference data.

The measurement of hip circumference requires a narrow (

The subject should wear only non-restrictive briefs or underwear, a light smock over underwear or light clothing. Belts and heavy outer clothing should be removed. Hip measurement should be taken over one layer of light clothing only.

The subject stands erect with arms at the sides, feet together and the gluteal muscles relaxed. The measurer sits at the side of the subject so that the level of maximum posterior extension of the buttocks can be seen. An inelastic tape is placed around the buttocks in a horizontal plane. To ensure contiguity of the two parts of the tape from which the circumference is to be determined, the cross-handed technique of measurement, as described by Norton et al. (1996), should be used. Ideally an assistant will check the position of the tape on the opposite side of the subject's body. The tape is in contact with the skin but does not compress the soft tissues. Fatty aprons should be excluded from the hip circumference measurement.

The measurement is recorded to the nearest 0.1 cm. Take a repeat measurement and record it to the nearest 0.1 cm. If the two measurements disagree by more than 1 cm, then take a third measurement.

All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured hip circumference is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over reporting. For example, a mean value of 102.25 cm would be rounded to 102.2 cm, while a mean value of 102.35 cm would be rounded to 102.4 cm.

Validation and quality control measures:

Steel tapes should be checked against a 1-metre engineer's rule every 12 months. If tapes other than steel are used they should be checked daily against a steel rule.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 2% and be less than 1.5% within observers.

Extreme values at the lower and upper end of the distribution of measured hip circumference should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Comments:

This metadata item applies to persons aged 18 years or older. It is recommended for use in population surveys and health care settings.

Its main use is to enable the calculation of adult waist-to-hip ratio which requires the measurement of hip circumference and waist circumference.

More recently it has emerged that waist circumference alone, or in combination with other metabolic measures, is a better indicator of risk and reduces the errors in waist-to-hip ratio measurements.

Waist-to-hip ratio is therefore no longer a commonly used measure.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present hip circumference data in categories. It is recommended that 5 cm groupings be used for this purpose. Hip circumference data should not be rounded before categorisation.

Relational attributes

Related metadata references:

Is used in the formation of Adult—waist-to-hip ratio, N.NN Health, Standard 01/03/2005

Supersedes Hip circumference - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (23.1 KB)

Histopathological grade

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person with cancer—histopathological grade, code N

METeOR identifier: 422555

Registration status: Health, Standard 07/12/2011

Definition: The histopathological grade or differentiation in a person with cancer, as represented by a code.

Data Element Concept: Person with cancer—histopathological grade

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:	Value	Meaning
	1	Grade 1: Low grade; well differentiated, differentiated, NOS
	2	Grade 2: Intermediate grade, moderately differentiated, moderately well differentiated, intermediate differentiation
	3	Grade 3: High grade, poorly differentiated
	4	Grade 4: Undifferentiated, anaplastic
Supplementary values:	9	Grade or differentiation not determined, not stated or not applicable

Data element attributes

Collection and usage attributes

Guide for use: Histopathological grade or differentiation describes how little the tumour resembles the normal tissue from which it arose.

Only malignant tumours are graded and only one code can be recorded.

When more than one grade is documented for the primary tumour within the same specimen report, use the highest grade. For example, if grade 2-3 is documented, record the grade as 3.

If the grades differ on multiple pathology reports for the same tumour, use the value from the larger specimen (for example, the grade from a surgical excision specimen would be used over the grade from a specimen from a diagnostic biopsy).

Breast cancer coding rules:

Use the Nottingham grade (Elston-Ellis modification of Bloom-Richardson grading system). This classification only uses grades 1-3, 9.

For an invasive tumour with an in situ component, record the grade for the invasive component only. If the grade of the invasive component is not reported, record the grade as unknown.

Collection methods:

Cancer registry use:

Collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.

Only malignant tumours are graded.

Source and reference attributes

Origin:

World Health Organization

Commission on Cancer American College of Surgeons

Reference documents:

Fritz A et al. 2000. International Classification of Diseases for Oncology, Third edition (ICD-O), 3rd edition. Geneva: World Health Organization

American College of Surgeons 1998. Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS), Volume II, Commission on Cancer

Johnson CH & Adamo M (Editors) 2007. SEER Program Coding and Staging Manual 2007. MD 2007. Bethesda: National Cancer Institute, NIH Publication number 07-5581

Relational attributes

Related metadata references:

Supersedes Person with cancer—histopathological grade, code N Health, Superseded 07/12/2011

Implementation in Data Set

Cancer (clinical) DSS Health, Standard 07/12/2011

Specifications:

Hormone therapy completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—hormone therapy completion date, DDMMYYYY
METeOR identifier:	393568
Registration status:	Health, Standard 07/12/2011
Definition:	The completion date of the **hormone therapy** administered during the initial course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—hormone therapy completion date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

Hormone therapy is cancer treatment that achieves its antitumour effect through changes in hormonal balance. This includes the administration of hormones, agents acting via hormonal mechanisms, antihormones and steroids.

The completion date of hormone treatment is the date of the last dose administered during the initial course of treatment. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The completion date of hormone therapy is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of immunotherapy.

Do not record the dates for prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment. Only record prednisone as hormone therapy when it is administered in combination with chemotherapy such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

Tumour involvement or cancer treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of the initial course of treatment.

A patient may undergo hormone therapy for an extended period of time.

Multiple entries are not permitted.

Dates of surgery, radiotherapy and other systemic treatments are collected as separate items. However, if a patient receives treatment with a protocol that includes different types of systemic therapy agents, for example, a chemotherapy agent and a hormone therapy agent, record the completion date of treatment in both relevant data items.

Collection methods: The information should be obtained from the patient's medical record.

Comments: Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references: See also Cancer treatment—hormone therapy start date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—systemic therapy agent or protocol, text X[(149)] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Hormone therapy for cancer cluster Health, Standard 07/12/2011

Conditional obligation:

Hormone therapy start date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Cancer treatment—hormone therapy start date, DDMMYYYY

METeOR identifier: 393527

Registration status: Health, Standard 07/12/2011

Definition: The start date of **hormone therapy** administered during the initial course of treatment for cancer, expressed as DDMMYYYY.

Data Element Concept: Cancer treatment—hormone therapy start date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: Hormone therapy is cancer treatment that achieves its antitumour effect through changes in hormonal balance. This includes the administration of hormones, agents acting via hormonal mechanisms, antihormones and steroids.

Record the first or earliest date hormone therapy was administered during the initial course of treatment. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The start date of hormone therapy is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of hormone therapy.

Do not record the dates for prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment. Only record prednisone as hormone therapy when it is administered in combination with chemotherapy such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

Tumour involvement or cancer treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of the initial course of treatment.

A patient may undergo hormone therapy for an extended period of time.

Multiple entries are not permitted.

Dates of surgery, radiotherapy and other systemic treatments are collected as separate items. However, if a patient receives treatment with a protocol that includes different types of systemic therapy agents, for example, a chemotherapy agent and a hormone therapy agent, record the start date of treatment in both relevant data items.

Collection methods: The information should be obtained from the patient's medical record.

Comments: Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references: See also Cancer treatment—hormone therapy completion date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—systemic therapy agent or protocol, text X[(149)] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Hormone therapy for cancer cluster Health, Standard 07/12/2011

Conditional obligation:

Hospital identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital—hospital identifier, XXXXX
METeOR identifier:	404239
Registration status:	Health, Standard 07/12/2011
Definition:	A unique identifier for a hospital, as represented by a combination of numeric and/or alphabetic characters.
Data Element Concept:	Hospital—hospital identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	XXXXX
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:

The complete identifier string, including State/Territory identifier, Region identifier, Organisation identifier and Hospital identifier, should be a unique code for the hospital in that state/territory.

The management of mental health services across a jurisdiction or area may result in a number of separate *Specialised mental health service organisations* reporting various mental health service units from a single hospital entity. In these cases, the Hospital identifier should be identical across all entries for the same hospital, within the same jurisdiction, regardless of the overarching organisational reporting structure.

The Hospital identifier should be identical to the Organisation identifier component, of the *Establishment—organisation identifier (Australian)* reported to the Public Hospital Establishments NMDS.

A *Specialised mental health service organisation* may consist of one or more clusters of service units providing services in admitted patient, residential and ambulatory settings. For example, a *Specialised mental health service organisation* may consist of several hospitals (clusters of admitted patient service units) and/or ambulatory or residential service unit clusters (for example, a cluster of child and adolescent ambulatory service units, and a cluster of aged residential service units).

To allow service units to be individually identified, but still also to be identified as part of a hospital (for the admitted patient service setting), or as part of another type of cluster (e.g. other cluster types for ambulatory or residential service setting), a separate reporting level called *Hospital* for admitted patient service units and *Service unit cluster* for ambulatory service units and residential service units is necessary.

The concept of hospital only applies to admitted service units. The equivalent entity for the grouping of ambulatory and residential service units is cluster.

Where applicable, service unit reporting structures should be identical between all mental health collections (e.g., Mental Health National Minimum Data Sets and the Mental Health National Outcomes and Casemix Collection (NOCC)).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Establishment—organisation identifier (Australian), NNX[X]NNNNN Health, Standard 01/03/2005

See also Establishment—organisation identifier (state/territory), NNNNN Health, Standard 01/03/2005

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Hospital insurance status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—hospital insurance status, code N
METeOR identifier:	270253
Registration status:	Health, Standard 01/03/2005

Definition:

Hospital insurance as represented by a code under one of the following categories:

- Registered insurance - hospital insurance with a health insurance fund registered under the National Health Act 1953 (Cwlth)
- General insurance - hospital insurance with a general insurance company under a guaranteed renewable policy providing benefits similar to those available under registered insurance
- No hospital insurance or benefits coverage under the above.

Data Element Concept: Patient—hospital insurance status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	1	Hospital insurance
	2	No hospital insurance
Supplementary values:	9	Unknown

Data element attributes

Collection and usage attributes

Guide for use: Persons covered by insurance for benefits of ancillary services only are included in 2 - no hospital insurance.

The ‘unknown’ category should not be used in primary collections but can be used to record unknown insurance status in databases.

This metadata item is to determine whether the patient has hospital insurance, not their method of payment for the episode of care.

Comments:

Insurance status was reviewed and modified to reflect changes to new private health insurance arrangements under the Health Legislation (Private Health Insurance Reform) Amendment Act 1995.

Employee health benefits schemes became illegal with the implementation of Schedule 2 of the private health insurance reforms, effective on 1 October 1995.

Under Schedule 4 of the private health insurance reforms, on 1 July 1997, the definition of the ‘basic private table’ or ‘basic table’, and ‘supplementary hospital table’ and any references to these definitions was omitted from the National Health Act 1953. All hospital tables offered by registered private health insurers since 29 May 1995 have been referred to as ‘Applicable Benefits Arrangements’ and marketed under the insurer’s own product name.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Hospital insurance status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.6 KB)

Implementation in Data Set Specifications: Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Hospital name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital—hospital name, text XXX[X(97)]
METeOR identifier:	407430
Registration status:	Health, Standard 07/12/2011
Definition:	The appellation by which a hospital is known or called, as represented by text.
Data Element Concept:	Hospital—hospital name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	XXX[X(97)]
Maximum character length:	100

Data element attributes

Collection and usage attributes

Guide for use:

Generally, the complete hospital name should be used to avoid any ambiguity in identification. This should usually be the same as company registration name. However, in certain circumstances (e.g. internal use), a short name (i.e. an abbreviated name by which the hospital is known) or a locally used name (e.g. where a hospital is known by a name that is different to the company registration name) can be used. At least one hospital name must be recorded for each hospital.

The management of mental health services across a jurisdiction or area may result in a number of separate *Specialised mental health service organisations* reporting various mental health service units from a single hospital entity. In these cases, the Hospital name need not be identical across all entries for the same hospital. A *Specialised mental health service organisation* may consist of one or more clusters of service units providing services in admitted patient, residential and ambulatory settings. For example, a *Specialised mental health service organisation* may consist of several hospitals (clusters of admitted patient service units) and/or ambulatory or residential service unit clusters (for example, a cluster of child and adolescent ambulatory service units, and a cluster of aged residential service units).

To allow service units to be individually identified, but still also to be identified as part of a hospital (for the admitted patient service setting), or as part of another type of cluster (e.g. other cluster types for ambulatory or residential service setting), a separate reporting level called *Hospital* for admitted patient service units and *Service unit cluster* for ambulatory service units and residential service units is necessary.

The concept of hospital only applies to admitted service units. The equivalent entity for the grouping of ambulatory service units is cluster.

Where applicable, service unit reporting structures should be identical between all mental health collections (e.g., Mental Health National Minimum Data Sets and the Mental Health National Outcomes and Casemix Collection (NOCC)).

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Hours on-call (not worked) by medical practitioner

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical practitioner—hours on-call, total NNN
METeOR identifier:	270138
Registration status:	Health, Standard 01/03/2005
Definition:	The number of hours in a week that a medical practitioner is required to be available to provide advice, respond to any emergencies etc.
Data Element Concept:	Medical practitioner—hours on-call

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure: Hour (h)

Collection and usage attributes

Guide for use: Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use: This metadata item relates to each position (job) held by a medical practitioner.

Collection methods: There are inherent problems in asking for information on number of hours on-call not worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours on-call not worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.

Relational attributes

Related metadata references: Supersedes Hours on-call (not worked) by medical practitioner, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.5 KB)

Hours worked in health profession—clinical

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Registered health professional—hours worked in clinical role, total hours NNN

METeOR identifier: 375301

Registration status: Health, Standard 10/12/2009

Definition: The total number of hours a health professional worked in their registered profession undertaking diagnosis, care and treatment of patients.

Context: Health labour force

Data Element Concept: Registered health professional—hours worked in clinical role

Value domain attributes

Representational attributes

Representation class: Total

Data type: String

Format: NNN

Maximum character length: 3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure: Hour (h)

Collection and usage attributes

Guide for use: Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use:

Total hours worked are for both employed and self-employed health professionals.

Total hours worked in clinical role:

- includes travel to home visits or calls out;
- excludes other time travelling between work locations; and
- excludes unpaid professional and/or voluntary activities.

Registered health professionals on leave at the time of registration are asked to report their usual hours worked.

Collection methods:

Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Medical practitioner—hours worked (in direct patient care), total NNN Health, Superseded 10/12/2009

See also Registered health professional—hours worked in health profession, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in non-clinical role Health, Standard 10/12/2009

See also Registered health professional—hours worked in non-clinical role, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in private sector, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in public sector, total hours NNN Health, Standard 10/12/2009

See also Work setting hours cluster Health, Standard 10/12/2009

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health,

Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Hours worked in health profession—non-clinical

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—hours worked in non-clinical role, total hours NNN
METeOR identifier:	375305
Registration status:	Health, Standard 10/12/2009
Definition:	The total number of hours a health professional worked in a non-clinical role in their registered profession.
Context:	Health labour force
Data Element Concept:	Registered health professional—hours worked in non-clinical role

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure: Hour (h)

Collection and usage attributes

Guide for use: Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use: Total hours worked are for both employed and self-employed health professionals.

Total hours worked in non-clinical role includes:

- time spent as an administrator, teacher/educator, researcher or other non-clinician role in the profession; and

- travel to home visits or calls out.

Total hours worked in non-clinical role excludes:

- time spent in the diagnosis, care and treatment of patients;
- time travelling between work locations; and
- unpaid professional and/or voluntary activities.

Registered health professionals on leave at the time of registration are asked to report their usual hours worked.

Collection methods:

Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Registered health professional—hours worked in clinical role, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in health profession, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in private sector, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in public sector, total hours NNN Health, Standard 10/12/2009

See also Work setting hours cluster Health, Standard 10/12/2009

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard

10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Hours worked in health profession—private sector

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—hours worked in private sector, total hours NNN
METeOR identifier:	382906
Registration status:	Health, Standard 10/12/2009
Definition:	The total number of hours a health professional worked in non-government sector employment in their registered profession.
Context:	Health labour force
Data Element Concept:	Registered health professional—hours worked in private sector

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	999	Not stated/inadequately described
Unit of measure:	Hour (h)	

Collection and usage attributes

Guide for use: Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use: Total hours worked are for both employed and self-employed health professionals.

Total hours worked in private sector:

- includes travel to home visits or calls out;
- excludes other time travelling between work locations; and
- excludes unpaid professional and/or voluntary activities.

Registered health professionals on leave at the time of registration are asked to report their usual hours worked.

Private sector employment is employment by an establishment that may receive some government funding but is run by the non-government sector. Private sector establishments are not controlled by government, are directed by a group of officers, an executive committee or a similar body elected by a majority of members, and may be an income tax exempt charity.

Collection methods: Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Registered health professional—hours worked in clinical role, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in health profession, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in non-clinical role, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in public sector, total hours NNN Health, Standard 10/12/2009

See also Work setting hours cluster Health, Standard 10/12/2009

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Hours worked in health profession—public sector

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—hours worked in public sector, total hours NNN
METeOR identifier:	382908
Registration status:	Health, Standard 10/12/2009
Definition:	The total number of hours a health professional worked in government sector employment in their registered profession.
Context:	Health labour force
Data Element Concept:	Registered health professional—hours worked in public sector

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure: Hour (h)

Collection and usage attributes

Guide for use: Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use: Total hours worked are for both employed and self-employed health professionals.

Total hours worked in public sector:

- includes travel to home visits or calls out;
- excludes other time travelling between work locations;

and

- excludes unpaid professional and/or voluntary activities.

Registered health professionals on leave at the time of registration are asked to report their usual hours worked.

Public sector employment is employment with an establishment run by the government sector. A public sector establishment:

- operates from the public accounts of a Commonwealth, state or territory government or is part of the executive, judicial or legislative arms of government,
- is part of the general government sector or is controlled by some part of the general government sector,
- provides government services free of charge or at nominal prices, and
- is financed mainly from taxation.

Collection methods: Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Registered health professional—hours worked in clinical role, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in health profession, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in non-clinical role, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in private sector, total hours NNN Health, Standard 10/12/2009

See also Work setting hours cluster Health, Standard 10/12/2009

Implementation in Data Set Specifications: Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Hours worked in health profession—total

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—hours worked in health profession, total hours NNN
METeOR identifier:	375286
Registration status:	Health, Standard 10/12/2009
Definition:	The total number of hours a health professional worked in their registered profession.
Context:	Health labour force
Data Element Concept:	Registered health professional—hours worked in health profession

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure: Hour (h)

Collection and usage attributes

Guide for use: Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use: Total hours worked are for both employed and self-employed health professionals.

Total hours worked in health profession:

- includes travel to home visits or calls out;
- excludes other time travelling between work locations;

and

- excludes unpaid professional and/or voluntary activities.

Registered health professionals on leave at the time of registration are asked to report their usual hours worked.

Collection methods: Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Health professional—hours worked (in all jobs), total NNN Health, Superseded 10/12/2009

Supersedes Medical practitioner—hours worked, total NNN Health, Superseded 10/12/2009

See also Registered health professional—hours worked in clinical role, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in non-clinical role, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in private sector, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in public sector, total hours NNN Health, Standard 10/12/2009

Implementation in Data Set Specifications:

Main job of registered chiropractor cluster Health, Standard 10/12/2009

Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Main job of registered medical professional cluster Health, Standard 10/12/2009

Main job of registered midwife cluster Health, Standard 10/12/2009

Main job of registered nursing professional cluster Health, Standard 10/12/2009

Main job of registered optometrist cluster Health, Standard 10/12/2009

Main job of registered osteopath cluster Health, Standard 10/12/2009

Main job of registered pharmacist cluster Health, Standard 10/12/2009

Main job of registered physiotherapist cluster Health, Standard 10/12/2009

Main job of registered podiatrist cluster Health, Standard 10/12/2009

Main job of registered psychologist cluster Health, Standard 10/12/2009

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Second job of registered chiropractor cluster Health, Standard 10/12/2009

Second job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Second job of registered medical professional cluster Health, Standard 10/12/2009

Second job of registered midwife cluster Health, Standard 10/12/2009

Second job of registered nursing professional cluster Health, Standard 10/12/2009

Second job of registered optometrist cluster Health, Standard 10/12/2009

Second job of registered osteopath cluster Health, Standard 10/12/2009

Second job of registered pharmacist cluster Health, Standard 10/12/2009

Second job of registered physiotherapist cluster Health, Standard 10/12/2009

Second job of registered podiatrist cluster Health, Standard 10/12/2009

Second job of registered psychologist cluster Health, Standard 10/12/2009

Work setting hours cluster Health, Standard 10/12/2009

Household annual gross income range

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Household—gross income (annual), dollar range code N

METeOR identifier: 290737

Registration status: Health, Standard 04/05/2005

Definition: The value of gross annual income from all sources (before deductions for income tax, superannuation, etc.) for all household members as represented by a dollar range code.

Context: Gross household income ranges are used as an indicator of the economic status of the household.

Data Element Concept: Household—gross income

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning

	1	Less than $ 20,000
	2	$ 20,001-$ 30,000
	3	$ 30,001-$ 50,000
	4	$ 50,001 - $ 100,000
	5	More than $ 100,000
Supplementary values:	6	Don't know/not sure
	7	Not stated

Data element attributes

Collection and usage attributes

Guide for use:

The main components of gross income are:

- current usual wages and salary;
- income derived from self-employment;
- government pensions, benefits and allowances; and
- other income comprising investments (including interest, dividends, royalties and rent) and other regular income (including superannuation, private scholarships received in cash, workers' compensation, accident compensation, maintenance or alimony, and any other allowances regularly received).

Gross income is regarded as all receipts which are received regularly and are of a recurring nature. Certain receipts such as lump sum receipts, windfall gains and withdrawals from savings are not considered to conform to these criteria and are not included as income.

Please note that this data element is not consistent with the ABS standards for cash income.

Source and reference attributes

Submitting organisation: National Public Health Information Working Group

Reference documents: Refer to the ABS website Statistical Standards/Standards for Social, Labour and Demographic Variables/Cash Income Variables:

1200.0 - Standards for Social, Labour and Demographic Variables, 1999

Relational attributes

Implementation in Data Set Specifications:	Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Household annual gross income range ($ 10,000 range)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Household—gross income (annual), ten thousand dollar range code N[N]
METeOR identifier:	290742
Registration status:	Health, Standard 04/05/2005
Definition:	The value of gross annual income from all sources (before deductions for income tax, superannuation, etc.) for all household members as represented by a ten thousand dollar range code.
Context:	Gross household income ($ 10,000 ranges) is used as an indicator of the economic status of the household.
Data Element Concept:	Household—gross income

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Less than $ 10,000
2	$ 10,000 - $ 20,000
3	$ 20,001 - $ 30,000
4	$ 30,001 - $ 40,000
5	$ 40,001 - $ 50,000
6	$ 50,001 - $ 60,000
7	$ 60,001 - $ 70,000
8	$ 70,001 - $ 80,000
9	$ 80,001 - $ 90,000

	10	$ 90,001 - $ 100,000
	11	More than $ 100,000
Supplementary values:	12	Don’t know / not sure
	13	Not stated

Data element attributes

Collection and usage attributes

Guide for use:

The main components of gross income are:

- current usual wages and salary;
- income derived from self-employment;
- government pensions, benefits and allowances; and
- other income comprising investments (including interest, dividends, royalties and rent) and other regular income (including superannuation, private scholarships received in cash, workers’ compensation, accident compensation, maintenance or alimony, and any other allowances regularly received).

Gross income is regarded as all receipts which are received regularly and are of a recurring nature. Certain receipts such as lump sum receipts, windfall gains and withdrawals from savings are not considered to conform to these criteria and are not included as income.

Please note that this data element is not consistent with the ABS standards for cash income.

Refer to the ABS website Standards for Social, Labour and Demographic Variables/Cash Income Variables: 1200.0 - Standards for Social, Labour and Demographic Variables, 1999

Source and reference attributes

Submitting organisation: National Public Health Information Working Group

Relational attributes

Implementation in Data Set Specifications: Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

HPI-O

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Healthcare provider—organisation identifier, N(16)

METeOR identifier: 426830

Registration status: Health, Standard 03/12/2011

Definition: The Healthcare provider identifier—organisation (HPI-O) is the numerical identifier that uniquely identifies organisations in Australia where healthcare is provided.

Data Element Concept: Healthcare provider—organisation identifier

Value domain attributes

Representational attributes

Representation class: Identifier

Data type: Number

Format: N(16)

Maximum character length: 16

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: National E-Health Transition Authority 2010. HI service: concept of operations. Version 2.0-final release. Sydney: National E-Health Transition Authority

Data element attributes

Collection and usage attributes

Guide for use: A Healthcare Provider Identifier-Organisation (HPI-O) identifies organisations where healthcare services are provided. For example, state health departments, hospitals, medical practices, pathology or radiology laboratories or pharmacies.

Each organisation’s HPI-O is unique within the Australian healthcare system.

The HPI-O is part of the government’s e-health initiative developed to enhance the way information is exchanged, shared and managed in the Australian health sector. Electronic identifiers and the systems underpinning them were developed and are maintained by Medicare Australia.

All organisations that provide healthcare services will be able to apply for a HPI-O. As part of establishing their eligibility, an organisation will need to provide evidence to the HI Service Operator that it is a legal entity and employs or contracts one or more individual healthcare providers or sole traders who are employed for the purpose of providing a health service. Registration is optional though desirable and the information guides and forms are available online at Medicare.

Organisations registered directly with the HI Service are referred to as "seed" organisations. Once registered, they can obtain identifiers for subordinate organisations or departments known as "network" organisations. For example, the seed organisation The North Shore Hospital may declare their radiology department as a network organisation so it will have its own unique identifier.

Record the full Healthcare Provider Identifier-Organisation (HPI-O) for an organisation.

All healthcare identifiers use the International Standard ISO 7812-1:2006 that specifies the numbering system for identification cards.

The format of the number is as follows:

- Digits N1-N6 consist of the issuer identification number
- N1-N2 Major industry identifier: 80 = health
- N3-N5 Country code: 036 = Australia
- N6 Number type: 2 = HPI-O
- Digits N7-N15 Individual account identification (9 digits for the unique identifier)
- Digit N16 Check digit

Comments: The Healthcare Provider Identifier-Organisation is part of the government’s e-health initiative and supports healthcare providers in their decision making by improving the quality and accessibility of patient information, facilitates communication between clinicians and patients, and advances policy development and healthcare planning by assisting in the collection of national, high quality health information.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: National E-Health Transition Authority 2010. HI service: concept of operations. Version 2.0-final release. Sydney: National E-Health Transition Authority

Relational attributes

Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Standard 07/12/2011

Human epidermal growth factor receptor-2 test result

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—human epidermal growth factor receptor-2 test result, code N
Synonymous names:	HER2 test result
METeOR identifier:	370572
Registration status:	Health, Standard 06/03/2009
Definition:	The result of a person's human epidermal growth factor receptor-2 (HER2) test, as represented by a code.
Data Element Concept:	Person with cancer—human epidermal growth factor receptor-2 test result

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:	Value	Meaning
	1	Positive
	2	Negative
	3	Equivocal
Supplementary values:	7	Unknown (test results not available)
	8	Not applicable (test not done)

Collection and usage attributes

Guide for use:

Record the reported conclusion of the HER2.

If no conclusion is reported use the following guidelines (from the National Breast and Ovarian Cancer Centre and Australian Cancer Network's pathology reporting guide (3rd ed.) for breast cancer):

CODE 1 Positive

- **For in situ hybridisation:**
  Result is more than 6 copies of the HER2 gene per nucleus OR a ratio of HER2 gene signals to chromosome 17 signals of more than 2.2.
- **For Immunochemistry:**
  Result is described as 3+ or +++ OR >30% of cancer cells show strong complete membrane staining without cytoplasmic staining and without staining of normal tissue.

CODE 2 Negative

- **For in situ hybridisation:**
  Result is less than 4 copies of the HER2 gene per nucleus OR a ratio of HER2 gene signals to chromosome 17 signals of less than 1.8.
- **For Immunochemistry:**
  Result described as 0, 1+ or + OR <10% of cancer cells show staining.

CODE 3 Equivocal

- **For in situ hybridisation:**
  Result is an average of between 4 and 6 HER2 gene copies per nucleus with a single probe OR a ratio of HER2 gene signals to chromosome 17 signals in the range of 1.8-2.2.
- **For Immunochemistry:**
  Result described as 2+ or ++ OR <10% of cancer cells show strong complete membrane staining (rare) OR 10-30% of cancer cells show weak to moderate complete membrane staining OR Strong cytoplasmic staining is present, making assessment of membrane staining difficult.

Supplementary codes

CODE 7 Unknown (test results not available)

Use this code when the test has been performed but the results are not yet available for analysis.

CODE 8 Not applicable (test not done)

This code is used as a validation measure, to show that the reason for the lack of results is due to the test not being performed.

Data element attributes

Collection and usage attributes

Collection methods: For cancer registries, collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or subsequent metastatic disease.

Where different values are available from multiple specimens, the appropriate values to enter are selected according to the following hierarchy of rules:

When multiple HER2 values are available, the value established by the most accurate test is used as per the hierarchy: FISH > CISH/SISH > IHC. (See Person with cancer—HER2 test type, code N) If the HER2 values differ on multiple pathology reports for the same tumour, use the value from the larger specimen.

For multifocal tumours, use the HER2 value from the largest focus or from a metastatic deposit; e.g. Lymph node metastasis. A smaller focus that is HER2 positive may in fact be the source of a metastasis and in this setting the patient would derive benefit from the therapy offered as a result of HER2 positive status.

Comments: Human epidermal growth factor receptor-2 (HER2) promotes the growth of cancer cells. HER2 is also known as c-erB-2 and Her2/neu. Tumours that are HER2-positive tend to grow more quickly than other types of cancer. HER2 status is an important prognostic marker and predicts the response to several therapies.

Source and reference attributes

Origin: National Breast and Ovarian Cancer Centre (NBOCC)

Australasian Association of Cancer Registries (AACR)

Australian Institute of Health and Welfare (AIHW)

Reference documents: National Breast and Ovarian Cancer Centre and Australian Cancer Network. The Pathology reporting of breast cancer. A guide for pathologists, surgeons, radiologists and oncologists (3rd edition). National Breast and Ovarian Cancer Centre, Surry Hills, NSW, 2008.

Relational attributes

Implementation in Data Set Specifications: Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Human epidermal growth factor receptor-2 test type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—human epidermal growth factor receptor-2 test type, code N
Synonymous names:	HER2 test type
METeOR identifier:	370607
Registration status:	Health, Standard 06/03/2009
Definition:	The type of test used to determine the results of human epidermal growth factor receptor-2 (HER2) at the time of diagnosis of the primary tumour, as represented by a code.
Data Element Concept:	Person with cancer—human epidermal growth factor receptor-2 test type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Fluorescence in situ hybridisation (FISH)
	2	Brightfield in situ hybridisation
	3	Immunochemistry (IHC)
	8	Other
Supplementary values:	9	Test type not stated or unknown

Collection and usage attributes

Guide for use: CODE 2 Brightfield in situ hybridisation

Includes Chromogenic in situ hybridisation (CISH) and Silver in situ hybridisation (SISH).

Data element attributes

Collection and usage attributes

Guide for use: Record the test type corresponding to the test result recorded in 'Person with Cancer - human epidermal growth factor receptor-2 test result'.

Comments: Immunochemistry (IHC) measures how much HER2 protein is present in the tumour sample. Fluorescence in situ hybridisation (FISH), chromogenic in situ hybridisation (CISH) and silver in situ hybridisation (SISH) measure the amount of amplification of the gene responsible for HER2. The type of HER2 test used to determine HER2 status affects the accuracy of the information.

Source and reference attributes

Origin: National Breast and Ovarian Cancer Centre (NBOCC)

Australasian Association of Cancer Registries (AACR)

Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications: Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Hypertension—treatment

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—hypertension treatment with antihypertensive medication indicator (current), code N

METeOR identifier: 302442

Registration status: Health, Standard 21/09/2005

Definition: Whether a person is currently being treated for hypertension (high blood pressure) using antihypertensive medication, as represented by a code.

Data Element Concept: Person—hypertension treatment with antihypertensive medication indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes

Record if a person is currently being treated for hypertension using antihypertensive medication.

CODE 2 No

Record if a person is not currently being treated for hypertension using antihypertensive medication.

Collection methods: Ask the individual if he/she is currently treated with anti-hypertensive medications. Alternatively obtain the relevant information from appropriate documentation.

Source and reference attributes

Submitting organisation: National diabetes data working group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Reference documents: Pahor M, Psaty BM, Furberg CD. Treatment of hypertensive patients with diabetes. Lancet 1998; 351:689-90. Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UKPDS 38. UK Prospective Diabetes Study Group [erratum appears in Br Med J 1999; 318:29]. Br Med J 1998; 317:703-13.

Grossman E, Messerli FH, Goldbourt U, Curb JD, Pressel SL, Cutler JA, Savage PJ, Applegate WB, Black H, et al. Effect of diuretic-based antihypertensive treatment on cardiovascular disease risk in older diabetic patients with isolated systolic hypertension. Systolic Hypertension in the Elderly Program Cooperative Research Group. JAMA 1996; 276:1886-92.

Hypertension in diabetes [Australian Prescriber Feb 2002]. American Journal of Preventive Medicine 2002;21.

Relational attributes

Related metadata references: Supersedes Person—hypertension treatment status (antihypertensive medication), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Diabetes (clinical) DSS Health, Standard 21/09/2005

Hypoglycaemia—severe

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—severe hypoglycaemia indicator, code N

METeOR identifier: 302825

Registration status: Health, Standard 21/09/2005

Definition: Whether a person has had **severe hypoglycaemia**, as represented by a code.

Data Element Concept: Person—severe hypoglycaemia indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes: Record if the person has a history of severe hypoglycaemia.

CODE 2 No: Record if the person has no history of severe hypoglycaemia.

Collection methods: Ask the individual if he/she has had a severe hypoglycaemia requiring assistance. Alternatively obtain the relevant information from appropriate documentation.

Comments: The medications used in the treatment of diabetes may cause the blood glucose value to fall below the normal range and this is called hypoglycaemia.

Source and reference attributes

Submitting organisation: National diabetes data working group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Reference documents: Definition corresponds with the Diabetes Control and Complications Trial (DCCT): DCCT New England Journal of Medicine, 329(14), September 30, 1993. Report of the Health Care Committee Expert Panel on Diabetes; Commonwealth of Australia 1991; ISBN 0644143207.

Relational attributes

Related metadata references: Supersedes Person—severe hypoglycaemia history, status code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Hysterectomy indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Female—hysterectomy indicator, yes/no code N

METeOR identifier: 457775

Registration status: Health, Standard 07/12/2011

Definition: An indicator of whether a female person has had a hysterectomy performed, as represented by a code.

Data Element Concept: Female—hysterectomy indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A female person has had a hysterectomy performed.

CODE 2 No

A female person has not had a hysterectomy performed.

A hysterectomy is the surgical removal of the uterus and, sometimes, the cervix.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Immunotherapy completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—immunotherapy completion date, DDMMYYYY
METeOR identifier:	393591
Registration status:	Health, Standard 07/12/2011
Definition:	The completion date of **immunotherapy** administered during the initial course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—immunotherapy completion date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

The completion date of immunotherapy treatment is the date of the last dose administered during the initial course of treatment. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The completion date of immunotherapy treatment is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of the immunotherapy.

A patient may undergo immunotherapy for an extended period of time.

The completion date of the immunotherapy treatment is recorded even if the agent is experimental.

Multiple entries are not permitted.

Dates of surgical, radiotherapy and other systemic treatments are collected as separate items. However, if a patient receives treatment with a protocol that includes different types of systemic therapy agents, for example, a chemotherapy agent and an immunotherapy agent, record the completion date of treatment in both relevant data items.

Collection methods: The information should be obtained from the patient's medical record.

Comments: Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Johnson CH & Adamo M (Editors) 2007. SEER Program Coding and Staging Manual 2007, MD 2008 revision. Bethesda:National Cancer Institute, NIH Publication number 07-5581

Relational attributes

Related metadata references: See also Cancer treatment—immunotherapy start date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—systemic therapy agent or protocol, text X[(149)] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Immunotherapy for cancer cluster Health, Standard 07/12/2011

Conditional obligation:

Immunotherapy start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—immunotherapy start date, DDMMYYYY
METeOR identifier:	393541
Registration status:	Health, Standard 07/12/2011
Definition:	The start date of **immunotherapy** administered during the initial course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—immunotherapy start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

Record the first or earliest date on which immunotherapy was administered during the initial course of treatment. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The start date of immunotherapy treatment is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of the immunotherapy.

A patient may undergo immunotherapy for an extended period of time.

The start date of the immunotherapy treatment is recorded even if the agent is experimental.

Multiple entries are not permitted.

Dates of surgery, radiotherapy and other systemic treatments are collected as separate items. However, if a patient receives treatment with a protocol that includes different types of systemic therapy agents, for example, a chemotherapy agent and an immunotherapy agent, record the completion date of treatment in both relevant data items.

Collection methods: The information should be obtained from the patient's medical record.

Comments: Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Johnson CH & Adamo M (Editors) 2007. SEER Program Coding and Staging Manual 2007, MD 2008 revision. Bethesda:National Cancer Institute, NIH Publication number 07-5581

Relational attributes

Related metadata references: See also Cancer treatment—immunotherapy completion date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—systemic therapy agent or protocol, text X[(149)] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Immunotherapy for cancer cluster Health, Standard 07/12/2011

Conditional obligation:

Impairment of body function

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—extent of impairment of body function, code (ICF 2001) N

METeOR identifier: 320138

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Definition: A person's degree of impairment in a specified body function, as represented by a code.

Context: Human functioning and disability

Data Element Concept: Person—extent of impairment of body function

Value domain attributes

Representational attributes

Classification scheme: International Classification of Functioning, Disability and Health 2001

Representation class: Code

Data type: String

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	0	No impairment
	1	Mild impairment
	2	Moderate impairment
	3	Severe impairment
	4	Complete impairment
Supplementary values:	8	Not specified
	9	Not applicable

Collection and usage attributes

Guide for use: This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Impairments of body structure or body function are problems in body structure or function such as a loss or significant departure from population standards or averages.

CODE 0 No impairment

Used when there is no significant variation from accepted population standards in the biomedical status of the body structure or its functions [0-4%].

CODE 1 Mild impairment

Used when there is a slight or low variation from accepted population standards in the biomedical status of the body structure or its functions [5-24%].

CODE 2 Moderate impairment

Used when there is a medium (significant but not severe) variation from accepted population standards in the biomedical status of the body structure or its functions [25-49%].

CODE 3 Severe impairment

Used when there is an extreme variation from accepted population standards in the biomedical status of the body structure or its functions [50-95%].

CODE 4 Complete impairment

Used when there is a total variation from accepted population standards in the biomedical status of the body structure or its functions [96-100%].

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/

- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This coding is to be used in conjunction with specified Body Functions domains. For example, 'a mild impairment of functions related to the brain' to indicate the area of impairment and, potentially, the sorts of interventions that may result in improved functioning. The body function in which an individual experiences an impairment is indicated using the metadata item Person—body function, code (ICF 2001) AN[NNNN].

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—body function, code (ICF 2001) AN[NNNN] Community Services, Standard 16/10/2006, Health, Standard 29/11/2006

Implementation in Data Set Specifications: Body functions cluster Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Impairment of body structure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—extent of impairment of body structure, code (ICF 2001) N
METeOR identifier:	320165
Registration status:	Community Services, Standard 16/10/2006 Health, Standard 29/11/2006
Definition:	A person's degree of impairment in a specified body structure, as represented by a code.
Data Element Concept:	Person—extent of impairment of body structure

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	N
Maximum character length:	1

Permissible values:	Value	Meaning
	0	No impairment
	1	Mild impairment
	2	Moderate impairment
	3	Severe impairment
	4	Complete impairment
Supplementary values:	8	Not specified
	9	Not applicable

Collection and usage attributes

Guide for use:	This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Impairments of body structure or body function are problems in body structure or function such as a loss or significant departure from population standards or averages.

CODE 0 No impairment

Used when there is no significant variation from accepted population standards in the biomedical status of the body structure or its functions [0-4%].

CODE 1 Mild impairment

Used when there is a slight or low variation from accepted population standards in the biomedical status of the body structure or its functions [5-24%].

CODE 2 Moderate impairment

Used when there is a medium (significant but not severe) variation from accepted population standards in the biomedical status of the body structure or its functions [25-49%].

CODE 3 Severe impairment

Used when there is an extreme variation from accepted population standards in the biomedical status of the body structure or its functions [50-95%].

CODE 4 Complete impairment

Used when there is a total variation from accepted population standards in the biomedical status of the body structure or its functions [96-100%].

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This data element is used in conjunction with specified body structures, for example 'mild impairment of structures related to movement'. This data element may also be used in conjunction with Person—nature of impairment of body structure, code (ICF 2001) N and Person—location of impairment of body structure, code (ICF 2001) N.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—location of impairment of body structure, code (ICF 2001) N Community Services, Standard 16/10/2006, Health, Standard 29/11/2006

See also Person—nature of impairment of body structure, code (ICF 2001) N Community Services, Standard 16/10/2006, Health, Standard 29/11/2006

Implementation in Data Set Specifications: Body structures cluster Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Imprisonment in the last 12 months indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Prison entrant—imprisonment in the last 12 months indicator, yes/no code N

METeOR identifier: 408416

Registration status: Health, Standard 25/08/2011

Definition: An indicator of whether a prison entrant has been imprisoned in the last 12 months, as represented by a code.

Data Element Concept: Prison entrant—imprisonment in the last 12 months indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the *Health service utilisation cluster* and the *Health service non-utilisation cluster* to determine the proportion of prison entrants in prison who consulted health service providers.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Health service non-utilisation cluster Health, Standard 25/08/2011

See also Health service utilisation cluster Health, Standard 25/08/2011

Implementation in Data Set Specifications: Prison entrants DSS Health, Standard 25/08/2011

Indicator procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—indicator procedure, code NN
METeOR identifier:	472513
Registration status:	Health, Standard 13/12/2011
Definition:	Indicator procedure for which an elective surgery patient is waiting, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—indicator procedure

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 7th edition
Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Cataract extraction
02	Cholecystectomy
03	Coronary artery bypass graft
04	Cystoscopy
05	Haemorrhoidectomy
06	Hysterectomy
07	Inguinal herniorrhaphy
08	Myringoplasty
09	Myringotomy
10	Prostatectomy
11	Septoplasty

	12	Tonsillectomy
	13	Total hip replacement
	14	Total knee replacement
	15	Varicose veins stripping and ligation
Supplementary values:	88	Other

Data element attributes

Collection and usage attributes

Guide for use:

The procedure terms are defined by the Australian Classification of Health Interventions (ACHI) codes which are listed in comments below. Where a patient is awaiting more than one indicator procedure, all codes should be listed. This is because the intention is to count procedures rather than patients in this instance.

These are planned procedures for the waiting list, not what is actually performed during hospitalisation.

Comments:

The list of indicator procedures may be reviewed from time to time. Some health authorities already code a larger number of waiting list procedures.

Waiting list statistics for indicator procedures give a specific indication of performance in particular areas of elective care provision. It is not always possible to code all elective surgery procedures at the time of addition to the waiting list. Reasons for this include that the surgeon may be uncertain of the exact procedure to be performed, and that the large number of procedures possible and lack of consistent nomenclature would make coding errors likely. Furthermore, the increase in workload for clerical staff may not be acceptable. However, a relatively small number of procedures account for the bulk of the elective surgery workload. Therefore, a list of common procedures with a tendency to long waiting times is useful. Waiting time statistics by procedure are useful to patients and referring doctors. In addition, waiting time data by procedure assists in planning and resource allocation, audit and performance monitoring.

The following is a list of ACHI (7th edition) codes, for the indicator procedures:

Cataract extraction:

42698-00 [195] 42702-00 [195] 42702-01 [195] 42698-01 [196] 42702-02 [196]

42702-03 [196] 42698-02 [197] 42702-04 [197] 42702-05 [197] 42698-03 [198]
42702-06 [198] 42702-07 [198] 42698-04 [199] 42702-08 [199] 42702-09 [199]
42731-01 [200] 42698-05 [200] 42702-10 [200] 42734-00 [201] 42788-00 [201]
42719-00 [201] 42731-00 [201] 42719-02 [201] 42791-02 [201] 42716-00 [202]
42702-11 [200] 42719-00 [201] 42722-00 [201]

Cholecystectomy:

30443-00 [965] 30454-01 [965] 30455-00 [965] 30445-00 [965] 30446-00 [965]
30448-00 [965] 30449-00 [965]

Coronary Artery bypass graft:

38497-00 [672] 38497-01 [672] 39497-02 [672] 38497-03 [672] 38497-04 [673]
38497-05 [673] 38497-06 [673] 39497-07 [673] 38500-00 [674] 38503-00 [674]
38500-01 [675] 38503-01 [675] 38500-02 [676] 38503-02 [676] 38500-03 [677]
38503-03 [677] 38500-04 [678] 38503-04 [678] 90201-00 [679] 90201-01 [679]
90201-02 [679] 90201-03 [679]

Cystoscopy:

36812-00 [1089] 36812-01 [1089] 36836-00 [1098]

Haemorrhoidectomy:

32138-00 [941] 32132-00 [941] 32135-00 [941] 32135-01 [941]

Hysterectomy:

35653-00 [1268] 35653-01 [1268] 35653-02 [1268] 35653-03 [1268] 35661-00 [1268]
35670-00 [1268] 35667-00 [1268] 35664-00 [1268] 35657-00 [1269] 35750-00 [1269]
35756-00 [1269] 35673-00 [1269] 35673-01 [1269] 35753-00 [1269] 35753-01 [1269]
35756-01 [1269] 35756-02 [1269] 35667-01 [1269] 35664-01 [1269] 90450-00 [989]
90450-01 [989] 90450-02 [989]

Inguinal herniorrhaphy:

30614-03 [990] 30615-00 [997] 30609-03 [990] 30614-02 [990] 30609-02 [990]

Myringoplasty:

41527-00 [313] 41530-00 [313] 41533-01 [313] 41542-00 [315]

41635-01 [313]

Myringotomy:

41626-00 [309] 41626-01 [309] 41632-00 [309] 41632-01 [309]

Prostatectomy:

37203-00 [1165] 37203-02 [1165] 37207-00 [1166] 37207-01
[1166] 37203-05 [1166]
37203-06 [1166] 37200-03 [1167] 37200-04 [1167] 37209-00
[1167] 37200-05 [1167]
90407-00 [1168] 37201-00 [1165] 37203-03 [1166] 37203-04
[1166] 37224-00 [1162]
37224-01 [1162]

Septoplasty:

41671-02 [379] 41671-01 [379] 41671-03 [379]

Tonsillectomy:

41789-00 [412] 41789-01 [412]

Total hip replacement:

49318-00 [1489] 49319-00 [1489] 49324-00 [1492] 49327-00
[1492] 49330-00 [1492]
49333-00 [1492] 49345-00 [1492]

Total knee replacement:

49518-00 [1518] 49519-00 [1518] 49521-00 [1519] 49521-01
[1519] 49521-02 [1519]
49521-03 [1519] 49524-00 [1519] 49524-01 [1519] 49527-00
[1524] 49530-00 [1523]
49530-01 [1523] 49533-00 [1523] 49554-00 [1523] 49534-00
[1519]

Varicose veins stripping and ligation:

32508-00 [727] 32508-01 [727] 32511-00 [727] 32504-01 [728]
32505-00 [728]
32514-00 [737]

Source and reference attributes

Origin: National Health Data Committee

Reference documents: National Centre for Classification in Health (NCCH) 2010. The Australian Classification of Health Interventions (ACHI) – Seventh Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.

Relational attributes

Related metadata references: Supersedes Elective surgery waiting list episode—indicator procedure, code NN Health, Superseded 13/12/2011

See also National Healthcare Agreement: PI 34-Waiting times for elective surgery, 2012 Health, Standard 31/10/2011

Implementation in Data Set Specifications:

Elective surgery waiting times (census data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 30/09/2012

Elective surgery waiting times (removals data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 01/07/2012

Indigenous status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—Indigenous status, code N
METeOR identifier:	291036
Registration status:	Community Services, Standard 25/08/2005 Housing assistance, Standard 15/04/2010 Health, Standard 04/05/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010 Tasmanian Health, Proposed 30/09/2011
Definition:	Whether a person identifies as being of Aboriginal or Torres Strait Islander origin, as represented by a code. This is in accord with the first two of three components of the Commonwealth definition.
Data Element Concept:	Person—Indigenous status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Aboriginal but not Torres Strait Islander origin
	2	Torres Strait Islander but not Aboriginal origin
	3	Both Aboriginal and Torres Strait Islander origin
	4	Neither Aboriginal nor Torres Strait Islander origin
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

This metadata item is based on the Australian Bureau of Statistics (ABS) standard for Indigenous status. For detailed advice on its use and application please refer to the ABS Website as indicated in the Reference documents.

The classification for Indigenous status has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. There is one supplementary category for 'not stated' responses. The classification is as follows:

Indigenous:

- Aboriginal but not Torres Strait Islander origin.
- Torres Strait Islander but not Aboriginal origin.
- Both Aboriginal and Torres Strait Islander origin.

Non-Indigenous:

- Neither Aboriginal nor Torres Strait Islander origin.

Not stated/ inadequately described:

This category is not to be available as a valid answer to the questions but is intended for use:

- Primarily when importing data from other data collections that do not contain mappable data.
- Where an answer was refused.
- Where the question was not able to be asked prior to completion of assistance because the client was unable to communicate or a person who knows the client was not available.

Only in the last two situations may the tick boxes on the questionnaire be left blank.

Data element attributes

Collection and usage attributes

Collection methods:

The standard question for Indigenous Status is as follows:

[Are you] [Is the person] [Is (name)] of Aboriginal or Torres Strait Islander origin?

(For persons of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes.)

No..

Yes, Aboriginal..............................

Yes, Torres Strait Islander............

This question is recommended for self-enumerated or interview-based collections. It can also be used in circumstances where a close relative, friend, or another member of the household is answering on behalf of the subject. It is strongly recommended that this question be asked directly wherever possible.

When someone is not present, the person answering for them should be in a position to do so, i.e. this person must know well the person about whom the question is being asked and feel confident to provide accurate information about them.

This question must always be asked regardless of data collectors' perceptions based on appearance or other factors.

The Indigenous status question allows for more than one response. The procedure for coding multiple responses is as follows:

If the respondent marks 'No' and either 'Aboriginal' or 'Torres Strait Islander', then the response should be coded to either Aboriginal or Torres Strait Islander as indicated (i.e. disregard the 'No' response).

If the respondent marks both the 'Aboriginal' and 'Torres Strait Islander' boxes, then their response should be coded to 'Both Aboriginal and Torres Strait Islander Origin'.

If the respondent marks all three boxes ('No', 'Aboriginal' and 'Torres Strait Islander'), then the response should be coded to 'Both Aboriginal and Torres Strait Islander Origin' (i.e. disregard the 'No' response).

This approach may be problematical in some data collections, for example when data are collected by interview or using screen based data capture systems. An additional response category

Yes, both Aboriginal and Torres Strait Islander...

may be included if this better suits the data collection practices of the agency or establishment concerned.

Comments:

The following definition, commonly known as 'The Commonwealth Definition', was given in a High Court judgement in the case of Commonwealth v Tasmania (1983) 46 ALR 625.

'An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives'.

There are three components to the Commonwealth definition:

- descent;
- self-identification; and
- community acceptance.

In practice, it is not feasible to collect information on the community acceptance part of this definition in general purpose statistical and administrative collections and therefore standard questions on Indigenous status relate to descent and self-identification only.

Source and reference attributes

Origin: National Health Data Committee

National Community Services Data Committee

Reference documents: Australian Bureau of Statistics 1999. Standards for Social, Labour and Demographic Variables. Cultural Diversity Variables, Canberra. Viewed 3 August 2005.

Relational attributes

Related metadata references: Supersedes Person—Indigenous status, code N Community Services, Superseded 25/08/2005, Health, Superseded 04/05/2005

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Cancer (clinical) DSS Health, Standard 07/12/2011

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Diabetes (clinical) DSS Health, Standard 21/09/2005

Elective surgery waiting times (census data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 30/09/2012

Elective surgery waiting times (removals data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 01/07/2012

Health care client identification DSS Health, Standard 03/12/2008

Indigenous primary health care DSS Health, Standard 07/12/2011

Medical indemnity DSS Health, Standard 07/12/2011

Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Prison clinic contact DSS Health, Standard 25/08/2011

Prison entrants DSS Health, Standard 25/08/2011

Prisoners in custody repeat medications DSS Health, Standard 25/08/2011

Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions (public psychiatric, alcohol and drug hospital)—emergency and outpatient

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment (public psychiatric or alcohol and drug hospital)—number of individual session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN]

Synonymous names: Type of non-admitted patient care (public psychiatric, alcohol & drug) - emergency and outpatient individual sessions

METeOR identifier: 270216

Registration status: Health, Standard 01/03/2005

Definition: The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the emergency and outpatient functional unit of a public psychiatric or alcohol and drug hospital.

Data Element Concept: Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNNN]

Maximum character length: 7

Unit of measure: Occasion of service

Data element attributes

Collection and usage attributes

Guide for use: Emergency patients and outpatients are persons who receive non-admitted care. Individual non-admitted care is care provided to a person who receives direct care within the **emergency department** or other designated clinics within the hospital and who is not formally admitted at the time when the care is provided. A person who first contacts the hospital and receives non-admitted care, for example through the emergency department, and is subsequently admitted should have both components of care enumerated separately.

Comments: A group is defined as two or more patients receiving a service together where all individuals are not members of the same family. Family services are to be treated as occasions of service to an individual.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care (public psychiatric, alcohol & drug), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions (public psychiatric, alcohol and drug hospital)—outreach and community

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (public psychiatric or alcohol and drug hospital)—number of individual session occasions of service for non-admitted patients (outreach and community), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care (public psychiatric, alcohol & drug) - outreach and community individual sessions
METeOR identifier:	270218
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients by outreach and community services units of a public psychiatric or alcohol and drug hospital.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	For outreach/community patients, care is delivered by hospital employees to the patient in the home, place of work or other non-hospital site.
Comments:	A group is defined as two or more patients receiving a

service together where all individuals are not members of the same family. Family services are to be treated as occasions of service to an individual.

Source and reference attributes

Submitting organisation:	National minimum data set working parities

Relational attributes

Related metadata references:	Supersedes Type of non-admitted patient care (public psychiatric, alcohol & drug), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.1 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions—alcohol and drug

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (alcohol and drug), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - alcohol and drug individual sessions
METeOR identifier:	270508
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the alcohol and drug functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For occasions of service as individual sessions to non-admitted patients attending designated drug and alcohol units within hospitals.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Occasions of service, version 1, Derived DE,

NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions—allied health services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (allied health services), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - allied health services individual sessions
METeOR identifier:	270502
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients by allied health services units or clinics of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

Allied health service units include those units primarily concerned with physiotherapy, speech therapy, family planning, dietary advice, optometry, occupational therapy, and so on.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions—community health services

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—number of individual session occasions of service for non-admitted patients (community health services), total N[NNNNNN]

Synonymous names: Type of non-admitted patient care - community health services individual sessions

METeOR identifier: 270395

Registration status: Health, Standard 01/03/2005

Definition: The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in designated community health services units of an establishment.

Data Element Concept: Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNNN]

Maximum character length: 7

Unit of measure: Occasion of service

Data element attributes

Collection and usage attributes

Guide for use: For occasions of service to non-admitted patients provided by designated community health units within the establishment.

Community health units include:

- baby clinics
- immunisation units
- aged care assessment teams
- other

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients.

This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary. For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions—dental

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (dental), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - dental individual sessions
METeOR identifier:	270513
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in designated dental units of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For all occasions of service as individual sessions to non-admitted patients attending designated dental units within hospitals.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a separation is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions—dialysis

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—number of individual session occasions of service for non-admitted patients (dialysis), total N[NNNNNN]

Synonymous names: Type of non-admitted patient care - dialysis individual sessions

METeOR identifier: 270503

Registration status: Health, Standard 01/03/2005

Definition: The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the dialysis functional unit of an establishment.

Data Element Concept: Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNNN]

Maximum character length: 7

Unit of measure: Occasion of service

Data element attributes

Collection and usage attributes

Guide for use: Dialysis:

This represents all non-admitted patients receiving dialysis within the establishment. Where patients receive treatment in a ward or clinic classified elsewhere (for example, an emergency department), those patients are to be counted as dialysis patients and to be excluded from the other category. All forms of dialysis which are undertaken as a treatment necessary for renal failure are to be included.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a separation is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions—district nursing services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (district nursing services), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - district nursing services individual sessions
METeOR identifier:	270512
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients by the district nursing services functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For occasions of service as individual sessions by district nursing services to non-admitted patients.

District nursing services:

- are for medical/surgical/psychiatric care
- are provided by a nurse, paramedic or medical officer
- involve travel by the service provider*
- are not provided by staff from a unit classified in the community health category above.

*Travel does not include movement within an establishment, movement between sites in a multi-campus establishment or between establishments. Such cases should be classified under the appropriate non-admitted patient category.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.
For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients.

This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary. For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions—emergency services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (emergency services), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care
METeOR identifier:	270506
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the emergency services functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

Emergency services:

Services to patients who are not admitted and who receive treatment that was either unplanned or carried out in designated emergency departments within a hospital. Unplanned patients are patients who have not been booked into the hospital before receiving treatment. In general it would be expected that most patients would receive surgical or medical treatment. However, where patients receive other types of treatment that are provided in emergency departments these are to be included. The exceptions are for dialysis and endoscopy and related procedures which have been recommended for separate counting.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service. The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB) Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Individual sessions—endoscopy and related procedures

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—number of individual session occasions of service for non-admitted patients (endoscopy and related procedures), total N[NNNNNN]

Synonymous names: Type of non-admitted patient care - endoscopy and related procedures individual sessions

METeOR identifier: 270507

Registration status: Health, Standard 01/03/2005

Definition: The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the endoscopy and related procedures functional unit of an establishment.

Data Element Concept: Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNNN]

Maximum character length: 7

Unit of measure: Occasion of service

Data element attributes

Collection and usage attributes

Guide for use: For all occasions of endoscopy and related procedures provided as individual sessions to non-admitted patients.

Endoscopy and related procedures include:

- cystoscopy
- gastroscopy
- oesophagoscopy

- duodenoscopy
- colonoscopy
- bronchoscopy
- laryngoscopy.

Where one of these procedures is carried out in a ward or clinic classified elsewhere, for example in the emergency department, the occasion is to be included under endoscopy and related procedures, and to be excluded from the other category. Care must be taken to ensure procedures for admitted patients are excluded from this category.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions—mental health

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (mental health), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - mental health individual sessions
METeOR identifier:	270504
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the mental health functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For all occasions of service as individual sessions to non-admitted patients attending designated psychiatric or mental health units within hospitals.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf

(26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions—other medical/surgical/diagnostic

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—number of individual session occasions of service for non-admitted patients (other medical/surgical/diagnostic), total N[NNNNNN]

Synonymous names: Type of non-admitted patient care - other medical/surgical/diagnostic individual sessions

METeOR identifier: 270511

Registration status: Health, Standard 01/03/2005

Definition: The total number of occasions of examination, consultation, treatment or other service provided to a patient in a medical/surgical/diagnostic unit of a health service establishment not defined elsewhere. Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.

Data Element Concept: Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNNN]

Maximum character length: 7

Unit of measure: Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For any occasion of service to a non-admitted patient given at a designated unit primarily responsible for the provision of medical/surgical or diagnostic services which have not already been covered in other data elements.

Other medical/surgical/diagnostic services include:

- electrocardiogram (ECG)
- obstetrics
- nuclear medicine
- general medicine
- general surgery
- fertility etc.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary from admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions—other outreach services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (other outreach services), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care
METeOR identifier:	270514
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients through the outreach services of an establishment not defined elsewhere.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For occasions of outreach services as individual sessions to non-admitted patients.

Other outreach services:

- involve travel by the service provider*
- are not classified in allied health or community health services above.

*Travel does not include movement within an establishment, movement between sites in a multi-campus establishment or between establishments. Such cases should be classified under the appropriate non-admitted patient category.

It is intended that these activities should represent non-medical/surgical/psychiatric services. Activities such as home cleaning, meals on wheels, home maintenance and so on should be included.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients.

This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary. For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions—pathology

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (pathology), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care
METeOR identifier:	270505
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the pathology functional unit of an establishment. Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For all occasions of service as individual sessions to non-admitted patients from designated pathology laboratories.

Occasions of service to all patients from other establishments should be counted separately.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods: The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Occasions of service, version 1, Derived DE,

NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions—pharmacy

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—number of individual session occasions of service for non-admitted patients (pharmacy), total N[NNNNNN]

Synonymous names: Type of non-admitted patient care

METeOR identifier: 270509

Registration status: Health, Standard 01/03/2005

Definition: The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the pharmacy functional unit of an establishment.

Data Element Concept: Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNNN]

Maximum character length: 7

Unit of measure: Occasion of service

Data element attributes

Collection and usage attributes

Guide for use: For all occasions of service as individual sessions to non-admitted patients from pharmacy departments.

Those drugs dispensed/administered in other departments such as the emergency department, or outpatient departments, are to be counted by the respective departments.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods: The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Occasions of service, version 1, Derived DE,

NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual sessions—radiology and organ imaging

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—number of individual session occasions of service for non-admitted patients (radiology and organ imaging), total N[NNNNNN]

Synonymous names: Type of non-admitted patient care

METeOR identifier: 270510

Registration status: Health, Standard 01/03/2005

Definition: The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the radiology and organ imaging functional unit of an establishment.

Data Element Concept: Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNNN]

Maximum character length: 7

Unit of measure: Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For all occasions of radiology and organ imaging services as individual sessions to non-admitted patients.

Radiology and organ imaging includes services undertaken in radiology (X-ray) departments as well as in specialised organ imaging clinics carrying out ultrasound, computerised tomography (CT) and magnetic resonance imaging (MRI).

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Individual/group session indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service contact—group session status, individual/group session indicator code ANN.N
METeOR identifier:	291057
Registration status:	Health, Standard 04/05/2005
Definition:	Whether two or more patients received services at the same time from the same hospital staff, as represented by a code.
Data Element Concept:	Service contact—group session status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN.N
Maximum character length:	5

Permissible values:

Value	Meaning
A12.1	Individual sessions
A12.2	Group sessions

Data element attributes

Collection and usage attributes

Guide for use: This excludes the situation where individuals all belong to the same family. In such cases, the service is being provided to the family unit and as a result the session should be counted as a single occasion of service to an individual.

Relational attributes

Related metadata references: Supersedes Individual/group session, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB)

Infant weight, neonate, stillborn

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth—birth weight, total grams NNNN
METeOR identifier:	269938
Registration status:	Health, Standard 01/03/2005
Definition:	The first weight, in grams, of the live-born or stillborn baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth.
Data Element Concept:	Birth—birth weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Gram (g)

Data element attributes

Collection and usage attributes

Guide for use:

For **live births**, **birthweight** should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 g groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.

In perinatal collections the birthweight is to be provided for liveborn and stillborn babies.

Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000g and age is less than 365 days.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Infant weight, neonate, stillborn, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.2 KB)
Implementation in Data Set Specifications:	Perinatal NMDS 2012-2013 Health, Standard 07/03/2012 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Influence of environmental factor

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—extent of environmental factor influence, code (ICF 2001) [X]N

METeOR identifier: 320198

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Definition: The degree to which a specified environmental factor influences the body function or structure, the activity or participation of a person, as represented by a code.

Context: The environment in which a person functions or experiences disability.

Data Element Concept: Person—extent of environmental factor influence

Value domain attributes

Representational attributes

Classification scheme: International Classification of Functioning, Disability and Health 2001

Representation class: Code

Data type: String

Format: [X]N

Maximum character length: 2

Permissible values:

Value	Meaning
0	No barrier
1	Mild barrier
2	Moderate barrier
3	Severe barrier
4	Complete barrier
+0	No facilitator
+1	Mild facilitator
+2	Moderate facilitator

	+3	Substantial facilitator
	+4	Complete facilitator
Supplementary values:	8	Barrier not specified
	+8	Facilitator not specified
	9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Extent of influence of environmental factors corresponds to the degree, strength or magnitude of the influence and the amount of time the influence is experienced by the person. It is essentially a summary measure, in which are embedded the concepts of availability, quality and importance, that indicates the effect the specified environmental factor has on the person.

Whether, and by how much, environmental factors are influencing an individual's level of functioning, and whether the influence is a facilitator or barrier, may indicate the sorts of interventions that will optimise the individual's functioning. This information may be for policy development, service provision, or advocacy purposes. Preventative strategies could be indicated by this information.

This value domain can be used to collect information across the whole spectrum of influence, for example, tactile flooring may be a facilitator to a person with visual impairment and a barrier to a person with mobility impairments. In line with the ICF approach to functioning and disability, this value domain recognises, and gives the means to record, the positive influence of environmental factors as well as those factors that limit the level of functioning of a person.

The codes are mutually exclusive. The choice of codes depends on the context of the data collection. For example; if collecting information about the positive influence of an environmental factor such as a community service it would be appropriate to use Code 0 No facilitator if the service was not influencing the person's level of functioning (even if the service were not a barrier to the person's functioning).

Code +0 No facilitator:

Used when the environment factor does not impact in a positive way on the body structure or function, activity or participation of a person.

Code +1 Mild facilitator:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 5-24% of the time the person participates in the specified domain of functioning or has a low level of impact on the person's functioning.

Code +2 Moderate facilitators:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 25-49% of the time the person participates in the specified domain of functioning or has a significant, but moderate impact on the person's functioning.

Code +3 Substantial facilitators:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 50-95% of the time the person participates in the specified domain of functioning or has an extreme effect on the person's functioning.

Code +4 Complete facilitators:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 96-100% of the time the person participates in the specified domain of functioning or the person functions optimally with this environmental factor.

Code +8 Facilitator not specified:

Used when there is insufficient information to record the Extent of environmental influence code (ICF 2001) N in classes +1 to +4.

Code 0 No barrier:

Used when the environment factor does not impact in a negative way on the body structure or function, activity or participation of a person.

Code 1 Mild barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 5-24% of the time the person participates in the specified domain of functioning or has a low level of impact on the person's functioning.

Code 2 Moderate barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 25-49% of the time the person participates in that specified domain of functioning or has a significant, but moderate impact on the person's functioning.

Code 3 Severe barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 50-95% of the time the person participates in that specified domain of functioning or has an extreme effect on the person's functioning.

Code 4 Complete barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 96-100% of the time the person participates in the specified domain of functioning or is of such magnitude that the person is unable to function.

Code 8 Barrier not specified:

Used when there is insufficient information to record the Extent of environmental influence code (ICF 2001) N in classes 1 to 4.

Code 9 Not applicable:

Used when environmental factors impacts in neither a positive or negative way on the body structure or function, activity or participation of a person or for between 0-4% of the time the person participates in that specified area and has minimal impact on the person's level of functioning in the specified domain.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website

http://www.who.int/classifications/icf/en/

- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use:

Environmental factors represent the circumstances in which the individual lives. These factors are conceived as immediate (e.g. physical features of the environment, social environment) and societal (formal and informal social structures, services and systems). Different environments may have a very different impact on the same individual with a given health condition.

The influence of environmental factors may be positive, increasing the level of functioning (a facilitator), or negative, decreasing the level of functioning (a barrier).

The extent of influence of the **Environmental factors** is affected both by the degree, strength of influence, and the amount of time the influence is experienced by the person.

This metadata item is recorded in conjunction with *Environmental factor code N* to indicate the extent to which specified environmental factors influence the body function or structure, the activity or participation of a person.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also Person—environmental factor, code (ICF 2001) AN[NNN] Community Services, Standard 16/10/2006, Health, Standard 29/11/2006

Implementation in Data Set Specifications:

Environmental factors cluster Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Influenza immunisation indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—influenza immunisation indicator, yes/no code N
METeOR identifier:	457688
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a person is immunised against influenza, as represented by a code.
Data Element Concept:	Person—influenza immunisation indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A person is immunised against influenza.

CODE 2 No

A person is not immunised against influenza.

A person is considered to be immunised against influenza if, in the last 12 months, they have received an immunisation approved for prevention of influenza.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Conditional obligation:
This item is only collected for persons aged 50 years and over.

Informal carer existence indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—informal carer existence indicator, code N

Synonymous names: Informal carer availability, Informal carer existence flag, Carer arrangements (informal)

METeOR identifier: 320939

Registration status: Community Services, Standard 29/04/2006
Health, Standard 04/07/2007

Definition: Whether a person has an **informal carer**, as represented by a code.

Data Element Concept: Person—informal carer existence indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

Informal carers may include those people who receive a pension or benefit for their caring role and people providing care under family care agreements. Excluded from the definition of informal carers are volunteers organised by formal services and paid workers.

This metadata item is purely descriptive of a client's circumstances. It is not intended to reflect whether the informal carer is considered by the service provider to be capable of undertaking the caring role. The expressed views of the client and/or their carer should be used as the basis for determining whether the client is recorded as having an informal carer or not.

When asking a client whether they have an informal carer, it is important for agencies or establishments to recognise that a carer does not always live with the person for whom they care. That is, a person providing significant care and assistance to the client does not have to live with the client in order to be called an informal carer.

Collection methods:

Agencies or establishments and service providers may collect this item at the beginning of each service episode and /or assess this information at subsequent assessments.

Some agencies, establishments/providers may record this information historically so that they can track changes over time. Historical recording refers to the practice of maintaining a record of changes over time where each change is accompanied by the appropriate date.

Examples of questions that have been used for data collection include:

Home and Community Care NMDS

'Do you have someone who helps look after you?'

Commonwealth State/Territory Disability Agreement NMDS

'Does the service user have an informal carer, such as ***family*** *member, friend or neighbour, who provides care and assistance on a regular and sustained basis?*

Comments:

Recent years have witnessed a growing recognition of the critical role that informal support networks play in caring for frail older people and people with disabilities within the community. Not only are informal carers responsible for maintaining people with often high levels of functional dependence within the community, but the absence of an informal carer is a significant risk factor contributing to institutionalisation. Increasing interest in the needs of carers and the role they play has prompted greater interest in collecting more reliable and detailed information about carers and the relationship between informal care and the provision of and need for formal services.

This definition of informal carer is not the same as the Australian Bureau of Statistics (ABS) definition of principal carer, 2003 Survey of Disability, Ageing and Carers and primary carer used in the 1998 survey. The ABS definitions require that the carer has or will provide care for a certain amount of time and that they provide certain types of care.

The ABS defines a primary carer as a person of any age who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be provided for one or more of the core activities (communication, mobility and self care). This may not be appropriate for community services agencies wishing to obtain information about a person's carer regardless of the amount of time that care is for, or the types of care provided.

Information such as the amount of time for which care is provided can of course be collected separately but, if it were not needed, it would place a burden on service providers.

Source and reference attributes

Origin:

Australian Institute of Health and Welfare

National Health Data Committee

National Community Services Data Committee

Reference documents:

Australian Bureau of Statistics (ABS) 1993 Disability, Ageing and Carers Survey and 2003 Survey of Disability, Ageing and Carers.

Australian Institute of Health and Welfare (2005) Commonwealth State/Territory Disability Agreement National Minimum Data Set collection (CSTDA NMDS) Data Guide: 2005-06.

National HACC Minimum Data Set User Guide Version 2 July 2005. Home and Community Care (HACC) Program.

Relational attributes

Related metadata references: Supersedes Person (requiring care)—carer availability status, code N Community Services, Superseded 29/04/2006, Health, Superseded 04/07/2007

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Initial visit indicator—diabetes mellitus

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—initial visit since diagnosis indicator (diabetes mellitus), code N
METeOR identifier:	302470
Registration status:	Health, Standard 21/09/2005
Definition:	Whether the visit to a health professional is an initial visit for diabetes, or other related condition, after a diagnosis of diabetes, as represented by a code.
Data Element Concept:	Patient—initial visit since diagnosis indicator (diabetes mellitus)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes: Record if this is the initial visit of the patient for diabetes, or a related condition, after diagnosis.

CODE 2 No: Record if this is not the initial visit of the patient for diabetes, or a related condition, after diagnosis.

Source and reference attributes

Submitting organisation: National diabetes data working group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Patient—initial visit since diagnosis status (diabetes mellitus), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Initiator of prison clinic visit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—prison health clinic visit initiator, code N
METeOR identifier:	376348
Registration status:	Health, Standard 25/08/2011
Definition:	The party responsible for initiating the prisoner's visit to the prison health clinic, as represented by a code.
Data Element Concept:	Health service event—prison health clinic visit initiator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Prisoner
	2	Staff
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Staff includes both custodial officers and those employed by prison health clinics.

Only one code is to be selected. Where the visit was a joint decision, code 1 (Prisoner) is to be reported.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Prison clinic contact DSS Health, Standard 25/08/2011

Injecting drug use status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Client—injecting drug use status, code N
METeOR identifier:	270113
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 01/03/2005
Definition:	The client's use of injection as a method of administering drugs, as represented by a code.
Data Element Concept:	Client—injecting drug use status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	1	Last injected three months ago or less
	2	Last injected more than three months ago but less than or equal to twelve months ago
	3	Last injected more than twelve months ago
	4	Never injected
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:

To be collected on commencement of treatment with a service.

For clients whose treatment episode is related to the alcohol and other drug use of another person, this metadata item should not be collected.

Comments:

This metadata item has been developed for use in clinical settings. A code that refers to a three-month period to define ‘current’ injecting drug use is required as a clinically relevant period of time.

The metadata item may also be used in population surveys that require a longer timeframe, for example to generate 12-month prevalence rates, by aggregating Codes 1 and 2. However, caution must be exercised when comparing clinical samples with population samples.

This metadata item is important for identifying patterns of drug use and harms associated with injecting drug use.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Injecting drug use status, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Instrumented bleeding location

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person with acute coronary syndrome—bleeding location, instrumented code N(N)

Synonymous names: Instrumented bleeding site

METeOR identifier: 344787

Registration status: Health, Standard 01/10/2008

Definition: The location of the person's bleeding episode, arising from an instrumented site, as represented by a code.

Data Element Concept: Person with acute coronary syndrome—bleeding location

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N[N]

Maximum character length: 2

	Value	Meaning
Permissible values:	1	Percutaneous coronary procedure arterial access site
	2	Coronary artery bypass graft site
	3	Gastrointestinal site
	4	Genitourinary site
	5	Intracranial site
	6	Pulmonary site
	7	Pericardial site
	8	Other site(s)
	9	Unidentified site
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Percutaneous coronary procedure arterial access site

Use this code when the person's bleeding is originating from the site of arterial access for a percutaneous coronary procedure. Procedures may include cardiac catheterisation, percutaneous coronary intervention, angiogram, intra-aortic balloon pump and/or arterial pressure monitoring sheaths.

CODE 2 Coronary artery bypass graft site

Use this code when the person's bleeding is originating from the site of a coronary artery bypass graft.

CODE 3 Gastrointestinal site

Use this code when the person's bleeding is originating from the gastrointestinal area with mechanical instrumentation.

CODE 4 Genitourinary site

Use this code when the person's bleeding is originating from the genitourinary area with mechanical instrumentation.

CODE 5 Intracranial site

Use this code when the person's bleeding is originating from an intracranial site with mechanical instrumentation.

CODE 6 Pulmonary site

Use this code when the person's bleeding is originating from a pulmonary site with mechanical instrumentation.

CODE 7 Pericardial site

Use this code when the person's bleeding is originating from the pericardium, following percutaneous coronary intervention. This code does not include bleeding that is secondary to a coronary artery bypass graft.

CODE 8 Other site(s)

Use this code when the person's bleeding is originating from a site with mechanical instrumentation that is not listed in codes 1-7, such as central line access.

CODE 9 Unidentified site

Use this code when the person has a fall in haemoglobin without an identifiable instrumented site of bleeding.

CODE 99 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: Record the location of all bleeding events that occur. More than one code can be applied.

Relational attributes

Related metadata references: See also Person with acute coronary syndrome—bleeding location, non-instrumented code N(N) Health, Standard 01/10/2008

See also Person—bleeding episode status, Thrombolysis in Myocardial Infarction (TIMI) code N Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Intended length of hospital stay

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of admitted patient care—intended length of hospital stay, code N

METeOR identifier: 270399

Registration status: Health, Standard 01/03/2005

Definition: The intention of the responsible clinician at the time of the patient's **admission** to hospital or at the time the patient is placed on an elective surgery waiting list, to discharge the patient either on the day of admission or a subsequent date, as represented by a code.

Data Element Concept: Episode of admitted patient care—intended length of hospital stay

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Intended same-day
2	Intended overnight

Data element attributes

Collection and usage attributes

Collection methods: The intended length of stay should be ascertained for all admitted patients at the time the patient is admitted to hospital.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Supersedes Intended length of hospital stay, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Intended place of birth

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Birth event—setting of birth (intended), code N

METeOR identifier: 269980

Registration status: Health, Standard 01/03/2005

Definition: The intended place of birth at the onset of labour, as represented by a code.

Context: Perinatal care

Data Element Concept: Birth event—setting of birth

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:		
	1	Hospital, excluding birth centre
	2	Birth centre, attached to hospital
	3	Birth centre, free standing
	4	Home
	8	Other
Supplementary values:	9	Not stated

Collection and usage attributes

Comments: The development of a definition of a birth centre is currently under consideration by the Commonwealth in conjunction with the states and territories.

Data element attributes

Collection and usage attributes

Guide for use:

Code 1 Hospital, excluding birth centre

Hospital, excluding birth centre, includes for women who have elective caesarean sections

Code 4 Home

Home, should be restricted to the home of the woman or a relative or friend.

Code 8 Other

Other, includes community (health) centres.

Comments:

Women who plan to give birth in birth centres or at home usually have different risk factors for outcome compared to those who plan to give birth in hospitals. Women who are transferred to hospital after the onset of labour have increased risks of intervention and adverse outcomes.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Intended place of birth, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Intended years in health profession

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—intended years in profession, total years NN
METeOR identifier:	375487
Registration status:	Health, Standard 10/12/2009
Definition:	The total number of years a health professional expects to remain practising in the registered profession.
Context:	Registered health labour force
Data Element Concept:	Registered health professional—intended years in profession

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

Guide for use:	Total years expressed as 00, 01 etc.
Comments:	The data element is an estimate of the future plans of the health professional, providing an indication of the future losses from the health labour force. It should be noted that the health professional's intentions may change therefore these data should be used with care.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Intention of treatment

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Patient—intention of treatment, code N

METeOR identifier: 448134

Registration status: Health, Standard 07/12/2011

Definition: The reason treatment is provided to a patient, as represented by a code.

Data Element Concept: Patient—intention of treatment

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Prophylactic
	2	Curative
	3	Palliative
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 1 Prophylactic

This code is used for treatment to prevent the occurrence or spread of disease.

CODE 2 Curative

This code is used when treatment is given for control of the disease.

CODE 3 Palliative

This code is used when treatment is given primarily for the purpose of pain control. Other benefits of the treatment are considered secondary contributions to quality of life.

CODE 9 Not stated/inadequately described

This code is used when treatment was administered and the intention was not stated or was inadequately described. This code is not intended for use in primary data collection but can be assigned for reporting purposes where there is missing data.

Data element attributes

Relational attributes

Implementation in Data Set Specifications:

Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Conditional obligation:
This item must be completed if Patient—radiotherapy start date, DDMMYYYY exists.

Intention of treatment for cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—intention of treatment, code N
METeOR identifier:	288690
Registration status:	Health, Standard 04/06/2004
Definition:	The intention of the initial treatment for cancer for the particular patient, as represented by a code.
Data Element Concept:	Cancer treatment—intention of treatment

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	Value	Meaning
	1	Prophylactic
	2	Curative
	3	Non-curative or palliative
Supplementary values:	0	Did not have treatment
	9	Not stated

Collection and usage attributes

Guide for use:

CODE 0 Did not have treatment

This code is used when the patient did not have treatment as part of the initial management plan

CODE 1 Prophylactic

This code is used when the cancer has not developed

CODE 2 Curative

This code is used when treatment is given for control of the disease

CODE 3 Non-curative or Palliative

This code is used when the cure is unlikely to be achieved and treatment is given primarily for the purpose of pain control. Other benefits of the treatment are considered secondary contributions to the patient's quality of life

CODE 9 Intention was not stated

Patient had treatment for cancer but the intention was not stated.

Data element attributes

Collection and usage attributes

Guide for use: This item is collected for surgical treatment, radiation therapy and systemic therapy agent treatment.

Source and reference attributes

Submitting organisation: National Cancer Control Initiative

Origin: Commission on Cancer, American College of Surgeons

New South Wales Health Department

Reference documents: Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references: Supersedes Intention of treatment for cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Inter-hospital contracted patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—inter-hospital contracted patient status, code N
METeOR identifier:	472024
Registration status:	Health, Standard 11/04/2012
Definition:	An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals, as represented by a code.
Data Element Concept:	Episode of care—inter-hospital contracted patient status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
		Contracted (destination) hospital
	1	Inter-hospital contracted patient from public sector hospital
	2	Inter-hospital contracted patient from private sector hospital
		Contracting (originating) hospital
	3	Inter-hospital contracted patient to public sector hospital
	4	Inter-hospital contracted patient to private sector hospital
	5	Not inter-hospital contracted
Supplementary values:	9	Not stated

Data element attributes

Collection and usage attributes

Guide for use:

Hospital activity provided under contract is to be reported by both the contracting (originating) hospital and by the contracted (destination) hospital, where the activity is recorded by both hospitals.

A specific arrangement should apply (either written or verbal) whereby one hospital contracts with another hospital for the provision of specific services. The arrangement may be between any combination of hospital; for example, public to public, public to private, private to private, or private to public.

This data element is designed to enable elimination of double counting of episodes of admitted patient care in national data compiled as per the APC NMDS. As such, contracted arrangements where the patient is only admitted to one hospital (i.e. contract type 4 where contract role=A) are not considered to be inter-hospital contracted care for the purposes of this data element. In contracted arrangements where the patient is admitted to both hospitals, provide data according to the guide for use below. In contracted arrangements where the patient is only admitted to one hospital, use code 5.

This data element item will be derived, using data elements Hospital—contract role, code A and Hospital—contract type, code N as follows.

If Contract role = B (Hospital B, that is, the provider of the hospital service; contracted hospital), and Contract type = 2, 3, 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.

If Contract role = A (Hospital A, that is, the hospital purchasing the activity; contracting hospital), and Contract type = 2, 3, or 5 (that is, the reporting hospital purchases the activity 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 3, if Hospital B is a public hospital or record a value of 4, if Hospital B is a private hospital.

Collection methods: All services provided at both the originating and destination hospitals should be recorded and reported by both hospitals. The destination hospital should record the admission as an 'Inter-hospital contracted patient' so that these services can be identified in the various statistics produced about hospital activity.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Episode of care—inter-hospital contracted patient status, code N Health, Standard 01/03/2005

Is formed using Hospital—contract role, code A Health, Standard 01/03/2005

Is formed using Hospital—contract type, code N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Interpreter services required

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—interpreter service required, yes/no code N

Synonymous names: Need for interpreter service

METeOR identifier: 304294

Registration status: Community Services, Standard 10/04/2006
Health, Standard 08/02/2006
Tasmanian Health, Proposed 28/09/2011

Definition: Whether an interpreter service is required by or for the person, as represented by a code.

Data Element Concept: Person—interpreter service required

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: Includes verbal language, non verbal language and languages other than English.

CODE 1 Yes

Use this code where interpreter services are required.

CODE 2 No

Use this code where interpreter services are not required.

Persons requiring interpreter services for any form of sign language should be coded as Interpreter required.

Collection methods:

Recommended question:

Do you [does the person] require an interpreter?

Yes

No

Relational attributes

Related metadata references:

Supersedes Person—interpreter service required status (health), code N Health, Superseded 08/02/2006

Jobseeker status in registered profession

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—jobseeker status in registered profession, code N
METeOR identifier:	383449
Registration status:	Health, Standard 10/12/2009
Definition:	Whether a registered health professional is looking for work in their registered profession, as represented by a code.
Data Element Concept:	Registered health professional—jobseeker status in registered profession

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	Value	Meaning
	1	Looking for work in Australia
	2	Not looking for work in Australia
Supplementary values:	9	Unknown/inadequately described

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

This data element is applicable to all health professionals who are not employed in Australia in the registered profession. It includes health professionals who are:

- employed in the registered profession overseas
- employed outside of the registered profession, and
- not employed at all.

Data are self-reported based on the jobseeker status in the registered profession in the week before registration.

CODE 1 LOOKING FOR WORK IN AUSTRALIA

This category includes persons who are not currently employed in the registered profession in Australia and who are actively looking for work in the registered profession in Australia.

'Actively looking for work' includes writing, telephoning or applying in person to an employer for work. It also includes answering a newspaper advertisement for a job, checking factory or job placement agency notice boards, being registered with a job placement agency, checking or registering with any other employment agency, advertising or tendering for work or contacting friends or relatives.

CODE 2 NOT LOOKING FOR WORK IN AUSTRALIA

All persons who are not 'looking for work in Australia' as defined above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Labour force status cluster Health, Standard 10/12/2009

Killip classification code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—Killip classification, code N
METeOR identifier:	285151
Registration status:	Health, Standard 04/06/2004
Definition:	The Killip class, as a measure of haemodynamic compromise, of the person at the time of presentation, as represented by a code.
Data Element Concept:	Person—Killip classification

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	1	Class 1
	2	Class 2
	3	Class 3
	4	Class 4
Supplementary values:	8	Other
	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Rales or crepitations represent evidence of pulmonary interstitial oedema on lung auscultation and an S_3 is an audible extra heart sound by cardiac auscultation.

CODE 1 Class 1

Absence of crepitations/rales over the lung fields and absence of $S_{3.}$

CODE 2 Class 2

Crepitations/rales over 50% or less of the lung fields or the presence of an $S_{3.}$

CODE 3 Class 3

Crepitations/rales over more than 50% of the lung fields.

CODE 4 Class 4

Cardiogenic Shock. Clinical criteria for cardiogenic shock are hypotension (a systolic blood pressure of less than 90 mmHg for at least 30 minutes or the need for supportive measures to maintain a systolic blood pressure of greater than or equal to 90 mmHg), end-organ hypoperfusion (cool extremities or a urine output of less than 30 ml/h, and a heart rate of greater than or equal to 60 beats per minute). The haemodynamic criteria are a cardiac index of no more than 2.2 l/min per square meter of body-surface area and a pulmonary-capillary wedge pressure of at least 15 mmHg.

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Killip classification code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.7 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Labour force status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—labour force status, code N
METeOR identifier:	270112
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005 Health, Standard 01/03/2005 Homelessness, Standard 23/08/2010
Definition:	The self reported status the person currently has in being either in the labour force (employed/unemployed) or not in the labour force, as represented by a code.
Data Element Concept:	Person—labour force status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Employed
	2	Unemployed
	3	Not in the labour force
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Employed:

Persons aged 15 years and over who, during the reference week:

(a) worked for one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm (comprising 'Employees', 'Employers' and 'Own Account Workers'); or

(b) worked for one hour or more without pay in a family business or on a farm (i.e. 'Contributing Family Worker'); or

(c) were 'Employees' who had a job but were not at work and were:

- on paid leave
- on leave without pay, for less than four weeks, up to the end of the reference week
- stood down without pay because of bad weather or plant

breakdown at their place of employment, for less than four weeks up to the end of the reference week

- on strike or locked out
- on workers' compensation and expected to be returning to their job, or
- receiving wages or salary while undertaking full-time study; or

(d) were 'Employers', 'Own Account Workers' or 'Contributing Family Workers' who had a job, business or farm, but were not at work.

CODE 2 Unemployed:

Unemployed persons are those aged 15 years and over who were not employed during the reference week, and:

(a) had actively looked for full-time or part-time work at any time in the four weeks up to the end of the reference week. Were available for work in the reference week, or would have been available except for temporary illness (i.e. lasting for less than four weeks to the end of the reference week). Or were waiting to start a new job within four weeks from the end of the reference week and would have started in the reference week if the job had been available then; or

(b) were waiting to be called back to a full-time or part-time job from which they had been stood down without pay for less than four weeks up to the end of the reference week (including the whole of the reference week) for reasons other than bad weather or plant breakdown. Note: Actively looking for work includes writing, telephoning or applying in person to an employer for work. It also includes answering a newspaper advertisement for a job, checking factory or job placement agency notice boards, being registered with a job placement agency, checking or registering with any other employment agency, advertising or tendering for work or contacting friends or relatives.

CODE 3 Not in the Labour Force:

Persons not in the labour force are those persons aged 15 years and over who, during the reference week, were not in the categories employed or unemployed, as defined. They include persons who were keeping house (unpaid), retired, voluntarily inactive, permanently unable to work, persons in institutions (hospitals, gaols, sanatoriums, etc.), trainee teachers, members of contemplative religious orders, and persons whose only activity during the reference week was jury service or unpaid voluntary work for a charitable organisation.

Collection methods: For information about collection, refer to the ABS website: http://www.abs.gov.au/Ausstats/abs@.nsf/0/AEB5AA310D68DF8FCA25697E0018FED8?Open

Source and reference attributes

Origin: Australian Bureau of Statistics 1995. Directory of Concepts and Standards for Social, Labour and Demographic Variables. Australia 1995. Cat. no. 1361.0.30.001. Canberra: AGPS.

http://www.abs.gov.au/Ausstats/abs@.nsf/0/AEB5AA310D68DF8FCA25697E0018FED8?Open (last viewed 21 December 2005)

Data element attributes

Collection and usage attributes

Comments: Labour force status is one indicator of the socio-economic status of a person and is a key element in assessing the circumstances and needs of individuals and families.

Source and reference attributes

Origin: Health Data Standards Committee

Relational attributes

Related metadata references: Supersedes Labour force status, version 3, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (19.5 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Labour force status 30 days prior to imprisonment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Prison entrant—labour force status 30 days prior to imprisonment, code N
METeOR identifier:	410617
Registration status:	Health, Standard 25/08/2011
Definition:	The self-reported labour force status of a prison entrant 30 days prior to imprisonment, as represented by a code.
Data Element Concept:	Prison entrant—labour force status 30 days prior to imprisonment

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Full-time work
	2	Part-time work or casual work
	3	Unemployed and looking for work
	4	Unemployed and not looking for work
	5	Unable to work due to disability, age or health condition
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Only one option may be selected.

CODE 1 Full-time work:

Employed persons are working full-time if they:

(a) usually work 35 hours or more in a week (in all paid jobs) or

(b) although usually work less than 35 hours a week, actually worked 35 hours or more a week during the 30 days prior to being imprisoned.

CODE 2 Part-time or casual work:

Employed persons are working part-time if they usually work less than 35 hours a week (in all paid jobs) during the

30 days prior to being imprisoned.

A person's employment is classed as casual work if they are not entitled to paid sick or holiday leave and considered their job to be casual, and who either: worked in someone else's business or reported that they worked in their own unincorporated business but did not invoice clients for own payment and paid PAYE tax.

CODE 3 and 4 Unemployed and looking for work/not looking for work:

Unemployed persons are defined as all persons 15 years of age and over who were not employed during the 30 days prior to being imprisoned, and

- had actively looked for full-time or part-time work at any time in the 30 days prior to being imprisoned and were available for work during that period or
- were waiting to start a new job within the 30 days prior to being in prison

'Looking for work' encompasses a range of formal and informal job search activities and includes: writing, telephoning or applying in person to an employer for work, answering an advertisement for a job, checking workplace noticeboards or the touchscreens at Centrelink offices, being registered as a job seeker with Centrelink, being registered with a Job Network agency or any other employment agency, advertising or tendering for work, and contacting friends or relatives. People actively looking for self-employment jobs (such as looking for a business or to purchase a lease) are also treated as looking for work. People who only looked in newspapers or read job advertisements are seen as passively, rather than actively, looking for work and so are not considered unemployed.

CODE 9 Not stated/ inadequately described:

Is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: ABS (Australian Bureau of Statistics) 1996. Standards for Labour Force Statistics Variables. Cat. no. 1288.0. Canberra: ABS

ABS 2007. Labour Statistics: Concepts, Sources and Methods, Apr 2007. Cat. no. 6102.0.55.001. Canberra: ABS

ABS 2009. Education and work. Cat. no. 6227.0. Canberra: ABS

Data element attributes

Collection and usage attributes

Guide for use:	This data element should be used in conjunction with the data element: *Prison entrant—education status 30 days prior to imprisonment, education status code N* to assist in identifying a person's pathway to prison and thereafter.
Comments:	Capturing the extent of employment participation of people entering prison is an important factor when following a throughcare approach to reducing recidivism and increasing protective factors for people involved in the criminal justice system.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Prison entrant—education attendance status 30 days prior to imprisonment, education attendance status code N Health, Standard 25/08/2011
Implementation in Data Set Specifications:	Prison entrants DSS Health, Standard 25/08/2011

Laterality of primary cancer

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person with cancer—laterality of primary cancer, code [N]

METeOR identifier: 422769

Registration status: Health, Standard 07/12/2011

Definition: The side of a paired organ that is the origin of the primary cancer in a person with cancer, as represented by a code.

Data Element Concept: Person with cancer—laterality of primary cancer

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: A

Maximum character length: 1

	Value	Meaning
Permissible values:	R	Right
	L	Left
	B	Bilateral
Supplementary values:	N	Not applicable
	U	Unknown

Data element attributes

Collection and usage attributes

Guide for use: Record the appropriate code at the time of diagnosis.

Definitions

Right:

Origin of primary site is on the right side of a paired organ.

Left:

Origin of primary site is on the left side of a paired organ.

Bilateral:

Origin of primary site is on both sides of a paired organ. (When tumours of the same morphology are diagnosed simultaneously in both sides of a paired organ.)

Includes organs that are bilateral as a single primary (e.g. bilateral retinoblastoma (M9510/3, C69.2), (M9511/3, C69.2), (M9512/3, C69.2), (C69.6, C48.0), bilateral Wilms tumours (C64.9, M8960/3))

Note: Bilateral cancers are very rare.

Unknown:

It is unknown whether, for a paired organ the origin of the cancer was on the left or right side of the body.

Paired organs and structures

The valid International Classification of Diseases for Oncology values for paired organs are provided in the list below:

C02.4	Lingual tonsil
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C11.1	Posterior wall of nasopharynx
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1-C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bones of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum)
C41.4	Pelvic bones (excluding sacrum, coccyx and symphysis pubis)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder

C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous and other soft tissues of lower limb and hip
C50.0-C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0-C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges, NOS
C71.0	Cerebrum
C71.1	Frontal lobe
C71.2	Temporal lobe
C71.3	Parietal lobe
C71.4	Occipital lobe
C72.2	Olfactory nerve
C72.3	Optic nerve
C72.4	Acoustic nerve
C72.5	Cranial nerve, NOS
C74.0-C74.9	Adrenal gland
C75.0	Parathyroid glands
C75.4	Carotid body
C76.4	Upper limb, NOS
C76.5	Lower limb, NOS
C77.3	Lymph nodes of axilla or arm
C77.4	Lymph nodes of inguinal region or leg

Collection methods: This information should be obtained from the patient's medical record and pathology report.

Comments: The laterality of the primary tumour may have implications for treatment and prognosis, and can be of assistance to cancer registries for the coding of subsequent tumours in paired organs.

Source and reference attributes

Origin: World Health Organization

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2010 revision. Commission on Cancer

Fritz A et al. 2000. International Classification of Diseases for Oncology (ICD-O), 3rd edition. Geneva: World Health Organization

Relational attributes

Related metadata references: Supersedes Person with cancer—laterality of primary cancer, code [N] Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Leave days from residential care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—number of leave days, total N[NN]
METeOR identifier:	379734
Registration status:	Health, Standard 07/12/2011
Definition:	The number of days spent on leave from a residential care service during an episode of residential care.
Data Element Concept:	Episode of residential care—number of leave days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

A day is measured from midnight to midnight.

Leave days can occur for a variety of reasons, including:

- treatment by a specialised mental health service
- treatment by a non-specialised health service
- time in the community.

The following rules apply in the calculation of leave days:

- the day the **resident** goes on leave is counted as a leave day
- days the resident is on leave are counted as leave days
- the day the resident returns from leave is not counted as a leave day
- if the resident starts a residential stay and goes on leave on the same day, this is not counted as a leave day
- if the resident returns from leave and then goes on leave again on the same day, this is counted as a leave day
- if the resident returns from leave and ends residential care on the same day, the day should not be counted as

leave day

- leave days at the end of a residential stay after the commencement of leave are not counted.

If a resident fails to return from leave, then the residential stay is formally ended.

Relational attributes

Related metadata references: Supersedes Episode of residential care—number of leave days, total N[NN] Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Legal status of prison entrant

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Prison entrant—legal status of prisoner, code N
METeOR identifier:	415751
Registration status:	Health, Standard 25/08/2011
Definition:	The legal status of a prison entrant, as represented by a code.
Data Element Concept:	Prison entrant—legal status of prisoner

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Remand
2	Sentenced

Collection and usage attributes

Guide for use:

CODE 1 Remand

Remand refers to a person who is held in prison while awaiting the outcome of a court hearing.

CODE 2 Sentenced

Sentenced prisoners are those persons who have received a term of imprisonment from a court. This includes offenders who have been given an indeterminate sentence or custodial order, for example, persons detained under the 'Governor's/His/Her Majesty's Pleasure' and forensic patients, or those who have received a life sentence.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Prison entrants DSS Health, Standard 25/08/2011

Legal status of prisoner

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—legal status of prisoner, code N
METeOR identifier:	410530
Registration status:	Health, Standard 25/08/2011
Definition:	The legal status of a prisoner, as represented by a code.
Data Element Concept:	Person—legal status of prisoner

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Remand
2	Sentenced

Collection and usage attributes

Guide for use:

CODE 1 Remand

Remand refers to a person who is held in prison while awaiting the outcome of a court hearing.

CODE 2 Sentenced

Sentenced prisoners are those persons who have received a term of imprisonment from a court. This includes offenders who have been given an indeterminate sentence or custodial order, for example, persons detained under the 'Governor's/His/Her Majesty's Pleasure' and forensic patients, or those who have received a life sentence.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: This data element is used in conjunction with the data element: *Establishment (prison)—number of prisoners released, number N[NN]* and *Person—prisoner health discharge* *summary indicator, yes/no code N* to obtain information on the proportion of prisoners released from a prison who have a health-related discharge summary at the time of their release.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Establishment (prison)—number of prisoners released, number N[NN] Health, Standard 25/08/2011

See also Person—prisoner health discharge summary indicator, yes/no code N Health, Standard 25/08/2011

Implementation in Data Set Specifications: Prisoner health discharge summary cluster Health, Standard 25/08/2011

Length of employment in health profession

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Registered health professional—length of employment in profession in Australia, total years NN

METeOR identifier: 375478

Registration status: Health, Standard 10/12/2009

Definition: The total number of years a health professional has been employed in the registered profession in Australia.

Context: Registered health labour force

Data Element Concept: Registered health professional—length of employment in profession in Australia

Value domain attributes

Representational attributes

Representation class: Total

Data type: String

Format: NN

Maximum character length: 2

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Unit of measure: Year

Data element attributes

Collection and usage attributes

Guide for use: Total years expressed as 00, 01 etc with values rounded up to the next value of years if the remaining time is greater than six full months.

The health professional may be employed in more than one profession. This data element applies only to the profession of registration, regardless of length of time spent working in related professions.

Collection methods: In total, how many years have you worked in the registered profession in Australia?

Include full-time and part-time work.

Exclude time spent not working and unpaid leave.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Length of non-admitted patient emergency department service episode

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN
METeOR identifier:	474181
Registration status:	Health, Standard 30/01/2012
Definition:	The amount of time, measured in minutes, between when a patient presents at an emergency department, and when the non-admitted emergency department service episode has concluded.
Context:	Emergency department care.
Data Element Concept:	Non-admitted patient emergency department service episode—service episode length

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNNN
Maximum character length:	5
Unit of measure:	Minute (m)

Data element attributes

Source and reference attributes

Submitting organisation:	National reference group for non-admitted patient data development, 2001-02

Relational attributes

Related metadata references:	Is formed using Emergency department stay—presentation date, DDMMYYYY Health, Standard 22/12/2011 Is formed using Emergency department stay—presentation time, hhmm Health, Standard 22/12/2011 Supersedes Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN Health, Superseded 30/01/2012
Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012
Implementation end date: 30/06/2013

Length of stay

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (excluding leave days), total N[NN]
METeOR identifier:	269982
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The length of stay of a patient, excluding leave days, measured in days.
Data Element Concept:	Episode of admitted patient care—length of stay (excluding leave days)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:	Formula: LOS = Separation date - Admission date - Total leave days The calculation is inclusive of admission and separation dates.
Comments:	Perinatal length of stay metadata items include leave days and so are not included in this metadata item.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011 Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Episode of admitted patient care—number of leave periods, total N[N] Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Supersedes Length of stay, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Length of stay (including leave days)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (including leave days), total N[NN]
METeOR identifier:	329889
Registration status:	Health, Standard 04/07/2007
Definition:	The total length of stay (LOS) of a patient, including leave days, measured in days.
Data Element Concept:	Episode of admitted patient care—length of stay (including leave days)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

Formula:

LOS (including leave days) = separation date - admission date

Total LOS is calculated by subtracting the patient's date of admission from their date of separation. It includes contract days and leave days.

For babies born in hospital: 1) only calculate the total LOS of live births and 2) their admission date is the same as their date of birth.

A **same-day patient** should be allocated a length of stay of one day.

Total LOS relates to the episode of care associated with the birth.

Babies born before arrival and still births are not within scope of this data element and should not have a total length of stay reported.

Comments:

All admitted patient episodes of care where it is required to know the total LOS in hospital (including leave days).

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Supersedes Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Length of stay (including leave days) (antenatal)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (including leave days) (antenatal), total N[NN]
METeOR identifier:	290577
Registration status:	Health, Standard 04/07/2007
Definition:	The length of stay (LOS) of a woman before the birth of her baby, including leave days, measured in days.
Context:	Perinatal
Data Element Concept:	Episode of admitted patient care—length of stay (including leave days)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

Formula:

LOS (antenatal) = baby's date of birth - mother's admission date

Antenatal LOS is calculated by subtracting the mother's admission date from the baby's date of birth. It includes contract days and leave days.

If the mother's admission date and the baby's date of birth are on the same date, count the LOS as 1 day.

Antenatal length of stay refers only to the admission associated with the birth.

Antenatal LOS relates only to the episode of admitted patient care associated with the birth.

In a multiple pregnancy, the date of birth of the first baby born should be used to calculate the mother's antenatal LOS.

To calculate the total LOS, use the data element - Episode of admitted patient care - length of stay (including leave days) total.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references:

Supersedes Episode of admitted patient care (antenatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Person—date of birth, DDMMYYYY Community Services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010, Tasmanian Health, Proposed 28/09/2011

Length of stay (including leave days) (postnatal)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of admitted patient care—length of stay (including leave days) (postnatal), total N[NN]

METeOR identifier: 300076

Registration status: Health, Standard 04/07/2007

Definition: The length of stay (LOS) of a woman following the birth of her baby, including leave days, measured in days.

Context: Perinatal.

Data Element Concept: Episode of admitted patient care—length of stay (including leave days)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NN]

Maximum character length: 3

Unit of measure: Day

Data element attributes

Collection and usage attributes

Guide for use: Formula:

LOS (postnatal) = mother's separation date - baby's date of birth

Postnatal LOS is calculated by subtracting the baby's date of birth from the mother's date of separation. It includes contract days and leave days.

If the mother's separation date and the baby's date of birth are on the same date, count the LOS as 1 day.

In a multiple pregnancy, the date of birth of the first baby born should be used to calculate the mother's postnatal LOS.

Postnatal length of stay refers only to the episode of care associated with the birth.

To calculate the total length of stay, use the data element - Episode of admitted patient care - length of stay (including leave days) total.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references:

Supersedes Episode of admitted patient care (postnatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Person—date of birth, DDMMYYYY Community Services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010, Tasmanian Health, Proposed 28/09/2011

Letters of family name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—letters of family name, text XXX
METeOR identifier:	349481
Registration status:	Community Services, Standard 27/03/2007 Housing assistance, Standard 23/08/2010 Health, Standard 07/12/2011 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010
Definition:	The combination of 2nd, 3rd and 5th letters of a person's family name.
Data Element Concept:	Person—letters of family name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	XXX
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:

In the three spaces, the agency should record the 2nd, 3rd and 5th letters of the client's family name.

For example: If the client's family name is Brown, the reported value should be RON. If the client's family name is Thompson, the reported value should be HOP.

If the client's family name includes non-alphabetic characters—for example hyphens (as in Lee-Archer), apostrophes (as in O'Mara) or blank spaces (as in De Vries)—these non-alphabetic characters should be ignored when counting the position of each character.

Regardless of the length of a person's name, the reported value should always be three characters long. If the legal family name is not long enough to supply the requested letters (i.e. a legal family name of less than five letters) then agencies should substitute the number '2' to reflect the missing letters. The placement of a number '2' should always correspond to the same space that the missing letter would have within the 3-digit field. A number (rather than a letter) is used for such a substitution in order to clearly indicate that an appropriate corresponding letter from the person's name is not available.

For example: If a person's family name is Farr, then value reported would be AR2 because the 2 is substituting for a missing 5th letter of the family name. Similarly, if the person's family name was Hua, then the value reported would be UA2 because the 2 is substituting for the missing 5th letter of the family name.

If a client's family name is missing altogether the agency should record the number 999 for all three spaces associated with the family name, (not the number 2). In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies should always ask the person to specify their legal first given name and their legal family name separately. These should then be recorded as first given name and family name as appropriate, regardless of the order in which they may be traditionally given.

Comments: The selected *Letters of family name* can be used in combination with *Letters of given name, Date of birth* and *Sex* to develop a statistical linkage key to facilitate the linkage of records for statistical purposes only. This key will also enable linkage to other related databases that either have the same linkage key or the fundamental information to form the same key. The linkage is to assist research and analysis of the data, not for tracking of individuals through the system for case management.

The provision of letters of a person's name can be a sensitive issue because of privacy and confidentiality concerns. The use of this information will be in accordance with privacy principles.

Relational attributes

Related metadata references: Is formed using Person (name)—family name, text X[X(39)] Community Services, Superseded 06/02/2012, Housing assistance, Standard 20/06/2005, Health, Standard 04/05/2005, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Record—linkage key, code 581 XXXXXDDMMYYYYN Community Services, Standard 21/05/2010, Housing assistance, Standard 23/08/2010, Health, Standard 07/12/2011, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Implementation in Data Set Specifications: Statistical linkage key 581 cluster Community Services, Standard 21/05/2010
Housing assistance, Standard 23/08/2010
Health, Standard 07/12/2011

Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Letters of given name

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—letters of given name, text XX

METeOR identifier: 349483

Registration status:
Community Services, Standard 27/03/2007
Housing assistance, Standard 23/08/2010
Health, Standard 07/12/2011
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Definition: The combination of the 2nd and 3rd letters of a person's given name.

Data Element Concept: Person—letters of given name

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: XX

Maximum character length: 2

Data element attributes

Collection and usage attributes

Guide for use: In the two spaces the agency should record the 2nd and 3rd letters of the client's given name.

For example: If the client's given name is Elizabeth the reported value should be LI. If the client's given name is Robert the reported value should be OB.

If the client's given name includes non-alphabetic characters—for example hyphens (as in Jo-Anne) or apostrophes (as in D'Arcy), these non-alphabetic characters should be ignored when counting the position of each character.

Regardless of the length of a person's given name, the reported value should always be two characters long. If the given name of the person is not long enough to supply the requested letters (i.e. a name of less than three letters) then agencies should substitute the number '2' to reflect the missing letters. The placement of a number '2' should always correspond to the same space that the missing letter would have within the 2-digit field. A number (rather than a letter) is used for such substitutions in order to clearly indicate that an appropriate corresponding letter from the person's name is not available.

For example: If the person's legal name was Jo then the value reported would be O2 because the 2 is substituting for the missing 3rd letter of the given name.

If the person's given name is missing altogether the agency should record 99 for the two spaces associated with the given name. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies should always ask the person to specify their given name and their family name separately. These should then be recorded as first given name and family name as appropriate, regardless of the order in which they may be traditionally given.

Comments:

The selected *Letters of given name* can be used in combination with *Letters of family name, Date of birth* and *Sex* to develop a statistical linkage key to facilitate the linkage of records for statistical purposes only. This key will also enable linkage to other related databases that either have the same linkage key or the fundamental information to form the same key. The linkage is to assist research and analysis of the data, not for tracking of individuals through the system for case management.

The provision of letters of a person's name can be a sensitive issue because of privacy and confidentiality concerns. The use of this information will be in accordance with privacy principles.

Relational attributes

Related metadata references:

Is formed using Person (name)—family name, text X[X(39)] Community Services, Superseded 06/02/2012, Housing assistance, Standard 20/06/2005, Health, Standard 04/05/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Person (name)—given name, text [X(40)] Community Services, Superseded 06/02/2012, Housing assistance, Standard 20/06/2005, Health, Standard 04/05/2005, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Record—linkage key, code 581 XXXXXDDMMYYYYN Community Services, Standard 21/05/2010, Housing assistance, Standard 23/08/2010, Health, Standard 07/12/2011, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Implementation in Data Set Specifications:

Statistical linkage key 581 cluster Community Services, Standard 21/05/2010
Housing assistance, Standard 23/08/2010
Health, Standard 07/12/2011

Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Level number identifier

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Address—level number, identifier X[XXXX]

Synonymous names: Floor number

METeOR identifier: 429068

Registration status:
Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Definition: A number, forming part of the address within a complex, used to identify a floor or level of a multi-storey building/sub-complex.

Data Element Concept: Address—level number

Value domain attributes

Representational attributes

Representation class: Identifier

Data type: String

Format: X[XXXX]

Maximum character length: 5

Data element attributes

Collection and usage attributes

Guide for use: The data element may include a leading alphabetic prefix or a trailing alphabetic suffix.

Usage Examples:

Mrs Joyce Citizen
Apartment 7
Level 3 (Level number is 3)
Apex Building
48 Johnson Rd
CLAYTON VIC 3168

Level 2 (Level number is 2)
Building 75
Monash University
1-131 Wellington Road
CLAYTON VIC 3168

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references: Supersedes Person (address)—floor/level identifier, [NNNA] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Supersedes Service provider organisation (address)—floor/level identifier, [NNNA] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Public hospital establishment address details DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on this component being part of the address of the Public hospital establishment.

Level of highest non-school qualification

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—level of highest non-school qualification, code N

Synonymous names: Level of education

METeOR identifier: 398769

Registration status: Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Definition: The highest non-school qualification attained by a person, as represented by a code.

Data Element Concept: Person—level of highest non-school qualification

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Trade Certificate (Certificate I-IV)
2	Advanced Diploma and Diploma
3	Bachelor degree
4	Graduate Diploma and Graduate Certificate
5	Postgraduate degree

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use: Non-school qualifications are awarded for educational attainments other than those of pre-primary, primary or secondary education. They include qualifications at the Postgraduate Degree level, Master Degree level, Graduate Diploma and Graduate Certificate level, Bachelor Degree level, Advanced Diploma and Diploma level, and Certificates I, II, III and IV levels.

CODE 1 Trade Certificate (Certificate I-IV)

Includes Certificate IV, Statement of Attainment at Certificate IV level, Bridging and Enabling Course at Certificate IV level, Certificate III, Statement of Attainment at Certificate III level, Bridging and Enabling Course at Certificate III level, Certificate II, Statement of Attainment at Certificate II level, Bridging and Enabling Course at Certificate II level, Certificate I, and Statement of Attainment at Certificate I level.

CODE 2 Advanced Diploma and Diploma

Includes Advanced Diploma, Statement of Attainment at Advanced Diploma Level, Associate Degree, Statement of Attainment at Associate Degree level, Bridging and Enabling Course at Advanced Diploma and Associate Degree level, Diploma, Statement of Attainment at Diploma level, and Bridging and Enabling Course at Diploma level. Excludes Graduate Diploma.

CODE 3 Bachelor degree

Includes Bachelor (Honours) Degree, Bachelor (Pass) Degree, Statement of Attainment at Bachelor Degree level, and Bridging and Enabling Course at Bachelor Degree level.

CODE 4 Graduate Diploma and Graduate Certificate

Includes Graduate Diploma, Graduate Qualifying or Preliminary, Professional Specialist Qualification at Graduate Diploma level, Statement of Attainment at Graduate Diploma level, Bridging and Enabling Course at Graduate Diploma level, Graduate Certificate, Professional Specialist Qualification at Graduate Certificate level, Statement of Attainment at Graduate Certificate level, and Bridging and Enabling Course at Graduate Certificate level.

CODE 5 Postgraduate degree

Includes Higher Doctorate, Doctorate by Research, Doctorate by Coursework Professional Specialist Qualification at Doctoral Degree level, Statement of Attainment at Doctoral Degree level, Bridging and Enabling Course at Doctoral Degree level, Master Degree by Research, Master Degree by Coursework, Professional Specialist Qualification at Master Degree level, Statement of Attainment at Master Degree level, Bridging and Enabling Course at Master Degree level.

CODE 9 Not stated/inadequately described

This code is not for use on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Comments: The categories in this metadata item are based on the Australian Bureau of Statistics Australian Standard Classification of Education, Level of Education (ASCED) 2001.

CODE 1 Trade Certificate (Certificate I-IV) maps to Broad Level, 5 Certificate Level of the ASCED

CODE 2 Advanced Diploma and Diploma maps to Broad Level 4, Advanced Diploma and Diploma of the ASCED

CODE 3 Bachelor Degree maps to Broad Level 3 Bachelor degree of the ASCED

CODE 4 Graduate Diploma and Graduate Certificate maps to Broad Level 2, Graduate Diploma and Graduate Certificate of the ASCED

CODE 5 Postgraduate degree maps to Broad Level 1 Postgraduate Degree level

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Australian Bureau of Statistics 2001. Australian Standard Classification of Education (ASCED) 2001. Cat. no. 1272.0. Canberra: ABS

Data element attributes

Collection and usage attributes

Collection methods: Operationally, 'level of highest non-school qualification' is defined as the highest completed non-school qualification reported for a person in any field of education except General Primary and Secondary Education Programmes. Data are obtained by direct question and often sequenced to follow a direct question on 'Highest year of school completed'. The question is worded in terms of qualifications attained and when information is not collected about multiple qualifications, the result is dependent on respondent perception of 'highest'.

The 'Level of highest non-school qualification' excludes partial completion of or current participation in a course of study and Statements of attainment awarded for partial completion of a course of study at a particular level.

Qualifications generally associated with school education, such as the Senior Secondary Certificate of Education, are excluded from this data element even if they are awarded as the result of study at a non-school institution (ABS 2001).

Comments: The level of non-school qualification categories are based on the ABS Australian Standard Classification of Education, Level of Education (ASCED) 2001.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: ABS (Australian Bureau of Statistics) 2001. Australian Standard Classification of Education (ASCED) 2001. ABS cat. no. 1272.0. Canberra: ABS

ABS 2002. Education variables. ABS cat. no. 1246.0. Canberra: ABS

Relational attributes

Related metadata references: See also Person—non-school qualification indicator, yes/no/not stated/inadequately described code N Community Services, Standard 06/02/2012, Health, Standard 25/08/2011

Implementation in Data Set Specifications: Non-school qualification cluster Health, Standard 25/08/2011

Conditional obligation:

Conditional on the person having completed a non-school qualification.

Level of palliative care service

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Service provider organisation—level of service delivery, palliative care code N

METeOR identifier: 334508

Registration status: Health, Standard 05/12/2007

Definition: The level of specialisation of the palliative care service delivered by a **palliative care agency**, as represented by a code.

Data Element Concept: Service provider organisation—level of service delivery

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Primary palliative care
2	Specialist palliative care level 1
3	Specialist palliative care level 2
4	Specialist palliative care level 3

Source and reference attributes

Origin: Palliative Care Australia 2005. A guide to palliative care service development: A population-based approach. Canberra: Palliative Care Australia, p39.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Primary palliative care

Capability: Clinical management and care coordination including assessment, triage, and referral using a palliative approach for patients with uncomplicated needs associated with a life limiting illness and/or end of life care. Has formal links with a specialist palliative care provider for purposes of referral, consultation and access to specialist care as necessary.

Typical resource profile: General medical practitioner, nurse practitioner, registered nurse, generalist community nurse, aboriginal health worker, allied health staff. Specialist health care providers in other disciplines would be included at this level.

CODE 2 Specialist palliative care level 1

Capability: Provides palliative care for patients, primary carers and families whose needs exceed the capability of primary palliative care providers. Provides assessment and care consistent with needs and provides consultative support, information and advice to primary palliative care providers. Has formal links to primary palliative care providers and level 2 and/or 3 specialist palliative care providers to meet the needs of patients, carers and families with complex problems. Has quality and audit program.

Typical resource profile: Multi–disciplinary team including medical practitioner with skills and experience in palliative care, clinical nurse specialist/consultant, allied health staff, pastoral care and volunteers. A designated staff member if available, coordinates a volunteer service.

CODE 3 Specialist palliative care level 2

Capability: As for level 1, able to support higher resource level due to population base (e.g. regional area). Provides formal education programs to primary palliative care and level 1 providers and the community. Has formal links with primary palliative care providers and level 3 specialist palliative care services for patients, primary carers and families with complex needs.

Typical resource profile: Interdisciplinary team including medical practitioner and clinical nurse specialist/consultant with specialist qualifications. Includes designated allied health and pastoral care staff.

CODE 4 Specialist palliative care level 3

Capability: Provides comprehensive care for the needs of patients, primary carers and families with complex needs. Provides local support to primary palliative care providers, regional level 1 and/or 2 services including education and formation of standards. Has a comprehensive research and teaching role. Has formal links with local primary palliative care providers and with specialist palliative care providers level 1 and 2, and relevant academic units including professorial chairs where available.

Typical resource profile: Interdisciplinary team including a medical director and clinical nurse consultant/nurse practitioner and allied health staff with specialist qualifications in palliative care.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:	Palliative care performance indicators DSS Health, Standard 05/12/2007

Lifestyle counselling type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—lifestyle counselling type, code N
METeOR identifier:	344710
Registration status:	Health, Standard 01/10/2008
Definition:	The counselling a person has received to modify lifestyle behaviour/s relevant to acute coronary syndromes, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—lifestyle counselling type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	1	Diet
	2	Physical activity
	3	Smoking cessation
	4	Weight management
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Counselling includes any method of individual or group counselling or advice directed towards any of the specific lifestyle behaviours.

This metadata item refers to counselling that was conducted by a healthcare professional during the hospital stay. This may include counselling that was performed in conjunction with referral to a cardiac rehabilitation service.

CODE 1 Diet

Use this code where a person has received counselling on their diet.

CODE 2 Physical activity

Use this code where a person has received counselling encouraging at least 30 to 60 minutes of physical activity in at least five sessions per week.

CODE 3 Smoking cessation

Use this code where a person has received counselling regarding the importance of stopping smoking.

CODE 4 Weight management

Use this code where a person, whose weight is greater than 120% of the ideal weight for height, has received counselling on weight management.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Lipid-lowering therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—lipid-lowering therapy status, code NN
METeOR identifier:	285159
Registration status:	Health, Standard 04/06/2004
Definition:	The person's lipid-lowering therapy status, as represented by a code.
Data Element Concept:	Person—lipid-lowering therapy status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

	Value	Meaning
Permissible values:	10	Given
	21	Not given - patient refusal
	22	Not given - true allergy to lipid lowering therapy
	23	Not given - previous myopathy
	24	Not given - hepatic dysfunction
	25	Not given - other
Supplementary values:	90	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODES 21 - 25 Not given

If recording `Not given', record the principal reason if more than one code applies.

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Lipid-lowering therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Listing date for care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective care waiting list episode—listing date for care, DDMMYYYY
METeOR identifier:	269957
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a hospital or a community health service accepts notification that a patient/client requires care/treatment.
Data Element Concept:	Elective care waiting list episode—listing date for care

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	For elective surgery, the listing date is the date on which the patient is added to an elective surgery waiting list. The acceptance of the notification by the hospital or community health service is conditional upon the provision of adequate information about the patient and the appropriateness of the patient referral.
Comments:	The hospital or community health service should only accept a patient onto the waiting list when sufficient information has been provided to fulfil state/territory, local and national reporting requirements.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Superseded 13/12/2011 Is used in the formation of Elective surgery waiting list

episode—waiting time (at a census date), total days N[NNN] Health, Standard 22/12/2011

Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Superseded 13/12/2011

Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 13/12/2011

Supersedes Listing date for care, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)

Implementation in Data Set Specifications:

Elective surgery waiting times (census data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 30/09/2012

Elective surgery waiting times (removals data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 01/07/2012

Elective surgery waiting times cluster Health, Standard 07/12/2011

Living arrangement

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—living arrangement, health sector code N

METeOR identifier: 299712

Registration status: Health, Standard 14/06/2005

Definition: Whether a person usually resides alone or with others, as represented by a code.

Context: Client support needs and clinical setting.

Data Element Concept: Person—living arrangement

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Lives alone
	2	Lives with others
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods: This item does not seek to describe the quality of the arrangements but merely the fact of the arrangement. It is recognised that this item may change on a number of occasions during the course of an episode of care.

Comments: Whether or not a person lives alone is a significant determinant of risk.

Living alone may preclude certain treatment approaches (e.g. home dialysis for end-stage renal disease). Social isolation has also been shown to have a negative impact on prognosis in males with known coronary artery disease with several studies suggesting increased mortality rates in those living alone or with no confidant.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Living arrangement, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.0 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Location of impairment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—location of impairment of body structure, code (ICF 2001) N
METeOR identifier:	320177
Registration status:	Community Services, Standard 16/10/2006 Health, Standard 29/11/2006
Definition:	The location of a person's impairment in a specified body structure, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—location of impairment of body structure

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:		
	0	More than one region
	1	Right
	2	Left
	3	Both sides
	4	Front
	5	Back
	6	Proximal
	7	Distal
Supplementary values:	8	Not specified
	9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Impairments of body structure are problems in body structure such as a loss or significant departure from population standards or averages.

Use only one code. Select the one that best describes the situation with this structure. Combinations are not possible.

CODE 0 More than one region (except both sides)

Used when the impairment is present in more than one body location (but not bilaterally see code 3); for example when burn scars affect many areas of skin.

CODE 1 Right

Used when the impairment is present to the right of the midline of the person's body.

CODE 2 Left

Used when the impairment is present to the left of the midline of the person's body.

CODE 3 Both sides (bilateral)

Used when the impairment is two-sided and disposed on opposite sides of the midline axis of the body, for example bilateral joint deformities.

CODE 4 Front

Used when the impairment is present in front of a line passing through the midline of the body when viewed from the side.

CODE 5 Back

Used when the impairment is present behind a line passing through the midline of the body when viewed from the side.

CODE 6 Proximal

Used when the impairment is situated towards the point of origin or attachment, as of a limb or bone (opposed to distal), for example the end of the structure that is closer to the centre of the body.

CODE 7 Distal

Used when the impairment is situated away from the point of origin or attachment, as of a limb or bone (opposed to proximal), for example the end of structure that is further away from the centre of the body.

CODE 8 Not specified

Used when there is an impairment of body structure but the location of the impairment is not recorded.

CODE 9 Not applicable

Used when it is not appropriate to code the location of an impairment of body structure.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health

Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This data element is to be used in conjunction with specified body structures, for example, 'impairment of proximal structures related to movement'. This data element may also be used in conjunction with Person—extent of impairment of body structure, code (ICF 2001) N and Person—nature of impairment of body structure, code (ICF 2001).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—extent of impairment of body structure, code (ICF 2001) N Community Services, Standard 16/10/2006, Health, Standard 29/11/2006

See also Person—nature of impairment of body structure, code (ICF 2001) N Community Services, Standard 16/10/2006, Health, Standard 29/11/2006

Implementation in Data Set Specifications: Body structures cluster Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Lot/section number (person)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person (address)—lot/section identifier, N[X(14)]

Synonymous names: Australian lot number, section, allotment

METeOR identifier: 270031

Registration status: Community Services, Superseded 06/02/2012
Health, Standard 01/03/2005

Definition: The unique identifier for the lot/section of the location where a person resides.

Data Element Concept: Person (address)—lot/section identifier

Value domain attributes

Representational attributes

Representation class: Identifier

Data type: String

Format: N[X(14)]

Maximum character length: 15

Data element attributes

Collection and usage attributes

Guide for use: This standard is suitable for postal purposes as well as the physical identification of addresses.

A lot number shall be used only when a street number has not been specifically allocated or is not readily identifiable with the property.

For identification purposes, the word 'Lot' or 'Section' should precede the lot number and be separated by a space.

Examples are as follows:

Section 123456

Lot 716

Lot 534A

Lot 17 Jones Street

Collection methods: The lot/section number is positioned before the Street name and type, located in the same line containing the Street name.

Comments: Lot/section numbers are generally used only until an area has been developed.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: AS 4590 Interchange of client information, Australia Post Address Presentation Standard

Reference documents: AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes Lot/section number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)

Is used in the formation of Person (address)—address line, text [X(180)] Community Services, Standard 30/09/2005, Health, Standard 04/05/2005

Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Lot/section number (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—lot/section identifier, N[X(14)]
METeOR identifier:	290230
Registration status:	Community Services, Superseded 06/02/2012 Health, Standard 04/05/2005
Definition:	The unique identifier for the lot/section of the location of an organisation.
Data Element Concept:	Service provider organisation (address)—lot/section identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	N[X(14)]
Maximum character length:	15

Data element attributes

Collection and usage attributes

Guide for use:

This standard is suitable for postal purposes as well as the physical identification of addresses.

A lot number shall be used only when a street number has not been specifically allocated or is not readily identifiable with the property.

For identification purposes, the word 'Lot' or 'Section' should precede the lot number and be separated by a space.

Examples are as follows:

Section 123456

Lot 716

Lot 534A

Lot 17 Jones Street

Collection methods:

The lot/section number is positioned before the Street name and type, located in the same line containing the Street name.

Comments:

Lot/section numbers are generally used only until an area has been developed.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS 4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Community Services, Standard 30/09/2005, Housing assistance, Recorded 13/10/2011, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Standard 03/12/2008

Lower limb amputation due to vascular disease

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—lower limb amputation due to vascular disease, code N
METeOR identifier:	270162
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a person has undergone an amputation of toe, forefoot or leg (above or below knee), due to vascular disease, as represented by a code.
Data Element Concept:	Person—lower limb amputation due to vascular disease

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Lower limb amputation - occurred in the last 12 months
	2	Lower limb amputation - occurred prior to the last 12 months
	3	Lower limb amputation - occurred both in and prior to the last 12 months
	4	No history of lower limb amputation due to vascular disease
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Collection methods: Ask the individual if he/she has had an amputated toe or forefoot or leg (above or below knee), not due to trauma or causes other than vascular disease. If so determine when it was undertaken; within or prior to the last 12 months (or both). Alternatively obtain this information from appropriate documentation.

Data element attributes

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Reference documents: Duffy MD, John C and Patout MD, Charles A. 1990. Management of the Insensitive Foot in Diabetes: Lessons from Hansen's Disease. Military Medicine, 155:575-579. Edmonds M, Boulton A, Buckenham T et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27-42. Sharon R O'Rourke and Stephen Colagiuri: The Lower Limb in People With Diabetes; Content 1997/98 Australian Diabetes Society. Colagiuri S, Colagiuri R, Ward J. National Diabetes Strategy and Implementation Plan. Canberra: Diabetes Australia, 1998.

Relational attributes

Related metadata references: Supersedes Lower limb amputation due to vascular disease, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.6 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Lymphovascular invasion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—lymphovascular invasion, code N
METeOR identifier:	370618
Registration status:	Health, Standard 06/03/2009
Definition:	The presence or absence of the invasion of cancer cells into blood vessel(s) and/or the lymphatic system, as represented by a code.
Data Element Concept:	Person with cancer—lymphovascular invasion

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Present
	2	Absent
	3	Suspicious
Supplementary values:	9	Not stated or unknown

Data element attributes

Collection and usage attributes

Guide for use:	The presence of lymphovascular invasion should be recorded as Code 1, regardless of whether the extent of the invasion is described or not.
Collection methods:	For cancer registries, collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease. If pathology report pertaining to initial diagnosis is for a metastasis, and not the primary tumour, record as 9.
Comments:	Invasion of the lymphatics or blood vessels by cancer cells is an important prognostic factor that indicates that the tumour is likely to spread. This item is included in data items defined for reporting in the pathology reporting guidelines as prepared by the National Breast and Ovarian Cancer Centre and Australian Cancer Network.

Source and reference attributes

Origin:	National Breast and Ovarian Cancer Centre (NBOCC) Australasian Association of Cancer Registries (AACR) Australian Institute of Health and Welfare (AIHW)
Reference documents:	National Breast and Ovarian Cancer Centre and Australian Cancer Network. The Pathology reporting of breast cancer. A guide for pathologists, surgeons, radiologists and oncologists (3rd edition). National Breast and Ovarian Cancer Centre, Surry Hills, NSW, 2008.

Relational attributes

Implementation in Data Set Specifications:	Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Main language other than English spoken at home

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—main language other than English spoken at home, code (ASCL 2011) NN{NN}

METeOR identifier: 460125

Registration status: Community Services, Standard 13/10/2011
Housing assistance, Standard 13/10/2011
Health, Standard 13/10/2011
Homelessness, Standard 13/10/2011

Definition: The language reported by a person as the main language other than English spoken by that person in his/her home (or most recent private residential setting occupied by the person) to communicate with other residents of the home or setting and regular visitors, as represented by a code.

Data Element Concept: Person—main language other than English spoken at home

Value domain attributes

Representational attributes

Classification scheme: Australian Standard Classification of Languages 2011

Representation class: Code

Data type: Number

Format: NN{NN}

Maximum character length: 4

Collection and usage attributes

Guide for use: The Australian Standard Classification of Languages (ASCL) has a three-level hierarchical structure. The most detailed level of the classification consists of base units (languages) which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow group level), identified by the first two digits. The most general level of the classification consists of broad groups of languages (the Broad group level) and is identified by the first digit. The classification includes Australian Indigenous languages and sign languages.

For example, the Lithuanian language has a code of 3102. In this case 3 denotes that it is an Eastern European language, while 31 denotes that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denotes that it is an Australian Indigenous language and 87 denotes that the language is a Western Desert language.

Language data may be output at the Broad group level, Narrow group level or base level of the classification. If necessary, significant languages within a Narrow group can be presented separately while the remaining languages in the Narrow group are aggregated. The same principle can be adopted to highlight significant Narrow groups within a Broad group.

Data element attributes

Collection and usage attributes

Collection methods:

Recommended question:

Do you/Does the person/Does (name) speak a language other than English at home? (If more than one language, indicate the one that is spoken most often.)

No (English only) ____

Yes, Italian ____

Yes, Greek ____

Yes, Cantonese ____

Yes, Arabic ____

Yes, Mandarin ____

Yes, Vietnamese ____

Yes, Spanish ____

Yes, German ____

Yes, Hindi ____

Yes, Other (please specify)

____

This list reflects the nine most common languages other than English spoken in Australia.

Languages may be added or deleted from the above short list to reflect characteristics of the population of interest.

Alternatively a tick box for 'English' and an 'Other - please specify' response category could be used.

Comments:

This metadata item is consistent with that used in the Australian Census of Population and Housing and is recommended for use whenever there is a requirement for comparison with Census data.

This data element is important in identifying those people most likely to suffer disadvantage in terms of their ability to access services due to language and/or cultural difficulties. In conjunction with Indigenous status, Proficiency in spoken English and Country of birth this data element forms the minimum core set of cultural and language indicators recommended by the Australian

Bureau of Statistics (ABS).

Data on main language other than English spoken at home are regarded as an indicator of 'active' ethnicity and also as useful for the study of inter-generational language retention. The availability of such data may help providers of health and community services to effectively target the geographic areas or population groups that need those services. It may be used for the investigation and development of language services such as interpreter/ translation services.

Source and reference attributes

Origin:

Health Data Standards Committee

National Community Services Data Committee

Australian Bureau of Statistics 2011. Australian Standard Classification of Languages (ASCL) 2011. Canberra: ABS. 16/8/2011.

Relational attributes

Related metadata references:

See also Person—first language spoken, code (ASCL 2005) NN{NN} Community Services, Superseded 13/10/2011, Housing assistance, Standard 10/02/2006, Health, Superseded 13/10/2011

See also Person—first language spoken, code (ASCL 2011) NN{NN} Community Services, Standard 13/10/2011, Housing assistance, Standard 13/10/2011, Health, Standard 13/10/2011, Homelessness, Standard 13/10/2011

Supersedes Person—main language other than English spoken at home, code (ASCL 2005) NN{NN} Community Services, Superseded 13/10/2011, Housing assistance, Standard 10/02/2006, Health, Superseded 13/10/2011

See also Person—preferred language, code (ASCL 2005) NN{NN} Community Services, Superseded 13/10/2011, Health, Superseded 13/10/2011, Tasmanian Health, Proposed 28/09/2011

See also Person—preferred language, code (ASCL 2011) NN{NN} Community Services, Standard 13/10/2011, Housing assistance, Standard 13/10/2011, Health, Standard 13/10/2011, Homelessness, Standard 13/10/2011

Main occupation of person

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—occupation (main), code (ANZSCO 1st edition) N[NNN]{NN}
METeOR identifier:	350899
Registration status:	Community Services, Standard 27/03/2007 Housing assistance, Standard 10/08/2007 Health, Standard 04/07/2007 Tasmanian Health, Proposed 28/09/2011
Definition:	The job in which the person is principally engaged, as represented by a code.
Data Element Concept:	Person—occupation (main)

Value domain attributes

Representational attributes

Classification scheme:	Australian and New Zealand Standard Classification of Occupations, First edition, 2006
Representation class:	Code
Data type:	Number
Format:	N[NNN]{NN}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:

A job in any given establishment is a set of tasks designed to be performed by one individual in return for a wage or salary. For persons with more than one job, the main job is the one in which the person works the most hours.

Caution is advised in its use with regard to service providers as their activity as a service provider may not be their main occupation.

Collection methods:

This metadata item should only be collected from people whose Labour force status is employed.

Occupation is too complex and diverse an issue to fit neatly into any useable small group of categories. Therefore ABS recommend that this metadata item be collected by using the following two open-ended questions:

Q1. In the main job held last week (or other recent reference period), what was your/the person’s occupation?

Q2. What are the main tasks that you/the person usually perform in that occupation? The information gained from these two questions can then be used to select an appropriate code from the ANZSCO at any of the available levels (see Guide for use section).

If only one question is asked, question one should be used. The use of question one only, however, sometimes elicits responses which do not provide a clear occupation title and specification of tasks performed. As a result accurate coding at unit group or occupation level may not be possible.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, due to the complexities of the metadata item 'Main occupation of person', this will result in inaccurate information. The recommended question should be used wherever possible.

Comments: This metadata item may be useful in gaining an understanding of a client's situation and needs. For example, the occupation of a person with a disability may be directly relevant to the type of aids that they require.

National Health Data Dictionary (NHDD) specific:

Injury surveillance - There is considerable user demand for data on occupation-related injury and illness, including from WorkSafe Australia and from industry, where unnecessary production costs are known in some areas and suspected to be related to others in work-related illness, injury and disability.

Source and reference attributes

Origin: Australian Bureau of Statistics 2006. Australian New Zealand Standard Classification of Occupations (ANZSCO) (Cat. no. 1220.0) (First edition), Viewed 13 March 2007.

Relational attributes

Related metadata references: See also Person—labour force status, code N Community Services, Standard 01/03/2005, Housing assistance, Standard 01/03/2005, Health, Standard 01/03/2005, Homelessness, Standard 23/08/2010

Supersedes Person—occupation (main), code (ASCO 2nd edn) N[NNN]{-NN} Community Services, Superseded 27/03/2007, Housing assistance, Superseded 10/08/2007, Health, Superseded 04/07/2007

Main treatment type for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—treatment type (main), code N
METeOR identifier:	270056
Registration status:	Health, Standard 01/03/2005
Definition:	The main activity determined at assessment by the treatment provider to treat the client's alcohol and/or drug problem for the principal drug of concern, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Withdrawal management (detoxification)
2	Counselling
3	Rehabilitation
4	Pharmacotherapy
5	Support and case management only
6	Information and education only
7	Assessment only
8	Other

Collection and usage attributes

Guide for use:

CODE 1 Withdrawal management (detoxification)

This code refers to any form of withdrawal management, including medicated and non-medicated, in any delivery setting.

CODE 2 Counselling

This code refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This code excludes counselling activity that is part of a rehabilitation program as defined in Code 3.

CODE 3 Rehabilitation

This code refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer-term duration. Rehabilitation activities can occur in residential or non-residential settings. Counselling that is included within an overall rehabilitation program should be coded to Code 3 for Rehabilitation, not to Code 2 as a separate treatment episode for counselling.

CODE 4 Pharmacotherapy

Refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, and methadone treatment) and those used as relapse prevention. Use Code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal. Note collection exclusions: excludes treatment episodes for clients who are on an opioid pharmacotherapy maintenance program and are not receiving any other form of treatment.

CODE 5 Support and case management only

Refers to when there is no treatment provided to the client other than support and case management (e.g. treatment provided through youth alcohol and drug outreach services). This choice only applies where support and case management treatment is recorded as individual client data and the treatment activity is not included in any other category.

CODE 6 Information and education only

Refers to when there is no treatment provided to the client other than information and education. It is noted that, in general, service contacts would include a component of information and education.

CODE 7 Assessment only

Refers to when there is no treatment provided to the client other than assessment. It is noted that, in general, service contacts would include an assessment component.

Data element attributes

Collection and usage attributes

Guide for use: Only one code to be selected.

To be completed at assessment or commencement of treatment.

The main treatment type is the principal activity as judged by the treatment provider that is necessary for the completion of the treatment plan for the principal drug of concern. The main treatment type for alcohol and other drugs is the principal focus of a single treatment episode. Consequently, each treatment episode will only have one main treatment type.

For brief interventions, the main treatment type may apply to as few as one contact between the client and agency staff.

Comments: Information about treatment provided is of fundamental importance to service delivery and planning.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Main treatment type for alcohol and other drugs, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.9 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Major diagnostic category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN
METeOR identifier:	391298
Registration status:	Health, Standard 22/12/2009 Tasmanian Health, Proposed 28/09/2011
Definition:	The category into which the patient's diagnosis and the associated Australian refined diagnosis related group (ARDG) falls, as represented by a code.
Data Element Concept:	Episode of admitted patient care—major diagnostic category

Value domain attributes

Representational attributes

Classification scheme:	Australian Refined Diagnosis Related Groups version 6
Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Data element attributes

Collection and usage attributes

Comments:	This metadata item has been created to reflect the development of Australian refined diagnosis related groups (AR-DRGs) (as defined in the metadata item Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA) by the Commonwealth Department of Health and Ageing. Due to the modifications in the diagnosis related group logic for the AR-DRGs, it is necessary to generate the major diagnostic category to accompany each diagnosis related group. The construction of the pre-major diagnostic category logic means diagnosis related groups are no longer unique. Certain pre-major diagnostic category diagnosis related groups may occur in more than one of the 23 major diagnostic categories.

Source and reference attributes

Submitting organisation: Department of Health and Ageing, Acute and Co-ordinated Care Branch

Relational attributes

Related metadata references:

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

See also Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is formed using Episode of admitted patient care—intended length of hospital stay, code N Health, Standard 01/03/2005

Supersedes Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Episode of admitted patient care—procedure, code (ACHI 7th edn) NNNNN-NN Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Episode of admitted patient care—separation mode, code N Health, Standard 01/03/2005

Is formed using Episode of care—additional diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

Is formed using Episode of care—mental health legal status, code N Health, Superseded 07/12/2011

Is formed using Episode of care—principal diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is formed using Person—date of birth, DDMMYYYY Community Services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010, Tasmanian Health, Proposed 28/09/2011

Is formed using Person—sex, code N Community Services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Is formed using Person—weight (measured), total grams NNNN Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Marital status

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—marital status, code N

METeOR identifier: 291045

Registration status: Community Services, Standard 25/08/2005
Housing assistance, Standard 10/02/2006
Health, Standard 04/05/2005

Definition: A person's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage, as represented by a code.

Data Element Concept: Person—marital status

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Never married
	2	Widowed
	3	Divorced
	4	Separated
	5	Married (registered and de facto)
Supplementary values:	6	Not stated/inadequately described

Collection and usage attributes

Guide for use: Refers to the current marital status of a person.

CODE 2 Widowed

This code usually refers to registered marriages but when self reported may also refer to de facto marriages.

CODE 4 Separated

This code refers to registered marriages but when self reported may also refer to de facto marriages.

CODE 5 Married (registered and de facto)

Includes people who have been divorced or widowed but have since re-married, and should be generally accepted as applicable to all de facto couples, including of the same sex.

CODE 6 Not stated/inadequately described

This code is not for use on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Source and reference attributes

Origin:

The ABS standards for the collection of Social and Registered marital status appear on the ABS Website. Australian Bureau of Statistics. Family, household and income unit variables. Cat. no. 1286.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

Collection methods:

This metadata item collects information on social marital status. The recommended question module is:

Do you/Does the person usually live with a partner in a registered or de facto marriage?

Yes, in a registered marriage

Yes, in a de facto marriage

No, never married

No, separated

No, divorced

No, widowed

It should be noted that information on marital status is collected differently by the ABS, using a set of questions. However, the question outlined above is suitable and mostly sufficient for use within the health and community services fields. See Source document for information on how to access the ABS standards.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, the recommended question should be used wherever practically possible.

Comments:

The ABS standards identify two concepts of marital status:

- Registered marital status - defined as whether a person has, or has had, a registered marriage;
- Social marital status - based on a person's living arrangement (including de facto marriages), as reported by the person.

It is recommended that the social marital status concept be collected when information on social support/home arrangements is sought, whereas the registered marital status concept need only be collected where it is specifically required for the purposes of the collection.

While marital status is an important factor in assessing the type and extent of support needs, such as for the elderly living in the home environment, marital status does not adequately address the need for information about social support and living arrangement and other data elements need to be formulated to capture this information.

Source and reference attributes

Origin:

National Health Data Standards Committee
National Community Services Data Committee

Relational attributes

Related metadata references:

Supersedes Person—marital status, code N Community Services, Superseded 25/08/2005, Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Maternal medical conditions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (pregnant)—maternal medical condition, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391328
Registration status:	Health, Standard 22/12/2009
Definition:	Pre-existing maternal diseases and conditions, and other diseases, illnesses or conditions arising during the current pregnancy, that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome, as represented by a code.
Context:	Perinatal statistics
Data Element Concept:	Female (pregnant)—maternal medical condition

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	Examples of such conditions include essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. There is no arbitrary limit on the number of conditions specified.
Comments:	Maternal medical conditions may influence the course and outcome of the pregnancy and may result in antenatal admission to hospital and/or treatment that could have adverse effects on the fetus and perinatal morbidity.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Female (pregnant)—maternal medical condition, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Maximum stenosis coronary artery

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—maximum stenosis coronary artery, percentage N[NN]

METeOR identifier: 344335

Registration status: Health, Standard 01/10/2008

Definition: The percentage of stenosis at its maximal point in a person's coronary artery.

Data Element Concept: Person—maximum stenosis coronary artery

Value domain attributes

Representational attributes

Representation class: Percentage

Data type: Number

Format: N[NN]

Maximum character length: 3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: Stenosis represents the percentage of occlusion, from 0 to 100%, associated with the identified vessel system. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the 'normal' vessel proximal and distal to the lesion.

In instances where multiple lesions are present in a coronary artery, record the highest percentage stenosis noted.

Collection methods: This data is derived from visual recording by the physician reporting the angiogram.

Relational attributes

Related metadata references: See also Person—coronary artery stenosis location, code N Health, Standard 01/10/2008

Implementation in Data Set Specifications: Coronary artery cluster Health, Standard 01/10/2008

MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) indicator, yes/no code N

METeOR identifier: 441371

Registration status: Health, Standard 07/12/2011

Definition: An indicator of whether a person has received a Medicare Benefits Schedule (MBS) Health Assessment for Aboriginal and Torres Strait Islander People (Item 715), as represented by a code.

Data Element Concept: Person—MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes

A person has received an MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715).

CODE 2 No

A person has not received an MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715).

Comments: The MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) is used to ensure that Aboriginal and Torres Strait Islander people receive primary health care matched to their needs, by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause morbidity and early mortality. The health assessment includes an assessment of the patient's health, including their physical, psychological and social wellbeing. It also assesses what preventive health care, education and other assistance should be offered to the patient to improve their health and wellbeing.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Origin: Department of Health and Ageing 2011. Medicare Benefits Schedule (MBS) Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715), Department of Health and Ageing, Canberra, viewed 27/05/2011, http://www.health.gov.au/internet/main/publishing.nsf/Content/C0D3F93D216CBEC2CA25771C000079D0/$File/6462(1004)%20Health%20Assessment%20Item%20Fact%20Sheet%20SCREEN.pdf

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Conditional obligation:
This item is only collected for persons aged 0-4 years, and persons aged 25 years and over.

Medical indemnity payment recipient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim management episode—medical indemnity payment recipient type, code N
METeOR identifier:	421927
Registration status:	Health, Standard 07/12/2011
Definition:	The recipient of a damages payment arising from a medical indemnity claim, as represented by a code.
Data Element Concept:	Medical indemnity claim management episode—medical indemnity payment recipient type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	2	Payment to patient only
	3	Payment to other party/parties only
	4	Payment to patient and other party/parties
Supplementary values:	7	Not applicable—no payment to claimant
	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

The claimant is the person who is pursuing a medical indemnity claim and may be the patient or some other party claiming for harm or loss allegedly resulting from the health-care incident that gave rise to the medical indemnity claim.

CODE 7 Not applicable—no payment to claimant

'Not applicable—no payment to claimant' should be used where no payment was made to the claimant; for example, if legal or investigative costs have been paid, but there has been no payment of damages.

CODE 9 Not stated/inadequately described

'Not stated/inadequately described' should be used when the information is not currently available.

Comments:

Related codes are collected by the Australian Prudential Regulation Authority (2006) as part of their National Claims and Policies Database.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: APRA (Australian Prudential Regulation Authority) 2006. Data specifications National Claims and Policies Database document number 3.1. Canberra: APRA

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Medical indemnity claim commencement date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Medical indemnity claim—medical indemnity claim commencement date, DDMMYYYY

METeOR identifier: 329623

Registration status: Health, Standard 07/12/2011

Definition: The date on which a medical indemnity claim commenced, as signalled by a trigger such as the issue of a letter of demand, issue of writ, or an offer made by the defendant to the claimant, expressed as DDMMYYYY.

Data Element Concept: Medical indemnity claim—medical indemnity claim commencement date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: The date recorded should be the date of the first trigger. For example, if a letter of demand is received and subsequently a writ is issued, the date recorded for this metadata item should be the date of the letter of demand.

The date the medical indemnity claim commenced must be a date that is the same as or after the date the health-care incident occurred. It may be a date before or after the date the reserve was placed.

A trigger for the commencement of a medical indemnity claim is any event that distinguishes the claim from potential claims, which have had a reserve set but may be based on no more information than a health-care incident report. Common triggers are allegations of harm or other loss from the patient or another party related to the patient, and offers of compensation by the defendant before an allegation of harm or other loss has been received.

This data element should be used in conjunction with the data element: *Date—accuracy indicator, code AAA* to flag whether each component in the claim commencement date is accurate, estimated or unknown.

Comments: Date information will assist in the analysis of temporal patterns in the Medical Indemnity National Collection.

A claim commencement trigger is not sufficient for a medical indemnity claim to be recognised. The critical event is the setting of a reserve which marks the health authority's recognition of the likelihood that costs will be incurred in finalising the claim. However, if a claim commencement trigger precedes when the reserve is set, than the claim will come into existence as a commenced, not a potential claim.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Date—accuracy indicator, code AAA Community Services, Standard 30/09/2005, Housing assistance, Standard 23/08/2010, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on the existence of a trigger for commencement of the medical indemnity claim.

Medical indemnity claim finalisation date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim management episode—medical indemnity claim finalisation date, DDMMYYYY
METeOR identifier:	329635
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which a medical indemnity claim was settled, a final court decision was delivered, or the claim file was closed (whichever occurred first), expressed as DDMMYYYY.
Data Element Concept:	Medical indemnity claim management episode—medical indemnity claim finalisation date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The medical indemnity claim finalisation date is the date on which a medical indemnity claim was settled, a final court decision was delivered, or the claim file was closed (whichever occurred first). This data element must remain blank if the medical indemnity claim has not yet been closed or a structured settlement is not yet agreed. However, it must be recorded if a medical indemnity claim is closed. This data element should be used in conjunction with the data element: *Date—accuracy indicator, code AAA* to flag whether each component in the date is accurate, estimated or unknown.
Comments:	This data item is collected by the Australian Prudential Regulation Authority (2006) as part of their National Claims and Policies Database.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: APRA (Australian Prudential Regulation Authority) 2006. Data specifications National Claims and Policies Database document number 3.1. Canberra: APRA

Relational attributes

Related metadata references: See also Date—accuracy indicator, code AAA Community Services, Standard 30/09/2005, Housing assistance, Standard 23/08/2010, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional upon a medical indemnity claim being finalised.

Medical indemnity claim identifier

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Medical indemnity claim—medical indemnity claim identifier, XXXXXX[X(14)]

METeOR identifier: 329778

Registration status: Health, Standard 07/12/2011

Definition: A unique identifier for a medical indemnity claim, as represented by text.

Data Element Concept: Medical indemnity claim —medical indemnity claim identifier

Value domain attributes

Representational attributes

Representation class: Identifier

Data type: String

Format: XXXXXX[X(14)]

Maximum character length: 20

Data element attributes

Collection and usage attributes

Guide for use: The medical indemnity claim identifier should not identify a patient by name and must be unique to a single claim within a health authority. The medical indemnity claim identifier must remain unchanged whenever the claim is reported on.

The field cannot be left blank.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Medical indemnity claim reserve size

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim management episode—reserve size, range code N[N]
METeOR identifier:	329868
Registration status:	Health, Standard 07/12/2011
Definition:	The estimated cost to the health authority of a medical indemnity claim when closed, including legal and investigative costs and claimant payment costs, as represented by a code.
Data Element Concept:	Medical indemnity claim management episode—reserve size

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Less than $10,000
2	$10,000 to less than $30,000
3	$30,000 to less than $50,000
4	$50,000 to less than $100,000
5	$100,000 to less than $250,000
6	$250,000 to less than $500,000
7	$500,000 to less than $1 million
8	$1 million to less than $2 million
9	$2 million to less than $5 million
10	$5 million or more

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: The health authority may adjust its reserve based on information that comes to hand subsequent to when the reserve was initially set, and/or based on expenses that are incurred prior to the finalisation of the claim. The amount recorded should reflect the current **reserve** against the medical indemnity claim at the end of the relevant financial year.

Comments: Insurance Statistics Australia produces a reserve estimate for current medical indemnity claims, by combining its National Claims and Policies Database (APRA 2006) data items 20 'Gross payments to date' and 22 'Gross case estimate at end of reporting period'. Addition of these two dollar amounts produces the reserve estimate, which can be mapped to the Medical Indemnity National Collection ranges (AIHW 2011).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: AIHW (Australian Institute of Health and Welfare) 2011. Public and private sector medical indemnity claims in Australia 2008–09. Safety and quality of health care series no.10. Cat. no. HSE 112. Canberra: AIHW

APRA (Australian Prudential Regulation Authority) 2006. Data specifications National Claims and Policies Database document number 3.1. Canberra: APRA

Relational attributes

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Medical indemnity claim size

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim—medical indemnity claim size, code N[N]
METeOR identifier:	330121
Registration status:	Health, Standard 07/12/2011
Definition:	The amount agreed to be paid to the patient or some other party claiming for loss allegedly resulting from harm involving health care, in total settlement of a medical indemnity claim, plus defence investigative and legal costs, as represented by a code.
Data Element Concept:	Medical indemnity claim—medical indemnity claim size

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]

Permissible values:

Value	Meaning
0	$0
1	$1 to less than $10,000
2	$10,000 to less than $30,000
3	$30,000 to less than $50,000
4	$50,000 to less than $100,000
5	$100,000 to less than $250,000
6	$250,000 to less than $500,000
7	$500,000 to less than $1 million
8	$1 million to less than $2 million
9	$2 million to less than $5 million
10	$5 million or more

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 0 $0

'$0' should only be used where the medical indemnity claim has been closed and no payment has been or is to be made to the claimant and there have been no claimant or defence investigative or legal costs. If no payment was made to the claimant but investigative or legal costs were incurred then the appropriate dollar range should be selected.

CODE 99 Not stated/inadequately described

'Not stated/inadequately described' should be used for medical indemnity claims that have not yet been closed, where a structured settlement has not yet been agreed or for finalised claims when information on total claim size is not yet available.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: The total claim size is the total amount paid to the patient or some other party claiming for harm or other loss allegedly resulting from health care in settlement of the matter, including any interim payments and claimant legal costs, plus defence investigative and legal costs. The amount should not include internal claim management costs. Total claim size should reflect costs paid (or agreed to be paid) by the health authority only; any third party contributions (for example payments from medical indemnity insurers) should be excluded.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Medical indemnity claim state/territory identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim management episode—Australian state/territory identifier, code N
METeOR identifier:	421974
Registration status:	Health, Standard 07/12/2011
Definition:	An identifier of the state or territory whose health authority is managing a medical indemnity claim, as represented by a code.
Data Element Concept:	Medical indemnity claim management episode—Australian state/territory identifier

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	New South Wales
2	Victoria
3	Queensland
4	South Australia
5	Western Australia
6	Tasmania
7	Northern Territory
8	Australian Capital Territory
9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)

Collection and usage attributes

Guide for use: The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Source and reference attributes

Reference documents: Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

Guide for use: Codes 1 to 8 are valid codes for the Medical Indemnity National Collection.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Medical indemnity claim status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim—medical indemnity claim status, code NN
METeOR identifier:	329644
Registration status:	Health, Standard 07/12/2011
Definition:	The status of a medical indemnity claim in terms of the stage it has reached in the claims management process from a reserve being set to file closure, as represented by a code.
Data Element Concept:	Medical indemnity claim—medical indemnity claim status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Not yet commenced, claim file open
11	Not yet commenced, claim file closed
20	Commenced, claim file open
30	Commenced, claim file closed
32	Structured settlement, claim file open
33	Structured settlement, claim file closed
40	Claim previously closed, now reopened
50	Claim record rescinded, not a medical indemnity claim

Collection and usage attributes

Guide for use:

CODE 10 Not yet commenced, claim file open

‘Not yet commenced, claim file open’ indicates that a reserve has been set for the medical indemnity claim but none of the events signalling claim commencement have yet occurred and the claim remains open.

CODE 11 Not yet commenced, claim file closed

‘Not yet commenced, claim file closed’ indicates that a reserve has been set for the medical indemnity claim but none of the events signalling claim commencement have occurred, so the claim has been finalised as a discontinued potential claim.

CODE 20 Commenced, claim file open

'Commenced, claim file open' indicates that the medical indemnity claim has commenced and remains open.

CODE 30 Commenced, claim file closed

'Commenced, claim file closed' indicates that the medical indemnity claim has commenced and has been closed.

CODE 32 Structured settlement, claim file open

'Structured settlement, claim file open' indicates where a decision on a structured settlement has been reached but the medical indemnity claim file remains open.

CODE 33 Structured settlement, claim file closed

'Structured settlement, claim file closed' indicates where the medical indemnity claim was subject to a structured settlement and the medical indemnity claim file has been closed.

CODE 40 Claim previously closed, now reopened

'Claim previously closed, now reopened' indicates instances where a medical indemnity claim previously recorded as finalised on the Medical Indemnity National Collection (Public Sector) database has been reopened.

CODE 50 Claim record rescinded, not a medical indemnity claim

'Claim record rescinded, not a medical indemnity claim' indicates when the health authority determines that a record previously transmitted to the Australian Institute of Health and Welfare (the National Data Custodian) is not a medical indemnity claim but is another type of claim, a duplicate record with a different claim identifier, or the record of a health-care incident construed as a potential claim but on insufficient justification.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Comments: This data element indicates the stage in the claims management process (that is, reserve placed, claim commenced and/or claim closed) that a medical indemnity claim has reached at the time that the data are provided to the National Data Custodian.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Medical indemnity claim—medical indemnity claim finalisation mode, code N[N] Health, Standard 07/12/2011
Implementation in Data Set Specifications:	Medical indemnity DSS Health, Standard 07/12/2011

Medicare card number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—government funding identifier, Medicare card number N(11)
METeOR identifier:	270101
Registration status:	Community Services, Recorded 27/03/2007 Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	Person identifier, allocated by the Health Insurance Commission to eligible persons under the Medicare scheme, that appears on a Medicare card.
Context:	Medicare utilisation statistics. Persons eligible for Medicare services.
Data Element Concept:	Person—government funding identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	N(11)
Maximum character length:	11

Collection and usage attributes

Guide for use:	Full Medicare number for an individual (i.e. family number plus person (individual reference) number).
Comments:	The Medicare card number is printed on a Medicare card and is used to access Medicare records for an eligible person. Up to 9 persons can be included under the one Medicare card number with up to five persons appearing on one physical card. Persons grouped under one Medicare card number are often a family, however, there is no requirement for persons under the same Medicare card number to be related. A person may be shown under separate Medicare card numbers where, for example, a child needs to be included on separate Medicare cards held by their parents. As a person can be identified on more than one Medicare card this is not a unique identifier for a person.

Data element attributes

Collection and usage attributes

Guide for use: The Medicare card number should only be collected from persons eligible to receive health services that are to be funded by the Commonwealth government. The number should be reported to the appropriate government agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any other purpose unless specifically authorised by law. For example, data linkage should not be carried out unless specifically authorised by law.

Comments: Note: Veterans may have a Medicare card number and a Department of Veterans' Affairs (DVA) number or only a DVA number.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS5017 Health care client identification

Relational attributes

Related metadata references: Supersedes Medicare card number, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.6 KB)

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Health care client identification DSS Health, Standard 03/12/2008

Medicare eligibility status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—eligibility status, Medicare code N
METeOR identifier:	481841
Registration status:	Health, Standard 08/02/2012
Definition:	An indicator of a person's eligibility for Medicare at the time of the episode of care, as specified under the Commonwealth Health Insurance Act 1973, as represented by a code.
Context:	Admitted patient care: To facilitate analyses of hospital utilisation and policy relating to health care financing.
Data Element Concept:	Person—eligibility status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Eligible
	2	Not eligible
Supplementary values:	9	Not stated/unknown

Data element attributes

Collection and usage attributes

Guide for use:

Eligible persons are

- Permanent residents of Australia
- Persons who have an application for permanent residence (not an aged parent visa), and have either:

- a spouse, parent or child who is an Australian citizen or permanent resident, OR

- authority from Department of Immigration and Multicultural and Indigenous Affairs to work

- Foreign spouses of Australian residents:

- must have an application for permanent residence, as above

- Asylum seekers who have been issued with valid temporary visas. The list of visas is subject to changes which may be applied by the Department of Immigration and Multicultural Affairs.
- American Fulbright scholars studying in Australia (but not their dependents)
- Diplomats and their dependants from reciprocal health countries (excluding New Zealand and Norway) have full access to Medicare without the restrictions for American Fulbright scholars.

Reciprocal health care agreements

Residents of countries with whom Australia has Reciprocal health care agreements are also eligible under certain circumstances. Australia has Reciprocal Health Care Agreements with Ireland, Italy, Finland, Malta, the Netherlands, New Zealand, Norway, Sweden and the United Kingdom. These Agreements give visitors from these countries access to Medicare and the Pharmaceutical Benefits Scheme for the treatment of an illness or injury which occurs during their stay, and which requires treatment before returning home (that is, these Agreements cover immediately necessary medical treatment, elective treatment is not covered). The Agreements provide for free accommodation and treatment as public hospital services, but do not cover treatment as a private patient in any kind of hospital.

– The Agreements with Finland, Italy, Malta, the Netherlands, Norway, Sweden and the United Kingdom provide free care as a public patient in public hospitals, subsidised out-of-hospital medical treatment under Medicare, and subsidised medicines under the Pharmaceutical Benefits Scheme.

– The Agreements with New Zealand and Ireland provide free care as a public patient in public hospitals and subsidised medicines under the Pharmaceutical Benefits Scheme, but do not cover out-of-hospital medical treatment.

– Visitors from Italy and Malta are covered for a period of six months from the date of arrival in Australia only.

Eligible patients may elect to be treated as either a public or a private patient.

A newborn will usually take the Medicare eligibility status of the mother. However, the eligibility status of the father will be applied to the newborn if the baby is not eligible solely by virtue of the eligibility status of the mother.

For example, if the mother of a newborn is an ineligible person but the father is eligible for Medicare, then the newborn will be eligible for Medicare.

Not eligible/ineligible: means any person who is not Medicare eligible. Ineligible patients may not elect to be treated as a public patient.

Prisoners are ineligible for Medicare, under Section 19 (2) of the Health Insurance Act 1973.

Collection methods:

In practice, the primary method for ascertaining Medicare eligibility status is undertaken by the healthcare organisation sighting the patient's Medicare card.

Relational attributes

Related metadata references:

Supersedes Person—eligibility status, Medicare code N Health, Superseded 08/02/2012

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Medication for mental health disorder indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—medication for mental health disorder indicator, yes/no code N
METeOR identifier:	376081
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	A self-reported indicator of whether a person is currently taking a legally prescribed medication for a **mental health disorder**, including drug and alcohol abuse, as represented by a code.
Data Element Concept:	Person—medication for mental health disorder indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data element: *Person – mental health disorder indicator, yes/no code N* to capture instances of mental illness that are formally diagnosed and medicated.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Person—mental health disorder indicator, yes/no code N Community Services, Standard 06/02/2012, Health, Standard 25/08/2011
Implementation in Data Set Specifications:	Prison entrants DSS Health, Standard 25/08/2011

Conditional obligation:
Conditional on prison entrant being told by a doctor, psychiatrist, psychologist or nurse that they have a mental health disorder (including drug and alcohol abuse).

Medication type

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—medication type, medication type (ATC/DDD) code A[{NN}AA{NN}]

METeOR identifier: 365469

Registration status: Health, Standard 25/08/2011

Definition: The type of prescribed medication administered to a person, as represented by a code

Context: Public health, health care and clinical settings.

Data Element Concept: Person—medication type

Value domain attributes

Representational attributes

Classification scheme: The Anatomical, Therapeutic, Chemical Classification System with Defined Daily Doses (ATC/DDD)

Representation class: Code

Data type: String

Format: A[{NN}AA{NN}]

Maximum character length: 7

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: World Health Organization Collaborating Centre for Drug Statistics Methodology 2009. ATC/DDD Index 2010. Norway: Norwegian Institute of Public Health.

Relational attributes

Implementation in Data Set Specifications: Prisoners in custody repeat medications DSS Health, Standard 25/08/2011

Mental health disorder indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—mental health disorder indicator, yes/no code N
Synonymous names:	Mental illness indicator
METeOR identifier:	376074
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	A self-reported indicator of whether a person has ever been told by a doctor, psychiatrist, psychologist or mental health nurse that they suffer from a **mental health disorder** (including drug and alcohol abuse), as represented by a code.
Data Element Concept:	Person—mental health disorder indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Comments:

The term mental illness is sometimes used instead of mental disorder.

Mental health disorders are generally classified according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or the *International Classification of Diseases* (ICD).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Person—medication for mental health disorder indicator, yes/no code N Community Services, Standard

06/02/2012, Health, Standard 25/08/2011

Implementation in Data Set Specifications: Prison entrants DSS Health, Standard 25/08/2011

Mental health legal status

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of care—mental health legal status, code N

METeOR identifier: 459215

Registration status: Health, Standard 07/12/2011

Definition: Whether a person is treated on an involuntary basis under the relevant state or territory mental health legislation, at any time during an episode of admitted patient care, an episode of residential care or treatment of a patient/client by a community based service during a reporting period, as represented by a code.

Data Element Concept: Episode of care—mental health legal status

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Involuntary patient
	2	Voluntary patient
Supplementary values:	9	Not reported/unknown

Collection and usage attributes

Guide for use: CODE 1 Involuntary patient

Involuntary patient should only be used by facilities which are approved for this purpose. While each state and territory mental health legislation differs in the number of categories of involuntary patient that are recognised, and the specific titles and legal conditions applying to each type, the legal status categories which provide for compulsory detention or compulsory treatment of the patient can be readily differentiated within each jurisdiction. These include special categories for forensic patients who are charged with or convicted of some form of criminal activity. Each state/territory health authority should identify which sections of their mental health legislation provide for detention or compulsory treatment of the patient and code these as involuntary status.

CODE 2 Voluntary patient

Voluntary patient to be used for reporting to the NMDS-Community mental health care, where applicable.

CODE 9 Not reported/unknown

This code is to be used if the mental health legal status for the patient is either not reported or unknown.

Data element attributes

Collection and usage attributes

Guide for use:

The mental health legal status of admitted patients treated within approved hospitals may change many times throughout the episode of care.

Patients may be admitted to hospital on an involuntary basis and subsequently be changed to voluntary status; some patients are admitted as voluntary but are transferred to involuntary status during the hospital stay. Multiple changes between voluntary and involuntary status during an episode of care in hospital or treatment in the community may occur depending on the patient's clinical condition and his/her capacity to consent to treatment.

Similarly, the mental health legal status of residents treated within residential care services may change on multiple occasions throughout the episode of residential care or residential stay.

Collection methods:

Admitted patients to be reported as involuntary if the patient is involuntary at any time during the episode of care.

Residents in **residential mental health services** to be reported as involuntary if the resident is involuntary at any time during the episode of residential care.

Patients of ambulatory mental health care services to be reported as involuntary if the patient is involuntary at the time of a service contact.

Relational attributes

Related metadata references:

Supersedes Episode of care—mental health legal status, code N Health, Superseded 07/12/2011

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Mental health service contact date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—service contact date, DDMMYYYY
METeOR identifier:	295481
Registration status:	Health, Standard 08/12/2004
Definition:	The date of each mental health service contact between a health service provider and patient/client.
Data Element Concept:	Mental health service contact—service contact date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Collection methods:

Requires services to record the date of each service contact, including the same date where multiple visits are made on one day (except where the visits may be regarded as a continuation of the one service contact). Where an individual patient/client participates in a group activity, a service contact date is recorded if the person's participation in the group activity results in a dated entry being made in the patient's/client's record.

For collection from community based (ambulatory and non-residential) agencies.

Comments:

The service contact is required for clinical audit and other quality assurance purposes.

Relational attributes

Implementation in Data Set Specifications:

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Mental health service contact duration

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Mental health service contact—service contact duration, total minutes NNN

METeOR identifier: 286682

Registration status: Health, Standard 08/12/2004

Definition: The time from the start to finish of a service contact.

Data Element Concept: Mental health service contact—mental health service contact duration

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: NNN

Maximum character length: 3

Data element attributes

Collection and usage attributes

Guide for use: For group sessions the time for the patient/client in the session is recorded for each patient/client, regardless of the number of patients/clients or third parties participating or the number of service providers providing the service.

Writing up details of service contacts is not to be reported as part of the duration, except if during or contiguous with the period of patient/client or third party participation.

Travel to or from the location at which the service is provided, for example to or from outreach facilities or private homes, is not to be reported as part of the duration of the service contact.

Comments: Counting the duration for each patient/client in a group session means that this data element cannot be used to measure the duration of service contacts from the perspective of the service provider.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Mental health service contact—patient/client participation indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—patient/client participation indicator, yes/no code N
METeOR identifier:	286859
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the patient/client has participated in a service contact, as represented by a code.
Data Element Concept:	Mental health service contact—patient/client participation indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Service contacts are not restricted to in-person communication but can include telephone, video link or other forms of direct communication.

- Code 1 is to be used for service contacts between a specialised mental health service provider and the patient/client in whose clinical record the service contact would normally warrant a dated entry, where the patient/client is participating.
- Code 2 is to be used for service contacts between a specialised mental health service provider and a third party(ies) where the patient/client, in whose clinical record the service contact would normally warrant a dated entry, is not participating.

Relational attributes

Implementation in Data Set Specifications:	Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Mental health service contact—session type

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Mental health service contact—session type, code N

METeOR identifier: 286832

Registration status: Health, Standard 08/12/2004

Definition: Whether a service contact is provided for one or more patient(s)/client(s), as represented by a code.

Data Element Concept: Mental health service contact—session type

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Individual session
2	Group session

Data element attributes

Collection and usage attributes

Guide for use: A service contact is regarded as an individual session where the service is provided for one patient/client with or without third party involvement.

A service contact is regarded as a group session where two or more patients/clients are participating in the service contact with or without third parties and the nature of the service would normally warrant dated entries in the clinical records of the patients/clients in question.

A service contact is also regarded as a group session where third parties for two or more patients/clients are participating in the service contact without the respective patients/clients and the nature of the service would normally warrant dated entries in the clinical records of the patients/clients in question.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Mental health service referral

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Prison entrant—mental health service referral, yes/no/not stated/inadequately described code N
METeOR identifier:	365460
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether a prison entrant has been referred to prison mental health services for observation and further assessment, as represented by a code.
Data Element Concept:	Prison entrant—mental health service referral indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Comments: At the prison reception assessment, prison entrants may be referred to prison mental health services for observation and further assessment. Prison mental health services provide access to specialist mental health nurses, psychiatrists, psychologists and in-patient services where the prisoners receive counselling and intervention programs.

Under the *National Action Plan on Mental Health 2006-2011* (COAG 2006) jurisdictions are required to provide details on the prevalence of mental illness among people who are newly sentenced to prison and enhance mental health services for people in contact with the justice system.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	COAG (Council of Australian Governments) 2006. National Action Plan on Mental Health 2006-2011. Canberra: COAG.

Relational attributes

Implementation in Data Set Specifications:	Prison entrants DSS Health, Standard 25/08/2011

Mental health services grants to non-government organisations by non-health departments

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: State or Territory Government—mental health services grants to non-government organisations by non-health departments, total Australian currency N[N(8)]

METeOR identifier: 298940

Registration status: Health, Standard 07/12/2005

Definition: Total amount of money in the form of grants made by state or territory departments outside the health portfolios directly to non-government organisations specifically for the provision of mental health activities or programs (other than staffed residential services).

Data Element Concept: State or Territory Government—mental health services grants to non-government organisations by non-health departments

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Where the exact dollar amount is unable to be provided an estimate should be derived from information available to the state or territory health department.

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Method of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—birth method, code N
METeOR identifier:	295349
Registration status:	Health, Standard 06/09/2006
Definition:	The method of complete expulsion or extraction from its mother of a product of conception in a birth event, as represented by a code.
Data Element Concept:	Birth event—birth method

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	1	Vaginal - non-instrumental
	2	Vaginal - forceps
	4	Caesarean section
	5	Vaginal - vacuum extraction
Supplementary values:	9	Not stated/inadequately described

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use:

In a vaginal breech with forceps to the after coming head, code as vaginal - forceps.

In a vaginal breech that has been manually rotated, code as vaginal - non-instrumental.

Where forceps/vacuum extraction are used to assist the extraction of the baby at caesarean section, code as caesarean section.

Where a hysterotomy is performed to extract the baby, code as caesarean section.

Collection methods: In the case of multiple births, method of birth should be recorded for each baby born.

Comments: Note: Code 3, which had a meaning in previous versions of the data standard is no longer used. As is good practice, the code will not be reused.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Birth event—delivery method, code N Health, Superseded 06/09/2006

Implementation in Data Set Specifications: Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Method of use for principal drug of concern

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Client—method of drug use (principal drug of concern), code N

METeOR identifier: 270111

Registration status: Community Services, Standard 06/02/2012
Health, Standard 01/03/2005

Definition: The client's self-reported usual method of administering the principal drug of concern, as represented by a code.

Data Element Concept: Client—method of drug use (principal drug of concern)

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Ingests
	2	Smokes
	3	Injects
	4	Sniffs (powder)
	5	Inhales (vapour)
	6	Other
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: CODE 1

Refers to eating or drinking as the method of administering the principal drug of concern.

Collection methods: Collect only for principal drug of concern.

To be collected on commencement of treatment with a service.

Comments: Identification of drug use methods is important for minimising specific harms associated with drug use, and is consequently of value for informing treatment approaches.

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:	Supersedes Method of use for principal drug of concern, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)
Implementation in Data Set Specifications:	Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Microalbumin level—albumin/creatinine ratio (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin level (measured), albumin/creatinine ratio N[NN].N
METeOR identifier:	270339
Registration status:	Health, Standard 01/03/2005
Definition:	A person's microalbumin level, measured as an albumin/creatinine ratio.
Data Element Concept:	Person—microalbumin level

Value domain attributes

Representational attributes

Representation class:	Ratio	
Data type:	Number	
Format:	N[NN].N	
Maximum character length:	4	
Supplementary values:	Value	Meaning
	999.9	Not stated/inadequately described
Unit of measure:	Milligram per millimole (mg/mmol)	
Unit of measure precision:	1	

Data element attributes

Collection and usage attributes

Collection methods:

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate, and if the albumin/creatinine ratio is found to be greater than 3.5 mg/mmol then a timed overnight sample should be obtained for estimation of the albumin excretion rate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are

- spot urine 30 to 300 mg/L; or
- timed urine (24 hour collection) 20 to 200 µg/min.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references: See also Laboratory standard—upper limit of normal range for microalbumin, albumin/creatinine ratio N[NN].N Health, Standard 01/03/2005

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin level—micrograms per minute (measured)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—microalbumin level (measured), total micrograms per minute N[NNN].N

METeOR identifier: 270336

Registration status: Health, Standard 01/03/2005

Definition: A person's microalbumin level measured in microgram per minute (µg/min).

Data Element Concept: Person—microalbumin level

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNN].N

Maximum character length: 5

Supplementary values:

Value	Meaning
9999.9	Not stated/inadequately described

Unit of measure: Microgram per minute (µg/min)

Unit of measure precision: 1

Data element attributes

Collection and usage attributes

Collection methods: Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are

- spot urine 30 to 300mg/L; or
- timed urine (24 hr collection) 20 to 200 µg/min.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references: See also Laboratory standard—upper limit of normal range for microalbumin, total micrograms per minute N[NN].N Health, Standard 01/03/2005

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin level—milligrams per 24 hour (measured)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—microalbumin level (measured), total milligrams per 24 hour N[NNN].N

METeOR identifier: 270337

Registration status: Health, Standard 01/03/2005

Definition: A person's microalbumin level measured in milligrams per 24 hours.

Data Element Concept: Person—microalbumin level

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNN].N

Maximum character length: 5

Supplementary values:

Value	Meaning
9999.9	Not stated/inadequately described

Unit of measure: Milligram per 24-hour period (mg/24h)

Unit of measure precision: 1

Data element attributes

Collection and usage attributes

Collection methods: Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are

- spot urine 30 to 300mg/L; or
- timed urine (24 hr collection) 20 to 200 ug/min.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references: See also Laboratory standard—upper limit of normal range for microalbumin, total milligrams per 24 hour N[NN].N Health, Standard 01/03/2005

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin level—milligrams per litre (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin level (measured), total milligrams per litre N[NNN].N
METeOR identifier:	270335
Registration status:	Health, Standard 01/03/2005
Definition:	A person's microalbumin level measured in milligrams per litre (mg/L).
Data Element Concept:	Person—microalbumin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN].N
Maximum character length:	5

Supplementary values:

Value	Meaning
9999.9	Not stated/inadequately described

Unit of measure:	Milligram per litre (mg/L)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are:

- spot urine 30 to 300mg/L; or
- timed urine (24 hr collection) 20 to 200 ug/min.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references: See also Laboratory standard—upper limit of normal range for microalbumin, total milligrams per litre N[NN].N Health, Standard 01/03/2005

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin level—upper limit of normal range (albumin/creatinine ratio)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, albumin/creatinine ratio N[NN].N
Synonymous names:	Albumin/creatinine ratio
METeOR identifier:	270344
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured as an albumin/creatinine ratio that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	N[NN].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not stated/inadequately described

Unit of measure:	Milligram per millimole (mg/mmol)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of the microalbumin normal reference range for the laboratory.

Collection methods: Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate and if the albumin/creatinine ratio is found to be greater than 3.5mg/mmol then a timed overnight sample should be obtained for estimation of the albumin excretion rate.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

See also Person—microalbumin level (measured), albumin/creatinine ratio N[NN].N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin level—upper limit of normal range (micrograms per minute)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, total micrograms per minute N[NN].N
METeOR identifier:	270341
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured in micrograms per minute (µg/min), that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4
Supplementary values:	Value Meaning 999.9 Not stated/inadequately described
Unit of measure:	Microgram per minute (µg/min)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:

Record the upper limit of the microalbumin normal reference range for the laboratory.

Collection methods:

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For

screening purposes an early morning urine specimen is adequate.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references: Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin level—upper limit of normal range (milligrams per 24 hour)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, total milligrams per 24 hour N[NN].N
METeOR identifier:	270343
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured in milligrams per 24 hour, that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[NN].N	
Maximum character length:	4	
Supplementary values:	Value	Meaning
	999.9	Not stated/inadequately described
Unit of measure:	Milligram per 24-hour period (mg/24h)	
Unit of measure precision:	1	

Data element attributes

Collection and usage attributes

Guide for use:

Record the upper limit of the microalbumin normal reference range for the laboratory.

Collection methods:

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For

screening purposes an early morning urine specimen is adequate.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin level—upper limit of normal range (milligrams per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, total milligrams per litre N[NN].N
METeOR identifier:	270334
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured in milligrams per litre (mg/L), that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[NN].N	
Maximum character length:	4	
Supplementary values:	Value	Meaning
	999.9	Not stated/inadequately described
Unit of measure:	Milligram per litre (mg/L)	
Unit of measure precision:	1	

Data element attributes

Collection and usage attributes

Guide for use:

Record the upper limit of the microalbumin normal reference range for the laboratory.

Collection methods:

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For

screening purposes an early morning urine specimen is adequate.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin urine test result

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin urine test result recorded indicator, yes/no code N
METeOR identifier:	464970
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a person has had a microalbumin urine test result recorded, as represented by a code.
Data Element Concept:	Person—microalbumin urine test result recorded indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A person has had a microalbumin urine test result recorded.

CODE 2 No

A person has not had a microalbumin urine test result recorded.

A microalbumin urine test is undertaken to test for the presence of the protein called microalbumin in the urine.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Minutes of operating theatre time

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Admitted patient hospital stay—operating theatre time, total minutes NNNN

METeOR identifier: 270350

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: Total time, in minutes, spent by a patient in operating theatres during current episode of hospitalisation.

Data Element Concept: Admitted patient hospital stay—operating theatre time

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: NNNN

Maximum character length: 4

Unit of measure: Minute (m)

Collection and usage attributes

Collection methods: Right justified, zero filled.

Data element attributes

Collection and usage attributes

Comments: This metadata item was recommended for inclusion in the *National Health Data Dictionary* by *Hindle (1988a, 1988b)* to assist with diagnosis related group costing studies in Australia.

This metadata item has not been accepted for inclusion in the National Minimum Data Set (NMDS) - Admitted patient care.

Source and reference attributes

Origin: Health Data Standards Committee

Relational attributes

Related metadata references: Supersedes Minutes of operating theatre time, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.3 KB)

Mode of admission

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission mode, code N
METeOR identifier:	269976
Registration status:	Health, Standard 01/03/2005
Definition:	The mechanism by which a person begins an episode of care, as represented by a code.
Data Element Concept:	Episode of admitted patient care—admission mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Admitted patient transferred from another hospital
2	Statistical admission - episode type change
3	Other

Collection and usage attributes

Guide for use:

CODE 2 Statistical admission - episode type change

Use this code where a new episode of care is commenced within the same hospital stay.

CODE 3 Other

Use this code for all planned admissions and unplanned admissions (except transfers into the hospital from another hospital).

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Mode of admission, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Admitted patient care NMDS 2012-2013 Health, Standard

Specifications: 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Mode of medical indemnity claim finalisation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim—medical indemnity claim finalisation mode, code N[N]
METeOR identifier:	330111
Registration status:	Health, Standard 07/12/2011
Definition:	The process by which a medical indemnity claim was finalised, as represented by a code.
Data Element Concept:	Medical indemnity claim—medical indemnity claim finalisation mode

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Permissible values:	Value	Meaning
	1	Settled through state or territory-based complaints processes
	2	Settled through court-based alternative dispute resolution processes
	3	Settled through statutorily mandated compulsory conference process
	4	Settled—other
	5	Court decision
	8	Discontinued commenced claim
	9	Discontinued potential claim
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Settled through state or territory-based complaints processes

'Settled through state or territory-based complaints processes' includes proceedings conducted in state or territory health rights and health complaints bodies.

CODE 2 Settled through court-based alternative dispute resolution processes

‘Settled through court-based alternative dispute resolution processes’ includes mediation, arbitration, and case appraisal provided for under civil procedure rules.

CODE 3 Settled through statutorily mandated compulsory conference process

‘Settled through statutorily mandated compulsory conference process’ includes settlement conferences required by statute as part of a pre-court process.

CODE 4 Settled—other

‘Settled—other’ includes instances where a medical indemnity claim is settled part way through a trial or a negotiated settlement.

CODE 8 Discontinued commenced claim

‘Discontinued commenced claim’ means the discontinued medical indemnity claim has already commenced and now has the status of ‘Commenced—claim file closed’.

Discontinued medical indemnity claims include claims which have been closed due to withdrawal by the claimant, or operation of statute of limitations, or particularly with potential claims where the claim manager decides to close the claim file because there has been a long period of inactivity on the matter. Discontinued medical indemnity claims also include instances where a commenced claim is discontinued part way through a trial.

CODE 9 Discontinued potential claim

‘Discontinued potential claim’ means the discontinued medical indemnity claim has not yet commenced and now has the status of ‘Not yet commenced—claim file closed’.

CODE 99 Not stated/inadequately described

‘Not stated/inadequately described’ should be used for medical indemnity claims that have not yet been closed or a structured settlement has not yet been agreed.

Comments: Code 5, ‘Court decision’, in this value domain maps to Code V, ‘Case was settled by court judgement’, in the Australian Prudential Regulation Authority National Claims and Policies Database ‘Litigation status’ data item (APRA 2006).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: APRA (Australian Prudential Regulation Authority) 2006. Data Specifications National Claims and Policies Database document number 3.1. Canberra: APRA

Data element attributes

Collection and usage attributes

Guide for use: Finalisation of a medical indemnity claim refers to the process by which a claim became closed.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Medical indemnity claim—medical indemnity claim status, code NN Health, Standard 07/12/2011

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Mode of separation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—separation mode, code N
METeOR identifier:	270094
Registration status:	Health, Standard 01/03/2005
Definition:	Status at **separation** of person (discharge/transfer/death) and place to which person is released, as represented by a code.
Data Element Concept:	Episode of admitted patient care—separation mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Discharge/transfer to (an)other acute hospital
2	Discharge/transfer to a residential aged care service, unless this is the usual place of residence
3	Discharge/transfer to (an)other psychiatric hospital
4	Discharge/transfer to other health care accommodation (includes mothercraft hospitals)
5	Statistical discharge - type change
6	Left against medical advice/discharge at own risk
7	Statistical discharge from leave
8	Died
9	Other (includes discharge to usual residence, own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services))

Collection and usage attributes

Guide for use:

CODE 4 Discharge/transfer to other health care accommodation (includes mothercraft hospitals)

In jurisdictions where mothercraft facilities are considered to be acute hospitals, patients separated to a mothercraft facility should have a mode of separation of Code 1. If the residential aged care service is the patient's place of usual residence then they should have a mode of separation of Code 9.

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Supersedes Mode of separation, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Month and year of birth

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—date of birth, MMYYYY

METeOR identifier: 375191

Registration status: Health, Standard 10/12/2009

Definition: The month and year of birth of the person.

Data Element Concept: Person—date of birth

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: MMYYYY

Maximum character length: 6

Data element attributes

Collection and usage attributes

Collection methods: In some collections data may be reported in DDMMYYYY format. Agencies providing data to other agencies may choose to provide the abbreviated version (MMYYYY) to protect the privacy of respondents.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Health Data Committee

National Community Services Data Committee

Reference documents: AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references: See also Date—accuracy indicator, code AAA Community Services, Standard 30/09/2005, Housing assistance, Standard 23/08/2010, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard

23/08/2010

See also Person—age, total years N[NN] Community Services, Standard 29/04/2006, Housing assistance, Standard 10/02/2006, Health, Standard 08/02/2006, Early Childhood, Standard 21/05/2010, Tasmanian Health, Proposed 28/09/2011

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Morphology of cancer

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person with cancer—morphology of cancer, code (ICD-O-3) NNNN/N

METeOR identifier: 399491

Registration status: Health, Standard 07/12/2011

Definition: The histological classification of the cancer tissue (histopathological type) in a person with cancer, and a description of the course of development that a tumour is likely to take: benign or malignant (behaviour), as represented by a code.

Data Element Concept: Person with cancer—morphology of cancer

Value domain attributes

Representational attributes

Classification scheme: International Classification of Diseases for Oncology 3rd edition

Representation class: Code

Data type: Number

Format: NNNN/N

Maximum character length: 5

Collection and usage attributes

Guide for use: ICD-O morphology describes histology and behaviour as separate variables, recognising that there are a large number of possible combinations.

In ICD-O, 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.

When the morphology is unknown, record 8000 and the appropriate behaviour code. For example, a tumour of unknown morphology with a behaviour code of "3" for a malignant primary site tumour would be recorded as 8000/3.

Source and reference attributes

Origin: International Classification of Diseases for Oncology, Third Edition (ICD-O-3)

Data element attributes

Collection and usage attributes

Guide for use:

Tumour morphology refers to the type of cell (histology) that has become neoplastic and its biologic activity (behaviour).

Record the tumour morphology for patients who have been diagnosed with cancer.

Record the tumour morphology relating to the initial diagnosis and not for recurrent disease.

Record morphology codes in accordance with ICD-O-3 coding standards. Use the 5th-digit to record behaviour. Refer to the coding guidelines for morphology in ICD-O-3, pp 27-34.

If the morphology differs on multiple pathology reports for the same tumour, use the value from the most representative tumour specimen examined. For example, if the tumour is described as ductal on core biopsy but undifferentiated carcinoma on the excision specimen, the morphology would be coded as undifferentiated carcinoma (a lower code) which has a less favourable diagnosis.

Collection methods:

This information should be obtained from the patient's pathology reports or, in the case of cancer registries, from the notification reports.

Comments:

The information is collected so that tumours can be classified into clinically relevant groups based on their primary site and morphology. This provides a basis for staging and the determination of treatment options. The morphology of the cancer also affects the course of the disease and prognosis.

Source and reference attributes

Submitting organisation:

Cancer Australia

Origin:

World Health Organization

New South Wales Health Department

State and Territory Cancer Registries

Reference documents:

New South Wales Inpatient Statistics Collection Manual. 2000/2001

Esteban D, Whelan S, Laudico A, Parkin DM (Editors) 1995. World Health Organization and International Association of Cancer Registries: Manual for cancer registry personnel, IARC Technical Report No 10. Lyon: International Agency for Research on Cancer

Fritz A et al. 2000. International Classification of Diseases for Oncology (ICD-O), 3rd edition. Geneva: World Health Organization

Relational attributes

Related metadata references:	Supersedes Person with cancer—morphology of cancer, code (ICDO-3) NNNN/N Health, Superseded 07/12/2011
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Standard 07/12/2011

Most common service delivery setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—most common service delivery setting, code N
METeOR identifier:	297708
Registration status:	Health, Standard 05/12/2007
Definition:	The setting in which the service provider organisation most commonly delivers services, as represented by a code.
Data Element Concept:	Service provider organisation—most common service delivery setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Mostly community-based setting
2	Mostly inpatient setting
3	Similar proportion in both settings

Collection and usage attributes

Collection methods: Record only one code.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Mostly community based setting

During the past 12 months, more than 60% of service delivery time was estimated to have been spent on delivering services to, and on behalf of, clients in community settings. This includes residential settings such as private residences (including caravans, mobile homes, houseboats or units in a retirement village), residential aged care facilities, prisons, and community living environments (including group homes); and non-residential settings such as day respite centres or day centres. It includes hospital outreach services and outpatient settings where these are delivered in the community setting.

CODE 2 Mostly inpatient setting

During the past 12 months, more than 60% of service delivery time was estimated to have been spent on delivering services to, and on behalf of, clients in inpatient settings. This includes hospitals, hospices or admitted patient settings. It excludes services delivered in outpatient settings and hospital outreach services delivered in the community setting.

CODE 3 Similar level in both settings

During the past 12 months, a similar proportion of service delivery time (between 40-60%) was estimated to have been spent on delivering services in community and inpatient settings.

Collection methods: Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Most valid basis of diagnosis of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—most valid basis of diagnosis of a cancer, code N
METeOR identifier:	422772
Registration status:	Health, Standard 07/12/2011
Definition:	The most valid basis of diagnosis in a person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—most valid basis of diagnosis of a cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	Death certificate only: Information provided is from a death certificate
1	Clinical: Diagnosis made before death, but without any of the following (codes 2-7)
2	Clinical investigation: All diagnostic techniques, including x-ray, endoscopy, imaging, ultrasound, exploratory surgery (e.g. laparotomy), and autopsy, without a tissue diagnosis
4	Specific tumour markers: Including biochemical and/or immunological markers that are specific for a tumour site
5	Cytology: Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates
6	Histology of metastasis: Histological examination of tissue from a metastasis, including autopsy specimens
7	Histology of a primary tumour: Histological

		examination of tissue from primary tumour, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of primary tumour
	8	Histology: either unknown whether of primary or metastatic site, or not otherwise specified
Supplementary values:	9	Unknown.

Collection and usage attributes

Guide for use: CODES 1 - 4

Non-microscopic.

CODES 5 - 8

Microscopic.

CODE 9

Other.

Comments: In a hospital setting this metadata item should be collected on the most valid basis of diagnosis at this admission. If more than one diagnosis technique is used during an admission, select the higher code from 1 to 8.

Data element attributes

Collection and usage attributes

Guide for use: The most valid basis of diagnosis may be the initial histological examination of the primary site, or it may be the post-mortem examination (sometimes corrected even at this point when histological results become available). In a cancer registry setting, this metadata item should be revised if later information allows its upgrading.

When considering the most valid basis of diagnosis, the minimum requirement of a cancer registry is differentiation between neoplasms that are verified microscopically and those that are not. To exclude the latter group means losing valuable information; the feasibility of making a morphological (histological) diagnosis is dependent upon a variety of factors, such as the health and age of the patient, accessibility of the tumour, availability of medical services, and the beliefs and decisions of the patient.

A biopsy of the primary tumour should be distinguished from a biopsy of a metastasis, for example, at laparotomy; a biopsy of cancer of the head of the pancreas versus a biopsy of a metastasis in the mesentery. However, when insufficient information is available, Code 8 should be used for any histological diagnosis. Cytological and histological diagnoses should be distinguished.

Morphological confirmation of the clinical diagnosis of malignancy depends on the successful removal of a piece of tissue that is cancerous. Especially when using endoscopic procedures (bronchoscopy, gastroscopy, laparoscopy, etc.), the clinician may miss the tumour with the biopsy forceps. These cases must be registered on the basis of endoscopic diagnosis and not excluded through lack of a morphological diagnosis.

Care must be taken in the interpretation and subsequent coding of autopsy findings, which may vary as follows:

a) the post-mortem report includes the post-mortem histological diagnosis (in which case, one of the histology codes should be recorded instead);

b) the autopsy is macroscopic only, histological investigations having been carried out only during life (in which case, one of the histology codes should be recorded instead);

c) the autopsy findings are not supported by any histological diagnosis.

Comments: Knowledge of the basis of the diagnosis underlying a cancer code is one of the most important elements in assessing the reliability of cancer statistics.

Source and reference attributes

Origin: International Agency for Research on Cancer
International Association of Cancer Registries

Relational attributes

Related metadata references: Supersedes Person with cancer—most valid basis of diagnosis of a cancer, code N Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Most valid basis of diagnosis of recurrence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—most valid basis of diagnosis of the first recurrence, code N
METeOR identifier:	394047
Registration status:	Health, Standard 07/12/2011
Definition:	The most valid basis of diagnosis of the first recurrence of locoregional cancer or distant metastasis in a person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—most valid basis of diagnosis of a cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	Death certificate only: Information provided is from a death certificate
1	Clinical: Diagnosis made before death, but without any of the following (codes 2-7)
2	Clinical investigation: All diagnostic techniques, including x-ray, endoscopy, imaging, ultrasound, exploratory surgery (e.g. laparotomy), and autopsy, without a tissue diagnosis
4	Specific tumour markers: Including biochemical and/or immunological markers that are specific for a tumour site
5	Cytology: Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates
6	Histology of metastasis: Histological examination of tissue from a metastasis, including autopsy specimens

	7	Histology of a primary tumour: Histological examination of tissue from primary tumour, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of primary tumour
	8	Histology: either unknown whether of primary or metastatic site, or not otherwise specified
Supplementary values:	9	Unknown.

Collection and usage attributes

Guide for use:

CODES 1 - 4

Non-microscopic.

CODES 5 - 8

Microscopic.

CODE 9

Other.

Comments:

In a hospital setting this metadata item should be collected on the most valid basis of diagnosis at this admission. If more than one diagnosis technique is used during an admission, select the higher code from 1 to 8.

Data element attributes

Collection and usage attributes

Guide for use:

Record the most valid basis of diagnosis that identifies the first recurrence of locoregional cancer or a distant metastasis.

The term recurrence refers to the return, reappearance or metastasis of cancer of the same histology after a disease-free period. It may be locoregional or a distant metastasis.

The information is collected for the first recurrence of cancer at any site.

The coding system is based on that recommended by the International Agency for Research on Cancer (IARC) and the International Association of Cancer Registries (IACR). The value "3" is not represented.

If more than one investigation identifying the recurrence is conducted at the same time, select the higher number code from 1 to 8 reflecting the most definitive method of diagnosis. For example, if the patient has both imaging (Code 2) and histology of a primary tumour (Code 7) to verify the cancer, record Code 7 as the most valid basis of diagnosis.

When considering the most valid basis of diagnosis, the minimum requirement of a cancer registry is differentiation between neoplasms that are verified microscopically and those that are not. To exclude the latter group means losing valuable information; the feasibility of making a morphological (histological) diagnosis is dependent upon a variety of factors, such as the health and age of the patient, accessibility of the tumour, availability of medical services, and the beliefs and decisions of the patient.

A biopsy of the primary tumour should be distinguished from a biopsy of a metastasis, for example, at laparotomy; a biopsy of cancer of the head of the pancreas versus a biopsy of a metastasis in the mesentery. However, when insufficient information is available to determine whether the site of the biopsy is primary or metastatic, Code 8. Cytological and histological diagnoses should also be distinguished.

Morphological confirmation of the clinical diagnosis of malignancy depends on the successful removal of a piece of tissue that is cancerous. When using endoscopic procedures such as bronchoscopy, gastroscopy or laparoscopy, the clinician may miss the tumour with the biopsy forceps. These cases must be registered on the basis of endoscopic diagnosis and not excluded through lack of a morphological diagnosis.

Care must be taken in the interpretation and subsequent coding of autopsy findings, which may vary as follows:

(a) The post-mortem report includes the post-mortem histological diagnosis (in which case, one of the histology codes should be recorded instead);

(b) The autopsy is macroscopic only, histological investigations having been carried out only during life (in which case, one of the histology codes should be recorded instead);

(c) The autopsy findings are not supported by any histological diagnosis.

Collection methods: The information should be obtained from the patient’s medical record.

Comments: Information regarding the basis of diagnosis is important for determining how definitively the malignancy was confirmed and subsequently the reliability of cancer statistics.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: International Agency for Research on Cancer (IARC)
International Association of Cancer Registries (IACR)

Relational attributes

Related metadata references:

See also Patient—diagnosis date of first recurrence as distant metastasis, DDMMYYYY Health, Standard 07/12/2011

See also Patient—diagnosis date of first recurrence as locoregional cancer, DDMMYYYY Health, Standard 07/12/2011

See also Person with cancer—region of first recurrence as distant metastasis, topography code (ICD-O-3) ANN.N Health, Standard 07/12/2011

See also Person with cancer—region of first recurrence as locoregional cancer, topography code (ICD-O-3) ANN.N Health, Standard 07/12/2011

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:

Conditional on the return, reappearance or metastasis of cancer of the same histology after a disease-free intermission or remission.

Mother’s original family name

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—mother’s original family name, text [X(40)]

METeOR identifier: 270262

Registration status: Community Services, Standard 01/03/2005
Health, Standard 01/03/2005

Definition: The original family name of the person’s mother as reported by the person, as represented by text.

Data Element Concept: Person—mother’s original family name

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: [X(40)]

Maximum character length: 40

Data element attributes

Collection and usage attributes

Guide for use: Mixed case should be used (rather than upper case only).

Collection methods: See relevant paragraphs in the collection methods section of the metadata item Person (name)—family name, text X[X(39)].

Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Committee

National Community Services Data Committee

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references: Supersedes Mother’s original family name, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Multi-disciplinary team status

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Non-admitted patient service event—multi-disciplinary team status, code N

METeOR identifier: 270104

Registration status: Health, Standard 01/03/2005

Definition: Whether a non-admitted patient service event involved a multi-disciplinary team, as represented by a code.

Data Element Concept: Non-admitted patient service event—multi-disciplinary team status

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Non-admitted multi-disciplinary team patient service event
2	Other non-admitted patient service event

Data element attributes

Relational attributes

Related metadata references: Supersedes Multi-disciplinary team status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)

Myocardial infarction (history)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—myocardial infarction (history), code N

METeOR identifier: 270285

Registration status: Health, Standard 01/03/2005

Definition: Whether the individual has had a myocardial infarction, as represented by a code.

Data Element Concept: Person—myocardial infarction

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Myocardial infarction - occurred in the last 12 months
	2	Myocardial infarction - occurred prior to the last 12 months
	3	Myocardial infarction - occurred both in and prior to the last 12 months
	4	No history of myocardial infarction
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods: Ask the individual if he/she has had a myocardial infarction. If so determine whether it was within or prior to the last 12 months (or both).Record if evidenced by ECG changes or plasma enzyme changes.

Alternatively obtain this information from appropriate documentation.

Source and reference attributes

Submitting organisation: National diabetes data working group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Reference documents: Long-term Results From the Diabetes and Insulin-Glucose Infusion in Acute Myocardial Infarction (DIGAMI) Study Circulation. 1999;99: 2626-2632.

Relational attributes

Related metadata references: Supersedes Myocardial infarction - history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Name context flag

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name conditional use flag, code N
Synonymous names:	Name conditional use flag
METeOR identifier:	287101
Registration status:	Community Services, Standard 25/08/2005 Health, Standard 04/05/2005
Definition:	An indicator of specific conditions that may be applied to an individual's name, as represented by a code.
Data Element Concept:	Person (name)—name conditional use flag

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Unreliable information
2	Name not for continued use
3	Special privacy/security requirement

Data element attributes

Collection and usage attributes

Guide for use:

A single Person name may have multiple Name conditional use flags associated with it. Record as many as applicable.

CODE 1 Unreliable information: should be used where it is known that the name recorded is a fictitious or partial name. These names should not be used for matching client data.

CODE 2 Name not for continued use, indicates that this name should NOT be used when referring to this person. The name is retained for identification purposes only. For Aboriginal and Torres Strait Islanders, certain tribal names may become 'not for continued use' due to the death of a relative.

CODE 3 Special privacy/security requirements– may apply to names for which episodes are attached that should only be accessible to specified authorised persons. There must be a specific need to implement this additional security level. Local policy should provide guidance to the use of this code.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Committee

National Community Services Data Committee

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references: Supersedes Person (name)—name context flag, code N Community Services, Superseded 25/08/2005, Health, Superseded 04/05/2005

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Name suffix

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person (name)—name suffix, text [A(12)]

METeOR identifier: 287164

Registration status: Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Definition: Additional term following a person's name used to identify a person when addressing them by name, whether by mail, by phone, or in person, as represented by text.

Data Element Concept: Person (name)—name suffix

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: [A(12)]

Maximum character length: 12

Collection and usage attributes

Guide for use: Valid abbreviations from the Australian Standard AS4590-1999 Interchange of client information.

Source and reference attributes

Origin: Standards Australia 1999. Australian Standard AS4590-1999 Interchange of Client Information. Sydney: Standards Australia Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Guide for use: Mixed case should be used (rather than upper case only).

Examples of name suffixes are 'Jr' for Junior and 'MP' for Member of Parliament.

Collection methods: A person's name may have multiple Name suffixes. For the purpose of positive identification of a person, each Name suffix must have an associated Name suffix sequence number recorded.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Person (name)—name suffix, text [A(12)] Community Services, Superseded 25/08/2005, Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008

Name suffix sequence number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name suffix sequence number, code N
METeOR identifier:	288226
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	The numeric order of any additional terms used at the conclusion of a name, as represented by a code.
Data Element Concept:	Person (name)—name suffix sequence number

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	First name suffix
2	Second name suffix
3	Third name suffix
4	Fourth name suffix
5	Fifth name suffix
6	Sixth name suffix
7	Seventh name suffix
8	Eighth name suffix
9	Ninth and subsequent name suffix

Data element attributes

Collection and usage attributes

Collection methods:

Multiple Name suffixes may be recorded. A Name suffix sequence number must be recorded for each Name suffix.

Example: For the name 'John Markham Jr MP', 'Jr' would have a name suffix sequence number of 1 and 'MP' would have a name suffix sequence number of 2.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008

Name title

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person (name)—name title, text [A(12)]

METeOR identifier: 287166

Registration status: Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Definition: An honorific form of address, commencing a name, used when addressing a person by name, whether by mail, by phone, or in person, as represented by text.

Data Element Concept: Person (name)—name title

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: A(12)

Maximum character length: 12

Collection and usage attributes

Guide for use: Valid abbreviations from the Australian Standard AS4590-1999 Interchange of client information.

Source and reference attributes

Origin: Standards Australia 1999. Australian Standard AS4590-1999 Interchange of Client Information. Sydney: Standards Australia

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Guide for use: Mixed case should be used (rather than upper case only).

The Name title for Master should only be used for persons less than 15 years of age.

Name titles for Doctor and Professor should only be applicable to persons of greater than 20 years of age.

More than one Name title may be recorded e.g. Prof Sir John Markham.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Committee

National Community Services Data Committee

Standards Australia 1999. Australian Standard AS4590-1999 Interchange of Client Information. Sydney: Standards Australia Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references: Supersedes Person (name)—name title, text [A(12)] Community Services, Superseded 25/08/2005, Health, Superseded 04/05/2005

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Name title sequence number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name title sequence number, code N
METeOR identifier:	288263
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	The numeric order of an honorific form of address commencing a person's name, as represented by a code.
Data Element Concept:	Person (name)—name title sequence number

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	First name title
2	Second name title
3	Third name title
4	Fourth name title
5	Fifth name title
6	Sixth name title
7	Seventh name title
8	Eighth name title
9	Ninth and subsequent name title

Data element attributes

Collection and usage attributes

Collection methods: Multiple Name titles may be recorded. For the purpose of positive identification of a person, each Name title must have a Name title sequence number recorded.

Example: Professor Sir John Markham

In the example above 'Professor' would have a name title sequence number of 1 and 'Sir' would have a name title sequence number of 2.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008

Name type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name type, code N
METeOR identifier:	287203
Registration status:	Community Services, Superseded 06/02/2012 Health, Standard 04/05/2005
Definition:	A classification that enables differentiation between recorded names for a person, as represented by a code.
Data Element Concept:	Person (name)—name type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Preferred name
2	Medicare name
3	Newborn name
4	Alias name

Data element attributes

Collection and usage attributes

Guide for use:

A person may have more than one name that they use. At least one name must be recorded for each person. Each name recorded must have one or more appropriate Person name type associated with it. Record all that are required.

One name is sufficient; however, where the person offers more than one name, clarification should be obtained from the person to ensure accurate identification of the person and recording of the various names. The currently used name, as well as names by which the person has previously been known, should be recorded if these are known.

Field value definitions for Person name type codes are:

CODE 1 Preferred name is the name by which the person chooses to be identified.
There should only be one preferred name recorded for a

person. Where the person changes their preferred name, record the previously recorded preferred name as an Alias name. Preferred name is the default name type (i.e. if only one name is recorded it should be the person's preferred name). There must be a preferred name recorded except for unnamed newborns where the newborn name is the only name recorded.

Also, if the person is a health care client, record his/her Medicare card name if different to the preferred name, and any known alias names.

CODE 2 Medicare name for a health care client, this is the person's name as it appears on their Medicare card. The name stated on the Medicare card is required for all electronic Medicare claim lodgement. If the preferred name of the person is different to the name on the Medicare card, the Medicare card name should also be recorded. For an individual health care provider, this is the person's name registered by Medicare (Health Insurance Commission).

CODE 3 Newborn name: type is reserved for the identification of unnamed newborn babies.

CODE 4 Alias name is any other name that a person is also known by, or has been known by in the past; that is, all alias names. This includes misspelt names or name variations that are to be retained as they have been used to identify this person. More than one alias name may be recorded for a person.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Committee

National Community Services Data Committee

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

In AS5017 and AS4846 alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references: Supersedes Person (name)—name type, code A Health, Superseded 04/05/2005

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard

Name type (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (name)—name type, code N
METeOR identifier:	288937
Registration status:	Community Services, Superseded 06/02/2012 Health, Standard 04/05/2005
Definition:	A classification that enables differentiation between recorded names for an establishment, agency or organisation, as represented by a code.
Data Element Concept:	Service provider organisation (name)—name type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Organisation unit/section/division
	2	Service location name
	3	Business name
	4	Locally used name
	5	Abbreviated name
	6	Enterprise name
	8	Other
Supplementary values:	9	Unknown

Collection and usage attributes

Guide for use:

CODE 1 Organisation unit/section/division

This code is used where a business unit, section or division within an organisation may have its own separate identity.

CODE 2 Service location name

This code is used where the service location name is an important part of the organisation name and is used for identification purposes, e.g. Mobile Immunisation Unit at Bankstown.

CODE 3 Business name

Business name used only for trading purposes.

CODE 4 Locally used name

This code is used where a local name is used, e.g. where a medical practice is known by a name that is different to the company registration name or business name.

CODE 5 Abbreviated name

A short name or an abbreviated name by which the organisation is known, e.g. HIC.

CODE 6 Enterprise name

Generally, the complete organisation name should be used to avoid any ambiguity in identification. This should usually be the same as company registration name.

CODE 8 Other

This code is used when the organisation name does not fit into any one of the categories listed above.

CODE 9 Unknown

This code is used when the organisation name type is unknown.

Data element attributes

Collection and usage attributes

Guide for use: At least one organisation name must be recorded for each organisation and each name must have an appropriate Organisation name type.

Relational attributes

Implementation in Data Set Specifications: Health care provider identification DSS Health, Standard 03/12/2008

Indigenous primary health care DSS Health, Standard 07/12/2011

Narrative description of injury event

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Injury event—external cause, text [X(100)]

METeOR identifier: 268946

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: A textual description of the environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect.

Data Element Concept: Injury event—external cause

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: [X(100)]

Maximum character length: 100

Data element attributes

Collection and usage attributes

Guide for use: Write a brief description of how the injury occurred. It should indicate what went wrong (the breakdown event); the mechanism by which this event led to injury; and the object(s) or substance(s) most important in the event. The type of place at which the event occurred, and the activity of the person who was injured should be indicated.

Comments: The narrative of the injury event is very important to injury control workers as it identifies features of the event not revealed by coded data.

This is a basic item for injury surveillance. The text description of the injury event is structured to indicate context, place, what went wrong and how the event resulted in injury. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Source and reference attributes

Submitting organisation: National Injury Surveillance Unit, Flinders University,

Adelaide

Relational attributes

Related metadata references: Supersedes Narrative description of injury event, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Implementation in Data Set Specifications: Injury surveillance DSS Health, Standard 14/12/2009

National standards for mental health services review status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service unit—implementation of National standards for mental health services status, code N
METeOR identifier:	287800
Registration status:	Health, Standard 08/12/2004
Definition:	The extent of progress made by a specialised mental health service unit in implementing the National Standards for Mental Health Services by or at 30 June, as represented by a code.
Data Element Concept:	Specialised mental health service unit—implementation of National standards for mental health services status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	The service unit had been reviewed by an external accreditation agency and was judged to have met the National standards
2	The service unit had been reviewed by an external accreditation agency and was judged to have met some but not all of the National standards
3	The service unit was in the process of being reviewed by an external accreditation agency but the outcomes were not known
4	The service unit was booked for review by an external accreditation agency and was engaged in self-assessment preparation prior to the formal external review
5	The service unit was engaged in self-assessment in relation to the National Standards but did not have a contractual arrangement with an external accreditation agency for review
6	The service unit had not commenced the

	preparations for review by an external accreditation agency but this was intended to be undertaken in the future
7	It had not been resolved whether the service unit would undertake review by an external accreditation agency under the National standards
8	The National standards are not applicable to this service unit

Collection and usage attributes

Guide for use:

Code 8 The National standards are not applicable to this service unit

This code should only be used for:

- non-government organisation mental health services and private hospitals (that receive some government funding to provide specialised mental health services) where implementation of National standards for mental health services has not been agreed with the relevant state or territory; or
- those aged care residential services (e.g. psychogeriatric nursing homes) in receipt of funding under the *Aged Care Act* and subject to Commonwealth residential aged care reporting and service standards requirements.

Data element attributes

Collection and usage attributes

Collection methods:

Report the review/accreditation status at 30 June for each service unit for the National standards for mental health services using the standard set of codes shown in the value domain.

For organisations that include more than one service unit the codes relating to each service should be completed. Reporting of progress at the individual service unit level recognises that parts rather than whole organisations may be implementing the standards.

NOTE: for admitted patient setting only, these data need to be disaggregated by specialised mental health service program type and specialised mental health service target population.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Nature of main injury (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—nature of main injury, non-admitted patient code NN{.N}
METeOR identifier:	268947
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The nature of the injury chiefly responsible for the attendance of the non-admitted patient at the health care facility, at represented by a code.
Data Element Concept:	Injury event—nature of main injury

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN{.N}
Maximum character length:	4

Permissible values:

Value	Meaning
01	Superficial (excludes eye injury code 13)
02	Open wound (excludes eye injury code 13)
03	Fracture (excludes dental injury code 21)
04	Dislocation (includes ruptured disc, cartilage, ligament)
05	Sprain or strain
06	Injury to nerve (includes spinal cord; excludes intracranial injury code 20)
07	Injury to blood vessel
08	Injury to muscle or tendon
09	Crushing injury
10	Traumatic amputation (includes partial amputation)
11	Injury to internal organ
12	Burn or corrosion (excludes eye injury code 13)

13	Eye injury (includes burns, excludes foreign body in external eye code 14.1)
14.1	Foreign body in external eye
14.2	Foreign body in ear canal
14.3	Foreign body in nose
14.4	Foreign body in respiratory tract (excludes foreign body in nose code 14.3)
14.5	Foreign body in alimentary tract
14.6	Foreign body in genitourinary tract
14.7	Foreign body in soft tissue
14.9	Foreign body, other/unspecified
20	Intracranial injury (includes concussion)
21	Dental injury (includes fractured tooth)
22	Drowning, immersion
23	Asphyxia or other threat to breathing (excludes drowning immersion code 22)
24	Electrical injury
25	Poisoning, toxic effect (excludes effect of venom, or any insect bite code 26)
26	Effect of venom, or any insect bite
27	Other specified nature of injury
28	Injury of unspecified nature
29	Multiple injuries of more than one 'nature'
30	No injury detected

Data element attributes

Collection and usage attributes

Guide for use:

If the full ICD-10-AM code is used to code the injury, this metadata item is not required (see metadata items principal diagnosis and additional diagnosis) When coding to the full ICD-10-AM code is not possible, use this metadata item with the items external cause of injury-non admitted patient, external cause of injury-human intent and bodily location of main injury.

Select the code which best characterises the nature of the injury chiefly responsible for the attendance, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. A major injury, if present, should always be coded rather than a minor injury. If a major injury has been sustained (e.g. a fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding 'multiple injuries'. As a general guide, an injury which, on its own, would be unlikely to have led to the attendance may be regarded as 'minor'.

If the nature of the injury code is 01 to 12 or 26 to 29 then the metadata item Bodily location of main injury should be used to record the bodily location of the injury. If another code is used, bodily location is implicit or meaningless. Bodily location of main injury, category 22 may be used as a filler to indicate that specific body region is not required.

Comments: Injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. This metadata item together with the metadata item bodily location of the main injury indicates the diagnosis.

This metadata item is related to the ICD-10-AM injury and poisoning classification. However, coding to the full ICD-10-AM injury and poisoning classification (see metadata item principal diagnosis) is not available in most settings where basic injury surveillance is undertaken. This item, in combination with the metadata item Bodily location of main injury, is a practicable alternative. Data coded to the full ICD-10-AM codes can be aggregated to match this item, facilitating data comparison. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Source and reference attributes

Submitting organisation: National Injury Surveillance Unit, Flinders University, Adelaide

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: Supersedes Nature of main injury - non-admitted patient, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.3 KB)

See also Person—bodily location of main injury, code NN Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Implementation in Data Set Specifications: Injury surveillance DSS Health, Standard 14/12/2009

Neo-adjuvant therapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—neoadjuvant therapy indicator, code N
METeOR identifier:	370014
Registration status:	Health, Standard 06/03/2009
Definition:	Whether a person with a solid tumour has received neoadjuvant therapy, as represented by a code.
Data Element Concept:	Person with cancer—neoadjuvant therapy indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

To be reported when therapy is received after a diagnosis of cancer and prior to primary surgical treatment.

This data item is used to flag cases in which tumour descriptors, for example solid tumour size, may be inaccurate due to shrinkage from neoadjuvant therapy.

Yes - indicates that the client has received neo-adjuvant therapy after a diagnosis of cancer and prior to primary surgical treatment

No - indicates that the client did not receive neo-adjuvant therapy after a diagnosis of cancer and prior to primary surgical treatment

For invasive breast cancer:

Information is obtained from

- Clinical notes on pathology report mentions that patient underwent chemotherapy prior to surgery
- Microscopy section of pathology report describes tumour changes as a result of neoadjuvant therapy (coder may be

alerted to look for this detail by a long interval between biopsy and wider excision)

- Hospital notification indicates that admission if for chemotherapy only (and admission date is before that for surgery)

Comments: Preoperative chemotherapy and/or radiotherapy may be received after a diagnosis of cancer but before surgical treatment.

The effects of chemotherapy and/or radiotherapy prior to surgery will shrink the tumour and so the size of the tumour found from the subsequent surgical excision will be smaller than the original size of the tumour at the time of diagnosis. This impacts on the TNM-T and staging classification, and is important to take into account for analysis and research.

Source and reference attributes

Origin: National Breast and Ovarian Cancer Centre (NBOCC)
Australasian Association of Cancer Registries (AACR)
Australian Institute of Health and Welfare (AIHW)

Reference documents: Johnson CH, Adamo M (eds.), SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007.

Relational attributes

Implementation in Data Set Specifications: Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Neonatal morbidity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Admitted patient (neonate)—neonatal morbidity, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391332
Registration status:	Health, Standard 22/12/2009
Definition:	Conditions or diseases of the baby, as represented by an ICD-10-AM code.
Data Element Concept:	Admitted patient (neonate)—neonatal morbidity

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Conditions should be coded within chapter of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

Guide for use:	There is no arbitrary limit on the number of conditions specified.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Admitted patient (neonate)—neonatal morbidity, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Net capital expenditure (accrual accounting)—buildings and building services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (buildings and building services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	269969
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on buildings and building services (including plant).
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (buildings and building services)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Net capital expenditure (accrual accounting)—constructions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (constructions) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270531
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on constructions (other than buildings).
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (constructions)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Net capital expenditure (accrual accounting)—equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270534
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on equipment.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Net capital expenditure (accrual accounting)—information technology

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (information technology) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270529
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on information technology.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (information technology)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Net capital expenditure (accrual accounting)—intangible assets

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—net capital expenditure (accrual accounting) (intangible assets) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270535

Registration status: Health, Standard 01/03/2005

Definition: Net capital expenditure, measured in Australian dollars, on intangible assets.

Data Element Concept: Establishment—net capital expenditure (accrual accounting) (intangible assets)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Round to nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Net capital expenditure (accrual accounting)—land

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (land) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270536
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on land.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (land)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Net capital expenditure (accrual accounting)—major medical equipment

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—net capital expenditure (accrual accounting) (major medical equipment) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270530

Registration status: Health, Standard 01/03/2005

Definition: Net capital expenditure, measured in Australian dollars, on major medical equipment.

Data Element Concept: Establishment—net capital expenditure (accrual accounting) (major medical equipment)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Round to nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Net capital expenditure (accrual accounting)—other equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (other equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270533
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on other equipment, such as furniture, art objects, professional instruments and containers.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (other equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Net capital expenditure (accrual accounting)—transport

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (transport) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270532
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure measured in Australian dollars on transport.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (transport)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

New/repeat status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—new/repeat status, code N
METeOR identifier:	270348
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a non-admitted patient service event is for a new problem not previously addressed at the same clinical service or for a repeat service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—new/repeat service event status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	New non-admitted patient service event
2	Repeat non-admitted patient service event

Collection and usage attributes

Guide for use:

CODE 1 New non-admitted patient service event:

New service events occur as each type of clinical service makes their full assessment consultation with the patient.

CODE 2 Repeat non-admitted patient service event:

Repeat visits include completion of an ambulatory procedure e.g. removal of sutures and removal of plaster casts.

Data element attributes

Relational attributes

Related metadata references: Supersedes New/repeat status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Non-Australian state/province (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—non-Australian state/province, text [X(40)]
Synonymous names:	International state/province
METeOR identifier:	288648
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country that is associated with the address of a person, as represented by text.
Data Element Concept:	Person (address)—non-Australian state/province

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The name of the state or territory or province should be recorded using the standard ASCII character set and should be done so in accordance with the official conventions of the country, for example, Hunan rather than Chinese characters.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare Standard Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 03/12/2008 Health care provider identification DSS Health, Standard

Non-Australian state/province (service provider organisation)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Service provider organisation (address)—non-Australian state/province, text [X(40)]

METeOR identifier: 288636

Registration status: Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Definition: The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country that is associated with the address of an establishment, as represented by text.

Data Element Concept: Service provider organisation (address)—non-Australian state/province

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: [X(40)]

Maximum character length: 40

Data element attributes

Collection and usage attributes

Guide for use: The name of the state or territory or province should be recorded using the standard ASCII character set and should be done so in accordance with the official conventions of the country.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Health care provider identification DSS Health, Standard

Specifications:	03/12/2008

Non-government non-profit indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—non-government non-profit indicator, yes/no code N
METeOR identifier:	378745
Registration status:	Health, Standard 01/12/2010
Definition:	An indicator of whether a specialised mental health service is operated as part of a non-government non-profit entity, as represented by a code.
Data Element Concept:	Specialised mental health service—non-government non-profit indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used to differentiate between services that receive some government funding but are run by the non-government non-profit sector (code 1) and other services (code 2).

CODE 1 is to be used when the service is managed by an organisation that:

- is not controlled by government, and is either,

- an income tax exempt charity; and/or
- does not distribute any profits to members or external parties.

CODE 2 is to be used for all other services.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Non-instrumented bleeding location

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—bleeding location, non-instrumented code N(N)
Synonymous names:	Non-instrumented bleeding site
METeOR identifier:	372012
Registration status:	Health, Standard 01/10/2008
Definition:	The location of the person's bleeding episode, arising from a non-instrumented site, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—bleeding location

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

	Value	Meaning
Permissible values:	1	Gastrointestinal site
	2	Genitourinary site
	3	Intracranial site
	4	Pulmonary site
	5	Pericardial site
	6	Other site(s)
	7	Unidentified site
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

NOTE: Excludes bleeding arising from instrumented sites.

CODE 1 Gastrointestinal site

Use this code when the person's spontaneous bleeding is originating from the gastrointestinal area.

CODE 2 Genitourinary site

Use this code when the person's spontaneous bleeding is originating from the genitourinary area.

CODE 3 Intracranial site

Use this code when the person's spontaneous bleeding is originating from an intracranial site.

CODE 4 Pulmonary site

Use this code when the person's spontaneous bleeding is originating from a pulmonary site.

CODE 5 Pericardial site

Use this code when the person's spontaneous bleeding is originating from the pericardium.

CODE 6 Other site(s)

Use this code when the person's spontaneous bleeding is originating from a site not listed in codes 1-5.

CODE 7 Unidentified site

Use this code when the person has a fall in haemoglobin without an identifiable spontaneous site of bleeding.

CODE 99 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: Record the location of all bleeding events that occur. More than one code can be applied.

Relational attributes

Related metadata references: See also Person with acute coronary syndrome—bleeding location, instrumented code N(N) Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Non-school qualification indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—non-school qualification indicator, yes/no/not stated/inadequately described code N

Synonymous names: Level of education

METeOR identifier: 376009

Registration status: Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Definition: An indicator of whether a person has attained a non-school qualification, as represented by a code.

Data Element Concept: Person—non-school qualification indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data element: *Person—highest level of non-school qualification, code N* to provide information on the highest level of non-school qualification that a person has attained.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Education variables. ABS cat. no. 1246.0. Canberra: ABS

Relational attributes

Related metadata references: See also Person—level of highest non-school qualification, code N Community Services, Standard 06/02/2012, Health, Standard 25/08/2011

Implementation in Data Set Specifications: Non-school qualification cluster Health, Standard 25/08/2011

Number of caesarean sections

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of caesarean sections, total count N[N]
METeOR identifier:	297820
Registration status:	Health, Standard 29/11/2006
Definition:	The total number of previous caesarean sections performed on the woman.
Data Element Concept:	Female—number of caesarean sections

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/Inadequately described
Unit of measure:	Caesarean sections	

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use:

In the case of multiple births, count the number of operations the mother has had, rather than the number of babies born.

Exclude the current birth if by caesarean section.

Record as 0 if no previous caesarean sections.

Comments:

Previous caesarean sections are associated with a higher risk of obstetric complications, and when used with other indicators provides important information on the quality of obstetric care.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Number of clients receiving services

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service—number of clients receiving services, total NNNNNN

METeOR identifier: 425401

Registration status: Health, Standard 07/12/2011

Definition: The total number of people or clients who received services provided by an **ambulatory mental health care service** unit.

Data Element Concept: Specialised mental health service—number of clients receiving services

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: NNNNNN

Maximum character length: 6

Unit of measure: Person

Data element attributes

Collection and usage attributes

Guide for use: The total number of clients is reported by ambulatory mental health care service units to the Mental health establishments NMDS. The total should be a count of uniquely identifiable individuals at the service unit level, regardless of the registration status of the client, who are reported to the Community mental health care NMDS.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Number of contacts—psychiatric outpatient clinic/day program

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—number of psychiatric outpatient clinic/day program attendances (financial year), total days N[NN]
METeOR identifier:	270121
Registration status:	Health, Standard 01/03/2005
Definition:	Number of days that a patient attended a psychiatric outpatient clinic or a day program during the relevant financial year.
Data Element Concept:	Patient—number of psychiatric outpatient clinic/day program attendances

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Collection methods:

All States and Territories where there are public psychiatric hospitals also collect date of contact, and number of contacts during the financial year can be derived from this. (Collection status for New South Wales is unknown at time of writing.)

Comments:

This metadata item gives a measure of the level of service provided.

In December 1998, the National Health Information Management Group decided that the new version of this metadata item (named Person—number of service contact dates, total N[NN]) would be implemented from 1 July 2000 in the Community Mental Health National Minimum Data Set (NMDS). Until then agencies involved in the Community mental health NMDS may report either Patient—number of psychiatric outpatient clinic/day program attendances (financial year), total days N[NN] or

Person—number of service contact dates, total N[NN] with the expectation that agencies will make their best efforts to report against the new version of this metadata item (Person—number of service contact dates, total N[NN]) from 1 July 1999.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Number of contacts (psychiatric outpatient clinic/day program), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Number of coronary artery lesions attempted

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—count of coronary artery lesions attempted, total number N[N]
METeOR identifier:	344404
Registration status:	Health, Standard 01/10/2008
Definition:	A count of number of a person's coronary artery lesions into which an attempt was made to pass a percutaneous coronary intervention (PCI) guidewire.
Data Element Concept:	Person—count of coronary artery lesions attempted

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Record the total number of lesions into which an attempt was made to pass a PCI guidewire during a single given PCI procedure, whether they were successful or not.

The number of lesions attempted should be reported for each PCI performed.

The value '99' is not for use in primary data collections.

Collection methods:

The number of lesions attempted should be recorded from the angioplasty report.

Relational attributes

Implementation in Data Set Specifications:

Coronary artery cluster Health, Standard 01/10/2008

Conditional obligation:

Record when a percutaneous coronary intervention is performed.

Number of coronary artery lesions successfully dilated

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—count of coronary artery lesions successfully dilated, total number N[N]
METeOR identifier:	344411
Registration status:	Health, Standard 01/10/2008
Definition:	The number of a person's coronary artery lesions successfully dilated.
Data Element Concept:	Person—count of coronary artery lesions successfully dilated

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

The number of lesions successfully dilated should be recorded for each percutaneous coronary intervention (PCI) performed.

Successful dilation is where:

- residual stenosis is less than 10% following coronary stenting; OR
- residual stenosis is less than 50% after balloon angioplasty alone.

The value '99' is not for use in primary data collections.

Collection methods:

The number of lesions successfully dilated should be recorded from the angioplasty report.

Relational attributes

Implementation in Data Set Specifications:

Coronary artery cluster Health, Standard 01/10/2008

Conditional obligation:
Record when a percutaneous coronary intervention is performed.

Number of coronary artery stents

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—count of coronary artery stents, total number N[N]
METeOR identifier:	344417
Registration status:	Health, Standard 01/10/2008
Definition:	The number of stents placed during a person's angioplasty procedure.
Data Element Concept:	Person—count of coronary artery stents

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: The value '99' is not for use in primary data collections.

Collection methods: Record the total number of coronary stents placed during the entire angioplasty procedure, regardless of the number of individual lesions.

Relational attributes

Implementation in Data Set Specifications: Coronary artery cluster Health, Standard 01/10/2008

Conditional obligation:

Record when a percutaneous coronary intervention with stent implantation (bare metal stent or drug eluting stent) is performed.

Number of days in special/neonatal intensive care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (special/neonatal intensive care), total days N[NN]
METeOR identifier:	270057
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of days spent by a neonate in a special care or neonatal intensive care nursery (in the hospital of birth).
Data Element Concept:	Episode of admitted patient care—length of stay (special/neonatal intensive care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

The number of days is calculated from the date the baby left the special/neonatal **intensive care unit** minus the date the baby was admitted to the special/neonatal intensive care unit.

Collection methods:

This item is to be completed if baby has been treated in an intensive care unit or a special care nursery (SCN).

Comments:

An indicator of the requirements for hospital care of high-risk babies in specialised nurseries that add to costs because of extra staffing and facilities.

SCN are staffed and equipped to provide a full range of neonatal services for the majority of complicated neonatal problems, including short-term assisted ventilation and intravenous therapy.

Neonatal intensive care nurseries (NICN) are staffed and equipped to treat critically ill newborn babies including those requiring prolonged assisted respiratory support, intravenous therapy, and alimentation and treatment of serious infections. Full supportive services are readily available throughout the hospital. These NICN also provide consultative services to other hospitals.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Number of days in special / neonatal intensive care, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Number of days of hospital-in-the-home care

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of admitted patient care—number of days of hospital-in-the-home care, total {N[NN]}

METeOR identifier: 270305

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: The number of **hospital-in-the-home** days occurring within an episode of care for an admitted patient.

Data Element Concept: Episode of admitted patient care—number of days of hospital-in-the-home care

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: {N[NN]}

Maximum character length: 3

Unit of measure: Day

Data element attributes

Collection and usage attributes

Guide for use: The rules for calculating the number of **hospital-in-the-home** days are outlined below:

- The number of hospital-in-the-home days is calculated with reference to the date of admission, date of separation, leave days and any date(s) of change between hospital and home accommodation;
- The date of admission is counted if the patient was at home at the end of the day;
- The date of change between hospital and home accommodation is counted if the patient was at home at the end of the day;
- The date of separation is not counted, even if the patient was at home at the end of the day;
- The normal rules for calculation of patient days apply, for example in relation to leave and same day patients.

Comments: Number of days of hospital-in-the-home care data will be collected from all states and territories except Western

Australia from 1 July 2001. Western Australia will begin to collect data from a later date.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Number of days of hospital-in-the-home care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.0 KB)

Implementation in Data Set Specifications: Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Number of doses of vaccines administered in a prison

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (prison)—number of vaccine doses administered, number N[NN]
METeOR identifier:	411925
Registration status:	Health, Standard 25/08/2011
Definition:	The total number of doses of vaccines administered in a prison.
Data Element Concept:	Establishment (prison)—number of vaccine doses administered

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	National Health and Medical Research Council 2008. The Australian Immunisation Handbook (9th edn). Canberra: Department of Health and Ageing.

Relational attributes

Related metadata references:	See also Establishment (prison)—type of vaccine administered, vaccine type, code N Health, Standard 25/08/2011
Implementation in Data Set Specifications:	Vaccines administered cluster Health, Standard 25/08/2011

Number of episodes of angina in last 24 hours

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—angina episodes count (24 hours preceding hospital presentation), total number NN[N]
METeOR identifier:	338293
Registration status:	Health, Standard 01/10/2008
Definition:	The number of angina episodes experienced by a person in the 24 hours preceding presentation to the hospital, including the current episode.
Data Element Concept:	Person—count of angina episodes

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Is the total number of distinct episodes of anginal pain that occurred in the 24 hours preceding presentation to the hospital, including the current episode for which the person presented to hospital.

An episode of angina may include chest pain (which may spread to either or both shoulders, the back, neck, jaws or down the arm) or overwhelming shortness of breath.

Collection methods:

Ask the individual how many distinct episodes of anginal pain he/she experienced in the 24 hours preceding presentation to hospital, including the current episode. Alternatively, if available, obtain this information from appropriate documentation.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Number of episodes of residential care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—number of episodes of residential care, total NNNN
METeOR identifier:	417667
Registration status:	Health, Standard 07/12/2011
Definition:	The total number of episodes of completed residential care occurring during the reference period (between 1 July and 30 June each year). This includes both formal and statistical episodes of residential care.
Data Element Concept:	Episode of residential care—number of episodes of residential care

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use:

The sum of the number of episodes of residential care where the Episode of residential care end date has a value:

- Equal to or greater than the beginning of the reference period (01 July each year); and
- Less than or equal to the end of the reference period (30 June each year at midnight).

Collection methods:

To be reported for all specialised residential mental health care services, including non-government residential mental health care services and

Relational attributes

Related metadata references:

Supersedes Episode of residential care—number of episodes of residential care, total N[NNN] Health, Superseded 07/12/2011

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Number of full-time equivalent prison staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (prison)—full-time equivalent staff, total number N[N]
METeOR identifier:	413019
Registration status:	Health, Standard 25/08/2011
Definition:	The total number of full-time equivalent staff working in a prison.
Data Element Concept:	Establishment (prison)—full-time equivalent staff

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Full-time equivalent prison staff cluster Health, Standard 25/08/2011

Number of group sessions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group sessions, total N[NNNNN]
Synonymous names:	Group occasions of service
METeOR identifier:	336900
Registration status:	Health, Standard 04/07/2007
Definition:	The total number of groups of patients receiving services. Each group is to be counted once, irrespective of the size of the group of patients or the number of staff providing services.
Data Element Concept:	Establishment—number of group sessions

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

A group is defined as two or more patients receiving the same services at the same time from the same hospital staff at the same clinics.

The following guides for use apply:

- a group session is counted only for two or more patients attending in the capacity of patients in their own right, even if other non-patient persons are present for the service.
- Spouses, parents or carers attending the session are counted for the group session only if they are also participating in the service as a patient.
- A group session is counted for staff attending clinics only if they are attending as a patient in their own right. Staff training and education is excluded.
- A group session may be delivered by more than one provider. A group session is counted for two or more

patients receiving the same services, even if more than one provider delivers that service simultaneously.

- Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services. Patients attending education sessions at chemotherapy or dialysis clinics are counted as group sessions, if two or more people are receiving the same services at the same time.

Collection methods: Where a patient receives multidisciplinary care within one booked clinic appointment as part of a group, one group session shall be recorded, regardless of the number of providers involved. For example, if a group session is jointly delivered by a physiotherapist and an occupational therapist, one group session is counted for the patients attending that session.

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Party, 2006

Relational attributes

Related metadata references: Supersedes Establishment—number of group sessions, total N[NNNNN] Health, Superseded 04/07/2007

Implementation in Data Set Specifications: Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Number of hospital transfers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (prison)—number of hospital transfers, number N[NN]
METeOR identifier:	412984
Registration status:	Health, Standard 25/08/2011
Definition:	The total number of transfers from prison to a community-based hospital.
Data Element Concept:	Establishment (prison)—number of hospital transfers

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Establishment (prison)—planned hospital transfer indicator, yes/no code N Health, Standard 25/08/2011
Implementation in Data Set Specifications:	Hospital transfer cluster Health, Standard 25/08/2011

Number of leave periods

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of admitted patient care—number of leave periods, total N[N]

METeOR identifier: 270058

Registration status: Health, Standard 01/03/2005

Definition: Number of leave periods in a hospital stay (excluding one-day leave periods for admitted patients).

Data Element Concept: Episode of admitted patient care—number of leave periods

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[N]

Maximum character length: 2

Unit of measure: Period

Data element attributes

Collection and usage attributes

Guide for use: If the period of leave is greater than seven days or the patient fails to return from leave, the patient is discharged.

Comments: Recording of leave periods allows for the calculation of patient days excluding leave. This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and **separation** rates, particularly for long-stay patients who may have several leave periods.

This data element was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients at the instigation of the National Mental Health Strategy Committee.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN]

Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Supersedes Number of leave periods, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)

Number of occasions of service

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—number of occasions of service, total N[NNNNNN]

Synonymous names: Individual occasions of service

METeOR identifier: 336947

Registration status: Health, Standard 04/07/2007

Definition: The total number of occasions of examination, consultation, treatment or other service provided to a patient.

Data Element Concept: Establishment—number of occasions of service

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNNN]

Maximum character length: 7

Unit of measure: Occasion of service

Data element attributes

Collection and usage attributes

Guide for use: The following guides for use apply:

- an occasion of service is counted for each person attending in the capacity of a patient in their own right, even if other non-patient persons are present for the service.
- spouses, parents or carers attending the session are only counted if they are also participating in the service as a patient.
- in the instance of a dependent child presenting to a clinic, the session is counted as a single Occasion of Service provided to the individual child for whom an event history is being recorded. Where parents/carers also attend in the capacity of patients themselves within a booked appointment, and receive the same services at the same time, the child and parent/carer can be counted as a group. In this instance a Group Session count would be recorded.
- An occasion of service is counted for staff attending

clinics of public hospitals only if they are attending as patients in their own right. Staff education and training is excluded.

- Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services. Patients attending education sessions at chemotherapy or dialysis clinics are counted as group sessions, if two or more people receiving the same services at the same time.

Collection methods:

- Where a patient receives the occasion of service is counted at the clinic of the public hospital where the patient is booked.
- Where a patient receives multidisciplinary care, within one booked clinic appointment by themselves, one occasion of service shall be recorded, regardless of the number of providers involved.
- Where patients have received more than one booked appointment, each appointment will be counted as one occasion of service. (Example: three booked appointments with all services provided on a single day will be counted as three occasions of service).
- The occasion of service count should be attributed to the clinic type associated with the booked appointment.
- Services to individual patients should be counted separately from services to groups of patients. An occasion of service is counted only for a service provided to an individual. Group sessions are reported separately under 'Establishment - number of group sessions total N[NNNNNN]'.

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Party, 2006

Relational attributes

Related metadata references: Supersedes Establishment—number of occasions of service, total N[NNNNNN] Health, Superseded 04/07/2007

See also Establishment—outpatient clinic type, code N[N] Health, Standard 04/07/2007

Implementation in Data Set Specifications: Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Number of positive sentinel lymph nodes

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—number of positive sentinel lymph nodes, total code N[N]
METeOR identifier:	370549
Registration status:	Health, Standard 06/03/2009
Definition:	The total number of sentinel lymph nodes reported as containing tumour after examination by a pathologist.
Data Element Concept:	Person with cancer—number of positive sentinel lymph nodes

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
997	Number of lymph nodes unknown

Data element attributes

Collection and usage attributes

Collection methods:	For cancer registries: Collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.
Comments:	Sentinel lymph nodes are the first nodes that filter fluid draining away from the area of cancer. The number of lymph nodes with metastasis is important for cancer staging

Source and reference attributes

Origin:	National Breast and Ovarian Cancer Centre (NBOCC) Australasian Association of Cancer Registries (AACR) Australian Institute of Health and Welfare (AIHW)
Reference documents:	Johnson CH, Adamo M (eds.), SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007.

Relational attributes

Implementation in Data Set Specifications:	Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Number of pregnant prisoners

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (prison)—number of pregnant prisoners, number N[NN]
METeOR identifier:	365492
Registration status:	Health, Standard 25/08/2011
Definition:	The total number of prisoners who were pregnant within a prison anytime over a specified 12 month period.
Data Element Concept:	Establishment (prison)—number of pregnant prisoners

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:	Pregnancy includes babies which were carried full term, abortions and miscarriages.
Comments:	Imprisonment may place pregnant women and their unborn child at increased health risk due to prison-related stressors. Alternatively, it may enhance pregnancy outcomes for women from disadvantaged backgrounds as it provides shelter, regular meals and medical care (Scott & Gerbasi 2005).

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	Scott C & Gerbasi J 2005. Handbook of correctional mental health. Virginia: American Psychiatric Publishing.

Relational attributes

Implementation in Data Set Specifications:	Prison establishments DSS Health, Standard 25/08/2011 *Conditional obligation:* Conditional on a prison housing female prisoners.

Number of prison entrants

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (prison)—number of prison entrants, number N[NN]
METeOR identifier:	376420
Registration status:	Health, Standard 25/08/2011
Definition:	The total number of prison entrants into a prison.
Data Element Concept:	Establishment (prison)—number of prison entrants

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:	This data element should be used in conjunction with the data element: *Person—sex, code N* to determine the number and sex of prison entrants into a prison during the National Prisoner Health Census period.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Sex of prison entrants cluster Health, Standard 25/08/2011

Number of prisoners released

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (prison)—number of prisoners released, number N[NN]
METeOR identifier:	410463
Registration status:	Health, Standard 25/08/2011
Definition:	The total number of prisoners released from a prison.
Data Element Concept:	Establishment (prison)—number of prisoners released

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:	Prisoners who are transferred to another prison are excluded. This data element is used in conjunction with the data elements: *Person—prisoner health discharge summary indicator, yes/no code N* and *Person—legal status of prisoner, code N* to determine the proportion of remand and sentenced prisoners released from a prison during the National Prisoner Health Census period who have a health-related discharge summary on their file at the time of their release.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Person—legal status of prisoner, code N Health, Standard 25/08/2011 See also Person—prisoner health discharge summary indicator, yes/no code N Health, Standard 25/08/2011
Implementation in Data Set Specifications:	Prisoner health discharge summary cluster Health, Standard 25/08/2011

Number of qualified days for newborns

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care (newborn)—number of qualified days, total N[NNNN]
METeOR identifier:	270033
Registration status:	Health, Standard 01/03/2005
Definition:	The number of qualified newborn days occurring within a newborn episode of care.
Data Element Concept:	Episode of admitted patient care (newborn)—number of qualified days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN]
Maximum character length:	5
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

The rules for calculating the number of qualified newborn days are outlined below. The number of qualified days is calculated with reference to the Episode of admitted patient care—admission date, DDMMYYYY, Episode of admitted patient care—separation date, DDMMYYYY and any Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY:

- the date of admission is counted if the patient was qualified at the end of the day
- the date of change to qualification status is counted if the patient was qualified at the end of the day
- the date of separation is not counted, even if the patient was qualified on that day
- the normal rules for calculation of patient days apply, for example in relation to leave and same day patients

The length of stay for a newborn episode of care is equal to the sum of the qualified and unqualified days.

Relational attributes

Related metadata references:

Is formed using Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY Health, Standard 01/03/2005

Is used in the formation of Establishment—number of patient days, total N[N(7)] Health, Standard 01/03/2005

Supersedes Number of qualified days for newborns, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Number of regional lymph nodes examined

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—number of regional lymph nodes examined, total N[N]
METeOR identifier:	415971
Registration status:	Health, Standard 07/12/2011
Definition:	The total number of regional lymph nodes examined by a pathologist in a person with cancer.
Data Element Concept:	Person with cancer—number of regional lymph nodes examined

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

A list of which lymph nodes are defined as regional lymph nodes for each cancer site may be found in the current edition of the TNM Classification of Tumours, UICC (International Union Against Cancer) or the AJCC (American Joint Committee on Cancer) Cancer Staging Manual.

The number includes all nodes examined regardless of whether they were removed and examined at a single or multiple procedures. For example, for breast cancer, record the sum of regional lymph nodes examined from node sampling, sentinel node biopsy and axillary clearance.

The number of regional lymph nodes is cumulative from all procedures that removed lymph nodes through the completion of surgeries for the initial treatment of the cancer. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

Breast cancer:

Regional lymph nodes include all ipsilateral axillary nodes (levels 1, 2 and 3), ipsilateral internal mammary nodes, supraclavicular nodes and intramammary lymph nodes. All other nodes (including contralateral axillary, contralateral internal mammary nodes and cervical nodes) are considered to be distant metastases and should not be recorded in this data item. Definitions are from the UICC TNM Classification of Malignant Tumours, 7th Edition.

Collection methods: For cancer registries, collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.

Source and reference attributes

Origin: Australian Cancer Network

Commission on Cancer American College of Surgeons

Reference documents: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II, Commission on Cancer

American Joint Committee on Cancer 2010. AJCC Cancer Staging Manual, 7th edition. New York: Springer

Australian Cancer Network & National Breast and Ovarian Cancer Network 2001. The pathology reporting of breast cancer: A guide for pathologists, surgeons, radiologists and oncologists, 3rd edition. Sydney: Australian Cancer Network & National Breast and Ovarian Cancer Network

Johnson CH & Adamo M (Editors) 2007. SEER Program Coding and Staging Manual 2007, MD 2008 revision. Bethesda: National Cancer Institute, NIH Publication number 07-5581

Sobin LH, Gospodarowicz MK, Wittekind C (Editors) 2009. International Union Against Cancer (UICC): TNM Classification of Malignant Tumours, 7th edition. Wiley-Blackwell

Relational attributes

Related metadata references: See also Person with cancer—number of positive regional lymph nodes, total N[N] Health, Standard 07/12/2011

Supersedes Person with cancer—number of regional lymph nodes examined, total code N[N] Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:

Conditional on the regional lymph nodes being excised and examined by a pathologist.

Number of sentinel lymph nodes examined

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—number of sentinel lymph nodes examined, total code N[N]
METeOR identifier:	370558
Registration status:	Health, Standard 06/03/2009
Definition:	The total number of a person's sentinel lymph nodes examined by the pathologist.
Data Element Concept:	Person with cancer—number of sentinel lymph nodes examined

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
997	Number of lymph nodes unknown

Data element attributes

Collection and usage attributes

Collection methods:	For cancer registries, collection of this data item should only be from pathology reports relating to initial diagnosis and not for recurrent or metastatic tumour.
Comments:	Sentinel lymph nodes are the first nodes that filter fluid draining away from the area of cancer. The presence of cancer cells in the lymph nodes indicates that cancer cells have already spread outside the primary site and may have spread to other areas of the body. This is important for cancer staging and treatment options.

Source and reference attributes

Origin:	National Breast and Ovarian Cancer Centre (NBOCC) Australasian Association of Cancer Registries (AACR) Australian Institute of Health and Welfare (AIHW)
Reference documents:	Johnson CH, Adamo M (eds.), SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH

Publication number 07-5581, Bethesda, MD 2007.

Relational attributes

Implementation in Data Set Specifications:	Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Number of service contact dates

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—number of service contact dates, total N[NN]

METeOR identifier: 270231

Registration status: Health, Standard 01/03/2005

Definition: The total number of dates where a service contact was recorded for the patient/client.

Data Element Concept: Person—number of service contact dates

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NN]

Maximum character length: 3

Unit of measure: Service contact date

Data element attributes

Collection and usage attributes

Guide for use: This metadata item is a count of service contact dates recorded on a patient or client record. Where multiple service contacts occur on the same date, the date is counted only once.

For collection from community-based (ambulatory and non-residential) agencies. Includes mental health day programs and psychiatric outpatients.

Comments: This metadata item gives a measure of the level of service provided to a patient/client.

Source and reference attributes

Submitting organisation: National Mental Health Information Strategy Committee

Relational attributes

Related metadata references: Supersedes Number of service contact dates, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Is formed using Service contact—service contact date, DDMMYYYY Health, Standard 01/03/2005

Number of service contacts

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—number of service contacts, total NNNNNN
METeOR identifier:	427098
Registration status:	Health, Standard 07/12/2011
Definition:	The total number of service contacts provided to individual patients or clients by an **ambulatory mental health care service**.
Data Element Concept:	Specialised mental health service—number of service contacts

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNNNN
Maximum character length:	6
Unit of measure:	Service contact

Data element attributes

Collection and usage attributes

Guide for use:

The total number of mental health service contacts is reported by ambulatory mental health care service units to the Mental Health Establishments NMDS. The total should be a count of contacts at the service unit level, regardless of the registration status of the client.

Each patient or client attending a group contact should be counted individually. For example, ten consumers in a group contact equates to ten contacts.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Mental health service contact Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012
Implementation end date: 30/06/2013

Number of service contacts within a treatment episode for alcohol and other drug

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—number of service contacts, total N[NN]
METeOR identifier:	270117
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of service contacts recorded between a client and the service provider within a treatment episode for the purpose of providing alcohol and other drug treatment.
Data Element Concept:	Episode of treatment for alcohol and other drugs—number of service contacts

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Service contact

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item is a count of service contacts related to treatment that are recorded on a client record. Any client contact that does not constitute part of a treatment should not be considered a service contact. Contact with the client for administrative purposes, such as arranging an appointment, should not be included. This item is not collected for residential clients. Where multiple service provider staff have contact with the client at the same time, on the same occasion of service, the contact is counted only once. When multiple service contacts are recorded on the same day, each independent contact should be counted separately.
Collection methods:	To be collated at the close of a treatment episode.

Comments: This metadata item provides a measure of the frequency of client contact and service utilisation within a treatment episode.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Number of service contacts within a treatment episode for alcohol and other drug, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Number of service events (non-admitted patient)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—number of non-admitted patient service events, total N[NNNNNN]

Synonymous names: Non-admitted patient service event count

METeOR identifier: 270108

Registration status: Health, Standard 01/03/2005

Definition: The total number of service events provided to non-admitted patients in the reference period, for each of the clinical service types in the hospital.

Data Element Concept: Establishment—number of non-admitted patient service events

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNNNN]

Maximum character length: 7

Unit of measure: Service event

Data element attributes

Collection and usage attributes

Guide for use: Count of non-admitted patient service events for each of the clinical service types listed in the value domain of the metadata item Non-admitted patient service event—service event type (clinical), code N[N].

For each Non-admitted patient service event count, specify the

- Non-admitted patient service event—service event type (clinical), code N[N]
- Non-admitted patient service event—multi-disciplinary team status, code N
- Service contact—group session status, individual/group session indicator code ANN.N
- Non-admitted patient service event—patient present status, code N
- Non-admitted patient service event—service mode,

hospital code N{N}

Comments: Public patients are defined in accordance with the *1998-2003 Australian Health Care Agreements*.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Non-admitted patient service event count, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)

Number of tobacco cigarettes smoked per day after 20 weeks of pregnancy

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Female (pregnant)—number of cigarettes smoked (per day after 20 weeks of pregnancy), number N[NN]

METeOR identifier: 365445

Registration status: Health, Standard 03/12/2008

Definition: The self-reported number of cigarettes usually smoked daily by a pregnant woman after the first 20 weeks of pregnancy until the birth

Context: Perinatal Statistics

Data Element Concept: Female (pregnant)—number of cigarettes smoked (after 20 weeks of pregnancy)

Value domain attributes

Representational attributes

Representation class: Quantity

Data type: Number

Format: N[NN]

Maximum character length: 3

Supplementary values:

Value	Meaning
998	Occasional smoking (less than one)
999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: Data should be collected after the birth.
 'After 20 weeks' is defined as greater than or equal to 20 completed weeks' gestation (>=20 weeks + 0 days).
 'Usually' is defined as 'according to established, or frequent usage; commonly, ordinarily; as a rule'. If a woman reports having quit smoking at some point between 20 weeks of pregnancy and the birth, the value recorded should be the number of cigarettes usually smoked daily prior to quitting.

Collection methods: Recommended question: 'How many tobacco cigarettes did the woman usually smoke each day after 20 weeks of pregnancy?', where after 20 weeks of pregnancy is defined as greater than or equal to 20 weeks + 0 days.

If a woman did not smoke tobacco cigarettes at any time after 20 weeks of pregnancy, a value of 000 should be recorded.

Occasional smoking
Women who report that they usually smoked less than one tobacco cigarette per day should have a value recorded of 998.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also Female (pregnant)—tobacco smoking indicator (first twenty weeks of pregnancy), yes/no code N Health, Standard 03/12/2008

Implementation in Data Set Specifications: Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:
Record if answer to Female (pregnant)—tobacco smoking indicator (after twenty weeks of pregnancy), yes/no code N is Yes

Number of tobacco cigarettes smoked per day first 20 weeks of pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (pregnant)—number of cigarettes smoked (per day first 20 weeks of pregnancy), number N[NN]
METeOR identifier:	365441
Registration status:	Health, Standard 03/12/2008
Definition:	The self-reported number of cigarettes usually smoked daily by a woman during the first 20 weeks of pregnancy
Context:	Perinatal Statistics
Data Element Concept:	Female (pregnant)—number of cigarettes smoked (first 20 weeks of pregnancy)

Value domain attributes

Representational attributes

Representation class:	Quantity
Data type:	Number
Format:	N[NN]
Maximum character length:	3

Supplementary values:

Value	Meaning
998	Occasional smoking (less than one)
999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Data should be collected after the first 20 weeks of pregnancy; e.g. the next antenatal visit after the first 20 weeks would be an ideal time.

'The first 20 weeks of pregnancy' is defined as less than or equal to 19 weeks + 6 days.

'Usually' is defined as 'according to established, or frequent usage; commonly, ordinarily; as a rule'. If a woman reports having quit smoking at some point during the first 20 weeks of pregnancy, the value recorded should be the number of cigarettes usually smoked daily prior to quitting.

Collection methods: Recommended question: ‘How many tobacco cigarettes did the woman usually smoke during the first 20 weeks of pregnancy?’, where the first 20 weeks of pregnancy is defined as less than or equal to 19 weeks + 6 days.

If a woman did not smoke tobacco cigarettes at any time during the first 20 weeks of pregnancy, a value of 000 should be recorded.

Occasional smoking
Women who report that they usually smoked less than one tobacco cigarette per day should have a value recorded of 998.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Nursing diagnosis—other

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—nursing diagnosis (other), code (NANDA 1997-98) N.N[{.N}{.N}{.N}{.N}]
METeOR identifier:	270466
Registration status:	Health, Standard 01/03/2005
Definition:	The nursing diagnosis other than the principal nursing diagnosis, as represented by a code.
Data Element Concept:	Episode of care—nursing diagnosis

Value domain attributes

Representational attributes

Classification scheme:	North American Nursing Diagnosis Association (NANDA) Taxonomy 1997-1998
Representation class:	Code
Data type:	Number
Format:	N.N[{.N}{.N}{.N}{.N}]
Maximum character length:	6

Collection and usage attributes

Guide for use:

The NANDA codes should be used in conjunction with a nursing diagnosis text. The NANDA coding structure is a standard format for reporting nursing diagnosis. It is not intended in any way to change or intrude upon nursing practice, provided the information available can transpose to the NANDA codes for the Community Nursing Minimum Data Set - Australia (CNMDSA).

Data element attributes

Collection and usage attributes

Guide for use:

Up to seven nursing diagnoses may be nominated, according to the following:

1. Nursing diagnosis most related to the principal reason for admission (one only)

2-6. Other nursing diagnoses or relevance to the current episode.

Collection methods:

In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place.

Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the codeset or automated mapping to it when the information is at a more detailed level are equally valid and viable options.

Comments: The Community Nursing Minimum Data Set - Australia (CNMDSA) Steering Committee considered information from users of the data in relation to this metadata item. Many users have found the taxonomy wanting in its ability to describe the full range of persons and conditions seen by community nurses in the Australian setting. In the absence of an alternative taxonomy with wide acceptance, the CNMDSA Steering Committee has decided to retain North American Nursing Diagnosis Association (NANDA). The University of Iowa has a written agreement with NANDA to expand the relevance of NANDA. The Australian Council of Community Nursing Services (ACCNS) has sought collaboration with a United States of America project at the University of Iowa which is seeking to refine, extend, validate and classify the NANDA taxonomy.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Nursing diagnosis, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Nursing diagnosis—principal

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of care—nursing diagnosis (principal), code (NANDA 1997-98) N.N[{.N}{.N}{.N}{.N}]

METeOR identifier: 270220

Registration status: Health, Standard 01/03/2005

Definition: The principal nursing diagnosis, as represented by a code.

Data Element Concept: Episode of care—nursing diagnosis

Value domain attributes

Representational attributes

Classification scheme: North American Nursing Diagnosis Association (NANDA) Taxonomy 1997-1998

Representation class: Code

Data type: Number

Format: N.N[{.N}{.N}{.N}{.N}]

Maximum character length: 6

Collection and usage attributes

Guide for use: The NANDA codes should be used in conjunction with a nursing diagnosis text. The NANDA coding structure is a standard format for reporting nursing diagnosis. It is not intended in any way to change or intrude upon nursing practice, provided the information available can transpose to the NANDA codes for the Community Nursing Minimum Data Set - Australia (CNMDSA).

Data element attributes

Collection and usage attributes

Guide for use: Up to seven nursing diagnoses may be nominated, according to the following:

1. Nursing diagnosis most related to the principal reason for admission (one only)

2-6. Other nursing diagnoses of relevance to the current episode.

Collection methods: In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place.

Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the code set or automated mapping to it when the information is at a more detailed level are equally valid and viable options.

Comments: The Community Nursing Minimum Data Set - Australia (CNMDSA) Steering Committee considered information from users of the data in relation to this metadata item. Many users have found the taxonomy wanting in its ability to describe the full range of persons and conditions seen by community nurses in the Australian setting. In the absence of an alternative taxonomy with wide acceptance, the CNMDSA Steering Committee has decided to retain North American Nursing Diagnosis Association (NANDA). The University of Iowa has a written agreement with NANDA to expand the relevance of NANDA. The Australian Council of Community Nursing Services (ACCNS) has sought collaboration with a United States of America project at the University of Iowa which is seeking to refine, extend, validate and classify the NANDA taxonomy.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Nursing diagnosis, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Nursing interventions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Community nursing service episode—nursing intervention, code N
METeOR identifier:	270223
Registration status:	Health, Standard 01/03/2005
Definition:	The nursing action intended to relieve or alter a person's responses to actual or potential health problems, as represented by a code.
Data Element Concept:	Community nursing service episode—nursing intervention

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Coordination and collaboration of care
2	Supporting informal carers
3	General nursing care
4	Technical nursing treatment or procedure
5	Counselling and emotional support
6	Teaching/education
7	Monitoring and surveillance
8	Formal case management
9	Service needs assessment only

Collection and usage attributes

Guide for use:

The following definitions are to assist in coding:

CODE 1 Coordination and collaboration of care

This code occurs when there are multiple care deliverers. The goal of coordination and collaboration is the efficient, appropriate integrated delivery of care to the person. Tasks which may be involved include: liaison, advocacy, planning, referral, information and supportive discussion and/or education. Although similar in nature to formal case management this intervention is not the one formally recognised by specific funding (see Code 8).

CODE 2 Supporting information carers

This code includes activities, which the nurse undertakes to assist the carer in the delivery of the carer's role. This does not include care given directly to the person. Examples of tasks involved in supporting the carer include: counselling, teaching, informing, advocacy, coordinating, and grief or bereavement support.

CODE 3 General nursing care

This code includes a broad range of activities, which the nurse performs to directly assist the person; in many cases, this assistance will focus on activities of daily living. This assistance will help a person whose health status, level of dependency, and/or therapeutic needs are such that nursing skills are required. Examples of tasks include: assistance with washing, grooming and maintaining hygiene, dressing, pressure area care, assistance with toileting, bladder and bowel care, assistance with mobility and therapeutic exercise, attention to physical comfort and maintaining a therapeutic environment.

CODE 4 Technical nursing treatment or procedure

This code refers to technical tasks and procedures for which nurses receive specific training and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. Some examples of technical care activities are: medication administration (including injections), dressings and other procedures, venipuncture, monitoring of dialysis, and implementation of pain management technology.

CODE 5 Counselling and emotional support

This code focuses on non-physical care given to the person, which aims to address the affective, psychological and/or social needs. Examples of these include: bereavement, well being, decision-making support and values-clarification.

CODE 6 Teaching/education

This code refers to providing information and/or instruction about a specific body of knowledge and/or procedure, which is relevant to the person's situation. Examples of teaching areas include: disease process, technical procedure, health maintenance, health promotion and techniques for coping with a disability.

CODE 7 Monitoring and surveillance

This code refers to any action by which the nurse evaluates and monitors physical, behavioural, social and emotional responses to disease, injury, and nursing or medical interventions.

CODE 8 Formal case management

This code refers to the specific formal service, which is funded to provide case management for a person. Note that coordination and collaboration of care (Code 1) is not the same as formal case management.

CODE 9 Service needs assessment only

This code is for assessment of the person when this is the only activity carried out and no further nursing care is given; for example, assessment for ongoing care and/or inappropriate referrals. Selection of this option means that no other intervention may be nominated. Thus, if an assessment for the domiciliary care benefit is the reason for a visit, but other interventions such as, counselling and support; coordination/collaboration of care are carried out, then the assessment only is not an appropriate code.

Data element attributes

Collection and usage attributes

Guide for use:

Up to eight codes may be selected. If Code 9 is selected no other nursing interventions are collected. If Code 9 is selected then code 07 in Community nursing service episode—goal of care, code NN must also be selected.

Collection methods:

Collect on continuing basis throughout the episode in the event of data collection that occurs prior to discharge. Up to eight codes may be collected. Within a computerised information system the detailed activities can be mapped to the Community Nursing Minimum Data Set Australia (CNMDSA) interventions enabling the option of a rich level of detail of activities or summarised information.

Comments:

For the purposes of the CNMDSA, the interventions are not necessarily linked to each nursing problem, nor are they specific tasks, but rather, broader-level intervention categories focusing on the major areas of a person's need. These summary categories subsume a range of specific actions or tasks.

The CNMDSA nursing interventions are summary information overlying the detailed nursing activity usually included in an agency data collection. They are not intended as a description of nursing activities in the CNMDSA. For instance, 'technical nursing treatment' or 'procedure' is the generic term for a broad range of nursing activities such as medication administration and wound care management.

Collection of this information at discharge carries with it the expectation that nursing records will lend themselves to this level of summarisation of the care episode. The selection of eight interventions if more are specified is a potentially subjective task unless the nursing record is structured and clear enough to enable such a selection against the reasons for admission to care, and the major focus of care delivery. Clearly, the task is easier if ongoing automated recording of interventions within an agency information system enables discharge reporting of all interventions and their frequency, over a care episode.

Those agencies providing allied health services may wish to use the Physiotherapy and Occupational Therapy Interventions developed in conjunction with the National Centre for Classification in Health in addition to the CNMDSA data element Nursing interventions or other more relevant code sets.

To enable analysis of the interventions within an episode of care, in relation to the outcome of this care, especially when linked with information on the diagnosis and goals. The recording of nursing interventions is critical information for health service monitoring and planning. It is a major descriptor of the care provided throughout an episode.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Origin: Australian Council of Community Nursing Services 1997. Community Nursing Minimum Data Set Australia (CNMDSA), version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Nursing interventions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (24.2 KB)

Occasions of service (residential aged care services)—outreach/community

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (residential aged care service)—number of occasions of service (outreach/community), total N[NN]
METeOR identifier:	270308
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of service delivered by a residential aged care service employees to the patient in the home, place of work or other non-establishment site.
Data Element Concept:	Establishment (residential aged care service)—number of occasions of service

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Comments:

Required to adequately describe the services provided to non-admitted patients.

Apart from acute hospitals, establishments generally provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore disaggregation by type of episode is not as necessary as in acute hospitals.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care (residential aged care services), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)

Occasions of service (residential aged care services)—outpatient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (residential aged care service)—number of occasions of service (outpatient), total N[NN]
METeOR identifier:	270290
Registration status:	Health, Standard 01/03/2005
Definition:	The number of occasions of service delivered by residential aged care service employees. Outpatients are patients who receive non-admitted care. Non-admitted care is care provided to a patient who is not formally admitted but receives direct care from a designated clinic within the residential aged care service.
Data Element Concept:	Establishment (residential aged care service)—number of occasions of service

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Comments:	Required to adequately describe the services provided to non-admitted patients. Apart from acute hospitals, establishments generally provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore disaggregation by type of episode is not as necessary as in acute hospitals.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Type of non-admitted patient care (residential aged care services), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)

Oestrogen receptor assay result

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—oestrogen receptor assay result, code N
METeOR identifier:	370036
Registration status:	Health, Standard 06/03/2009
Definition:	The result of oestrogen receptor assay at the time of diagnosis of the primary breast tumour, as represented by a code.
Data Element Concept:	Person with cancer—oestrogen receptor assay result

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	1	Positive
	2	Negative
	3	Equivocal
Supplementary values:	7	Unknown (test results not available)
	8	Not applicable (test not done)

Collection and usage attributes

Guide for use:

Supplementary codes

CODE 7 Unknown (test results not available)

Use this code when the test has been performed but the results are not yet available for analysis.

CODE 8 Not applicable (test not done)

This code is used as a validation measure, to show that the reason for the lack of results is due to the test not being performed.

Data element attributes

Collection and usage attributes

Guide for use: Where the pathologist has stated the test result in the conclusion of the pathology report as being positive, negative or equivocal this value should be coded. If the report does not specifically state the test result, this should be interpreted from the reported % nuclei stained positive. If => 1% of nuclei are reported as stained regardless of stain intensity (weak, intermediate or high/strong) the result is positive. If % nuclei stained is <1% the result is negative. Definitions from NBOCC & ACN Pathology Reporting Guidelines.

Collection methods: For cancer registries:

Collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or subsequent metastatic disease.

Where there are multiple reports relating to the primary breast tumour (from different specimens), the 'most positive' value is chosen according to the following hierarchy: Positive > Equivocal > Negative> Test done but results not known > Test not done.

If oestrogen receptor assay tests are completed for invasive tumours with an in situ component, use the values from the invasive tumour.

Do not record oestrogen receptor values for in situ tumours.

For multifocal tumours, use the oestrogen receptor value from the largest focus or from a metastatic deposit, e.g. Lymph node metastasis. A smaller focus that is ER positive may in fact be the source of a metastasis and in this setting the patient would derive benefit from the therapy offered as a result of hormone receptor positive status.

Comments: Hormone receptor status is an important prognostic indicator for breast cancer.

The Australian Cancer Network Working Party established to develop guidelines for the pathology reporting of breast cancer recommends that hormone receptor assays be performed on all cases of invasive breast carcinoma. The report should include

- the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high) and
- a conclusion as to whether the assay is positive or negative.

Source and reference attributes

Origin: Royal College of Pathologists of Australasia

Australian Cancer Network

Commission on Cancer American College of Surgeons

Reference documents: Royal College of Pathologists of Australasia Manual of Use and Interpretation of Pathology Tests: Third Edition Sydney (2001)

Australian Cancer Network Working Party The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001)

Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references: Supersedes Person with cancer—oestrogen receptor assay results, code N Health, Superseded 06/03/2009

Implementation in Data Set Specifications: Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Onset of labour

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Birth event—labour onset type, code N

METeOR identifier: 269942

Registration status: Health, Standard 01/03/2005

Definition: The manner in which labour started in a birth event, as represented by a code.

Data Element Concept: Birth event—labour onset type

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:	Value	Meaning
	1	Spontaneous
	2	Induced
	3	No labour
Supplementary values:	4	Not stated

Collection and usage attributes

Guide for use: Labour commences at the onset of regular uterine contractions, which act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes.

If prostaglandins were given to induce labour and there is no resulting labour until after 24 hours, then code the onset of labour as spontaneous.

CODE 3 No labour
Can only be associated with a caesarean section.

Data element attributes

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Onset of labour, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Implementation in Data Set Specifications:

Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Ophthalmological assessment—outcome (left retina)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—ophthalmological assessment outcome (left retina) (last 12 months), code N
METeOR identifier:	270472
Registration status:	Health, Standard 01/03/2005
Definition:	The result of an ophthalmological assessment for the left retina during the last 12 months, as represented by a code.
Data Element Concept:	Person—ophthalmological assessment outcome

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	Value	Meaning
	1	Normal
	2	Diabetes abnormality
	3	Non-diabetes abnormality
	4	Not visualised
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

This is a repeating record of both eyes.

1st field - Right retina

2nd field - Left retina

Record the result of the fundus examination for each eye as: Normal/ Diabetes abnormality/ Non-diabetes abnormality/ or Not visualised.

Example:

- code 12 for right retina Normal and left retina Diabetes abnormality
- code 32 for right retina Non-diabetes abnormality and left retina Diabetes abnormality

Only the result of an assessment carried out in the last 12 months should be recorded.

Collection methods: Ophthalmological assessment should be performed by an ophthalmologist or a suitably trained clinician.

A comprehensive ophthalmological examination includes:

- Checking visual acuity with Snellen chart - correct with pinhole if indicated;
- Examination for cataract;
- Examination of fundi with pupils dilated.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Ophthalmological assessment - outcome, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.5 KB)

See also Person—ophthalmological assessment outcome (right retina) (last 12 months), code N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Ophthalmological assessment—outcome (right retina)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—ophthalmological assessment outcome (right retina) (last 12 months), code N

METeOR identifier: 270363

Registration status: Health, Standard 01/03/2005

Definition: The result of an ophthalmological assessment for the right retina during the last 12 months, as represented by a code.

Data Element Concept: Person—ophthalmological assessment outcome

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Normal
	2	Diabetes abnormality
	3	Non-diabetes abnormality
	4	Not visualised
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: This is a repeating record of both eyes.

1st field - Right retina

2nd field - Left retina

Record the result of the fundus examination for each eye as: Normal/ Diabetes abnormality/ Non-diabetes abnormality/ or Not visualised.

Example:

- code 12 for right retina Normal and left retina Diabetes abnormality
- code 32 for right retina Non-diabetes abnormality and left retina Diabetes abnormality

Only the result of an assessment carried out in the last 12 months should be recorded.

Collection methods: Ophthalmological assessment should be performed by an ophthalmologist or a suitably trained clinician.

A comprehensive ophthalmological examination includes:

- Checking visual acuity with Snellen chart - correct with pinhole if indicated;
- Examination for cataract;
- Examination of fundi with pupils dilated.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Ophthalmological assessment - outcome, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.5 KB)

See also Person—ophthalmological assessment outcome (left retina) (last 12 months), code N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Ophthalmoscopy performed indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—ophthalmoscopy performed indicator (last 12 months), code N

METeOR identifier: 302821

Registration status: Health, Standard 21/09/2005

Definition: Whether or not an examination of the fundus of the eye by an ophthalmologist or optometrist, as a part of the ophthalmological assessment, has been undertaken in the last 12 months, as represented by a code.

Data Element Concept: Person—ophthalmoscopy performed indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes: Record if a fundus examination of eye has occurred.

CODE 2 No: Record if a fundus examination of eye has not occurred.

Collection methods: Ask the individual if he/she has undertaken an eye check, including examination of fundi with pupils dilated. Pupil dilatation and an adequate magnified view of the fundus is essential, using either detailed direct or indirect ophthalmoscopy or fundus camera. This will usually necessitate referral to an ophthalmologist.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Person—ophthalmoscopy performed status (previous 12 months), code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Organisation end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—organisation end date, DDMMYYYY
METeOR identifier:	288733
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	The date on which an establishment, agency or organisation stopped or concluded operations or practice.
Data Element Concept:	Service provider organisation—organisation end date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Standard 03/12/2008

Organisation expenses, total Australian currency

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Organisation—expenses, total Australian currency NNNNN.N

METeOR identifier: 359963

Registration status: Health, Standard 05/12/2007

Definition: Expenses of an organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, workers compensation premiums and payouts, purchases of goods and services and consumption of fixed capital (depreciation), in Australian currency.

Data Element Concept: Organisation—expenses

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: NNNNN.N

Maximum character length: 6

Unit of measure: Australian currency (AU$)

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use: Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.

Expenses are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).

Includes:

- Salaries, wages and supplements
- Superannuation employer contributions

- Workers compensation premiums and payments
- Consumption of fixed capital (depreciation).
- Administrative expenses (excluding workers compensation premiums and payouts)
- Domestic services
- Drug supplies
- Food supplies
- Grants
- Medical and surgical supplies
- Patient transport
- Payments to visiting medical officers
- Repairs and maintenance
- Social benefits
- Subsidy expenses
- Other expenses

Collection methods:

Expenses are to be reported for the *Health industry relevant organisation type* and *Type of health and health related functions* data elements.

Health industry relevant organisation type

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments:

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Origin:

Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, reference: http://www.aasb.com.au/

Relational attributes

Related metadata references:

Is formed using Organisation—capital consumption expenses, total Australian currency NNNNN.N Health, Standard 01/04/2009

Is formed using Organisation—employee related expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007

Is formed using Organisation—purchase of goods and services, total Australian currency NNNNN.N Health, Standard 05/12/2007

Implementation in Data Set Specifications:

Government health expenditure organisation expenditure data element cluster Health, Standard 01/04/2009

Organisation identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—organisation identifier, XXXX
METeOR identifier:	404186
Registration status:	Health, Standard 07/12/2011
Definition:	A unique identifier assigned to a specialised mental health service organisation, as represented by a combination of numeric and/or alphabetic characters.
Data Element Concept:	Specialised mental health service organisation—organisation identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	XXXX
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use: The complete identifier string, including State/Territory identifier, Region identifier and Organisation identifier, should be a unique code for the specialised mental health service organisation in that state/territory. Service unit reporting structures should be identical between all mental health collections (e.g. Mental Health National Minimum Data Sets and the Mental Health National Outcomes and Casemix Collection (NOCC)).

Relational attributes

Implementation in Data Set Specifications:

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Organisation name

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Service provider organisation (name)—organisation name, text [X(200)]

METeOR identifier: 288917

Registration status: Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005
Early Childhood, Superseded 09/03/2012

Definition: The appellation by which an establishment, agency or organisation is known or called, as represented by text.

Data Element Concept: Service provider organisation (name)—organisation name

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: [X(200)]

Maximum character length: 200

Data element attributes

Collection and usage attributes

Guide for use: Generally, the complete establishment, agency or organisation name should be used to avoid any ambiguity in identification. This should usually be the same as company registration name. However, in certain circumstances (e.g. internal use), a short name (i.e. an abbreviated name by which the organisation is known) or a locally used name (e.g. where a medical practice is known by a name that is different to the company registration name) can be used. Further, a business unit within an organisation may have its own separate identity; this should be captured (as the unit name – see Organisation name type).

More than one name can be recorded for an organisation. That is, this field is a multiple occurring field. At least one organisation name must be recorded for each organisation and each name must have an appropriate Organisation name type.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS4846 Health Care Provider Identification, 2004, Sydney:

Standards Australia

Relational attributes

Implementation in Data Set Specifications:

Health care provider identification DSS Health, Standard 03/12/2008

Indigenous primary health care DSS Health, Standard 07/12/2011

Prison establishments DSS Health, Standard 25/08/2011

Organisation name—specialised mental health service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—organisation name, text XXX[X(97)]
METeOR identifier:	405767
Registration status:	Health, Standard 07/12/2011
Definition:	The appellation by which a specialised mental health service organisation is known or called, as represented by text.
Data Element Concept:	Specialised mental health service organisation—organisation name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	XXX[X(97)]
Maximum character length:	100

Data element attributes

Collection and usage attributes

Guide for use:

The name of specialised mental health service organisations are determined by the relevant state or territory. Note that organisation is defined according to the object class *Specialised mental health service organisation*.

The name should be unique for the organisation in that state/territory. Mental health data collections are hierarchical in nature. An identical reporting structure, including organisation name, should be common between all mental health collections, including the Mental Health Establishments (MHE), Community Mental Health Care (CMHC) and Residential Mental Health Care (RMHC) NMDS's, the Mental Health National Outcomes and Casemix collection and any future mental health collections.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013 Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013 Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Organisation revenues

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—revenue, total Australian currency NNNNN.N
METeOR identifier:	357510
Registration status:	Health, Standard 05/12/2007
Definition:	Revenues of an organisation relating to **patient fees**, **recoveries**, and **other revenue** in Australian currency.
Data Element Concept:	Organisation—revenue

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	NNNNN.N
Maximum character length:	6
Unit of measure:	Australian currency (AU$)

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use:

Revenues are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

Revenue arises from:

- the sale of goods,
- the rendering of services, and
- the use by others of entity assets yielding interest, royalties and dividends.

Goods includes goods produced by the entity for the purpose of sale and goods purchased for resale, such as merchandise purchased by a retailer or land and other property held for resale.

The rendering of services typically involves the performance by the entity of a contractually agreed task over an agreed period of time. The services may be rendered within a single period or over more than one period. Some contracts for the rendering of services are directly related to construction contracts, for example, those for the services of project managers and architects. Revenue arising from these contracts is not dealt with in this Standard but is dealt with in accordance with the requirements for construction contracts as specified in AASB 111 Construction Contracts.

The use by others of entity assets gives rise to revenue in the form of:

(a) interest – charges for the use of cash or cash equivalents or amounts due to the entity;

(b) royalties – charges for the use of long-term assets of the entity, for example, patents, trademarks, copyrights and computer software; and

(c) dividends – distributions of profits to holders of equity investments in proportion to their holdings of a particular class of capital.

Revenue is the gross inflow of economic benefits during the period arising in the course of the ordinary activities of an entity when those inflows result in increases in equity, other than increases relating to contributions from equity participants.

Revenue includes only the gross inflows of economic benefits received and receivable by the entity on its own account.

Amounts collected on behalf of third parties such as sales taxes, goods and services taxes and value added taxes are not economic benefits which flow to the entity and do not result in increases in equity. Therefore, they are excluded from revenue. Similarly, in an agency relationship, the gross inflows of economic benefits include amounts collected on behalf of the principal and which do not result in increases in equity for the entity. The amounts collected on behalf of the principal are not revenue. Instead, revenue is the amount of commission.

Collection methods: Revenues are to be reported for the *Source of public and private revenue* and *Health industry relevant organisation type* data elements.

Source of public and private revenue

State and territory health authorities are NOT to report the following codes:

Codes 101–103; 204; 207; 301

Health industry relevant organisation type

State and territory health authorities are NOT to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents: ABS 2003. Australian System of Government Finance Statistics: Concepts, Sources and Methods (Cat. no.

5514.0.55.001) 10/10/2003.

Australian Accounting Standards Board 118, July 2007, <www.aasb.com.au>.

Relational attributes

Implementation in Data Set Specifications:

Government health expenditure function revenue data element cluster Health, Standard 03/12/2008

Government health expenditure organisation revenue data element cluster Health, Standard 01/04/2009

Organisation start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—organisation start date, DDMMYYYY
METeOR identifier:	288963
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	The date on which an establishment, agency or organisation started or commenced operations or service.
Data Element Concept:	Service provider organisation—organisation start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use: This field must—

- be a valid date;
- be less than or equal to the Organisation end date.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Standard 03/12/2008

Other cancer treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—other cancer treatment, text [X(150)]
METeOR identifier:	403836
Registration status:	Health, Standard 07/12/2011
Definition:	The cancer-directed treatment administered during the initial course of treatment for cancer, other than surgery, radiotherapy or systemic therapy, as represented by text.
Data Element Concept:	Cancer treatment—other cancer treatment

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(150)]
Maximum character length:	150

Source and reference attributes

Submitting organisation:	Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use:

This data item is to record cancer-directed treatments that cannot be appropriately assigned to the specific treatment codes in the cancer treatment data items for surgery, radiotherapy, systemic therapy agents and systemic therapy procedures.

Cancer-directed treatments refer to those treatments that destroy or modify cancer tissue anywhere in the body. The exception to this is treatments for hematopoietic diseases (refer to additional notes below).

Cancer-directed treatments may be palliative (to control symptoms, alleviate pain, or make the patient more comfortable) or curative.

Record all other treatments administered during the initial course of treatment. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

Each treatment event delivered to the patient should be recorded; multiple entries are permitted.

Record antibody treatments, vaccine treatments, and those targeted therapies that use drugs or substances other than chemotherapy agents in this data item. Targeted therapies using chemotherapy agents are recorded in the data items for chemotherapy. Targeted therapies are treatments that use drugs or other substances to identify and attack specific cancer cells.

Do not record ancillary drugs. For example, allopurinol, which is commonly used as prophylaxis with chemotherapy agents to prevent severe hyperuricemia. A list of drugs regarded as ancillary is available in the SEER*Rx-Interactive Antineoplastic Drugs Database Version 1.4.1.

Treatment events may include (for example):

- Treatment unique to hematopoietic diseases, for example, phlebotomy, transfusions or aspirin. ONLY record aspirin therapy used to thin the blood for symptomatic control of thrombocythemia. Do not record aspirin used for pain or cardiovascular protection.
- Embolisation that is performed using alcohol as an embolising agent or for embolisation to a site other than the liver where the embolising agent is unknown. Embolisation using chemotherapeutic agents is coded separately with chemotherapy, and embolisation using a radioactive agent or seeds is coded with brachytherapy-radiation treatment.
- Any experimental or newly developed treatment that cannot be appropriately assigned to other specific treatment data items.
- A double-blind clinical trial. Record the treatment actually administered to the patient in the appropriate treatment data item when the double-blind trial code is broken.
- Cancer treatments administered by non-medical personnel. This includes unconventional methods whether administered as single therapy or in combination with conventional therapies. Record alternative therapies only if the patient doesn’t receive any other type of treatment.

Collection methods: The information should be obtained from the patient’s medical record.

Comments: Information on other cancer treatments is used to describe and evaluate the quality of care and treatment practices.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Johnson CH & Adamo M (Editors) 2007. SEER Program Coding and Staging Manual 2007, MD 2008 revision. Bethesda:National Cancer Institute, NIH Publication number 07-5581

Relational attributes

Related metadata references: See also Cancer treatment—cancer treatment type, code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on the patient having treatment that cannot be defined as surgery, radiotherapy or systemic therapy according to the definitions of those data items in this data set specification.

Other drug of concern

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—drug of concern (other), (ASCDC 2011 extended) code NNNN
METeOR identifier:	467579
Registration status:	Health, Standard 07/12/2011
Definition:	A drug apart from the principal drug of concern which the client states as being a concern, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—drug of concern

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Drugs of Concern 2011
Representation class:	Code
Data type:	String
Format:	NNNN
Maximum character length:	4

Supplementary values:

Value	Meaning
0005	Opioid analgesics not further defined
0006	Psychostimulants not further defined

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Drugs of Concern (ASCDC) provides a number of supplementary codes that have specific uses and these are detailed within the ASCDC, e.g. 0000 = inadequately described.

Other supplementary codes that are not already specified in the ASCDC may be used in National Minimum Data Sets (NMDS) when required. In the Alcohol and other drug treatment service NMDS, two additional supplementary codes have been created which enable a finer level of detail to be captured:

CODE 0005 Opioid analgesics not further defined

This code is to be used when it is known that the client's principal drug of concern is an opioid but the specific opioid used is not known. The existing code 1000 combines opioid analgesics and non-opioid analgesics together into Analgesics nfd and the finer level of detail, although known, is lost.

CODE 0006 Psychostimulants not further defined

This code is to be used when it is known that the client's principal drug of concern is a psychostimulant but not which type. The existing code 3000 combines stimulants and hallucinogens together into Stimulants and hallucinogens nfd and the finer level of detail, although known, is lost.

Psychostimulants refer to the types of drugs that would normally be coded to 3100-3199, 3300-3399 and 3400-3499 categories plus 3903 and 3905.

Data element attributes

Collection and usage attributes

Guide for use:

Record each additional drug of concern (according to the client) relevant to the treatment episode. The other drug of concern does not need to be linked to a specific treatment type.

More than one drug may be selected. There should be no duplication with the principal drug of concern.

Collection methods:

Any other drug of concern for the client should be recorded upon commencement of a treatment episode.

For clients whose treatment episode is related to the alcohol and other drug use of another person, this metadata item should not be collected.

Comments:

This item complements principal drug of concern. The existence of other drugs of concern may have a role in determining the types of treatment required and may also influence treatment outcomes.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Episode of treatment for alcohol and other drugs—drug of concern (other), code (ASCDC 2000 extended) NNNN Health, Superseded 07/12/2011

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Other treatment type for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—treatment type (other), code [N]
METeOR identifier:	270076
Registration status:	Health, Standard 01/03/2005
Definition:	All other forms of treatment provided to the client in addition to the main treatment type for alcohol and other drugs, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	[N]
Maximum character length:	1

Permissible values:

Value	Meaning
1	Withdrawal management (detoxification)
2	Counselling
3	Rehabilitation
4	Pharmacotherapy
5	Other

Collection and usage attributes

Guide for use:

CODE 1 Withdrawal management (detoxification)

Refers to any form of withdrawal management, including medicated and non-medicated.

CODE 2 Counselling

Refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This selection excludes counselling activity that is part of a rehabilitation program as defined in Code 3.

CODE 3 Rehabilitation

Refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer-term duration. Rehabilitation activities can occur in residential or non-residential settings. Counselling that is included within an overall rehabilitation program should be coded to Code 3 for Rehabilitation, not to Code 2 as a separate treatment episode for counselling.

CODE 4 Pharmacotherapy

Refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, and methadone treatment) and those used as relapse prevention. Use Code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal. Note collection exclusions: excludes clients who are on an opioid pharmacotherapy maintenance program and are not receiving any other form of treatment.

Data element attributes

Collection and usage attributes

Guide for use:

To be completed at cessation of treatment episode.

Only report treatment recorded in the client's file that is in addition to, and not a component of, the main treatment type for alcohol and other drugs. Treatment activity reported here is not necessarily for principal drug of concern in that it may be treatment for other drugs of concern.

More than one code may be selected.

Collection methods:

This field should be left blank if there are no other treatment types for the episode.

Comments:

Information about treatment provided is of fundamental importance to service delivery and planning.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Other treatment type for alcohol and other drugs, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Other/Underlying cause of acute coronary syndrome

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—underlying cause of acute coronary syndrome, code N
Synonymous names:	Secondary cause of ACS
METeOR identifier:	338310
Registration status:	Health, Standard 01/10/2008
Definition:	The condition or event, other than the usual risk factors, which has caused a person's acute coronary syndrome symptoms, as represented by a code
Data Element Concept:	Person—underlying cause of acute coronary syndrome

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N[N]	
Maximum character length:	9	
Permissible values:	Value	Meaning
	1	Anaemia
	2	Severe valvular disease
	3	Thyrotoxicosis
	4	Fever
	5	Hypoxaemia
	6	Trauma
	7	Surgery
Supplementary values:	88	Other
	99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:	This is to be recorded by the clinician.
Comments:	This identifies whether the person experiencing acute coronary syndrome (ACS) symptoms is doing so due to another condition or event and where the treatment would be primarily targeted at managing that condition.

The presence of one of these conditions or events has a significant impact on the appropriate treatment modalities for ACS. Therefore, the person's treatment may be different from those recommended for ACS.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Outcome of last previous pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy (last previous)—pregnancy outcome, code N
METeOR identifier:	270006
Registration status:	Health, Standard 01/03/2005
Definition:	Outcome of the most recent pregnancy preceding this pregnancy, as represented by a code.
Data Element Concept:	Pregnancy (last previous)—pregnancy outcome

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Single live birth - survived at least 28 days
2	Single live birth - neonatal death (within 28 days)
3	Single stillbirth
4	Spontaneous abortion
5	Induced abortion
6	Ectopic pregnancy
7	Multiple live birth - all survived at least 28 days
8	Multiple birth - one or more neonatal deaths (within 28 days) or stillbirths

Data element attributes

Collection and usage attributes

Guide for use: In the case of multiple pregnancy with fetal loss before 20 weeks, code on outcome of surviving fetus(es) beyond 20 weeks.

Comments: This data item is recommended by the World Health Organization. It is collected in some states and territories.

Adverse outcome in previous pregnancy is an important risk factor for subsequent pregnancy.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Outcome of last previous pregnancy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Outcome of treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—outcome of treatment, code N.N
METeOR identifier:	402047
Registration status:	Health, Standard 07/12/2011
Definition:	The response of the tumour at the completion of the initial course of treatment for cancer, as represented by a code.
Data Element Concept:	Cancer treatment—outcome of treatment

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N.N
Maximum character length:	2

	Value	Meaning
Permissible values:	1.0	Complete response/no evidence of disease
	2.1	Partial response
	2.2	Stable or static disease
	2.3	Progressive disease
Supplementary values:	7.0	Not assessed or unable to be assessed
	8.0	Unknown
	9.0	Not stated/inadequately described

Collection and usage attributes

Guide for use:

The outcome of treatment is recorded at the completion of the initial course of treatment for the cancer. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

CODE 1.0 Complete response/no evidence of disease

Complete disappearance of all measurable disease, including tumour markers, for at least four weeks. No new lesions or new evidence of disease. For breast cancer, this reflects "No evidence of disease".

CODE 2.1 Partial response

A decrease by at least 50% of the sum of the products of the maximum diameter and perpendicular diameter of all measurable lesions, for at least four weeks. No new lesions or worsening of disease.

CODE 2.2 Stable or static disease

No change in measurable lesions qualifying as partial response or progression and no evidence of new lesions.

CODE 2.3 Progressive disease

An increase by at least 25% of the sum of the products of the maximum diameter and a perpendicular diameter of any measurable lesion, or the appearance of new lesions.

CODE 9.0 Not stated/inadequately described

The tumour was assessed but the percentage of increase or decrease in the tumour size is not stated or is inadequately described.

Source and reference attributes

Submitting organisation: Cancer Australia

Data element attributes

Collection and usage attributes

Collection methods: This information should be obtained from the patient's medical record.

Comments: Information regarding the outcome of treatment is required for patient follow-up and outcomes studies.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: New South Wales Health Department

Reference documents: Public Health Division 2001. NSW Clinical Cancer Data Collection for Outcomes and Quality: Data Dictionary, Version 1. Sydney:NSW Health Department

Relational attributes

Related metadata references: Supersedes Cancer treatment—outcome of treatment, code N.N Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Outpatient clinic type—non-admitted patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—outpatient clinic type, code N[N]
METeOR identifier:	400598
Registration status:	Health, Standard 06/10/2010
Definition:	The organisational unit or organisational arrangement through which a hospital provides a service to a non-admitted patient, as represented by a code.
Context:	This data element, for use in the Non-admitted patient context, uses a value domain developed for the Outpatient care NMDS, which includes one reference to 'occasions of service'. In this context, 'occasions of service' should be interpreted as synonymous to a 'non-admitted patient service event'.
Data Element Concept:	Non-admitted patient service event—outpatient clinic type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Allied Health
2	Dental
3	Gynaecology
4	Obstetrics
5	Cardiology
6	Endocrinology
7	Oncology
8	Respiratory
9	Gastroenterology
10	Medical
11	General practice/primary care
12	Paediatric medical
13	Endoscopy
14	Plastic surgery

15	Urology
16	Orthopaedic surgery
17	Ophthalmology
18	Ear, nose and throat
19	Pre-admission and pre-anaesthesia
20	Chemotherapy
21	Dialysis
22	Surgery
23	Paediatric surgery
24	Renal medical

Collection and usage attributes

Guide for use:

The rules for allocating (mapping) clinic services to the clinic codes structure is the responsibility of each State and Territory and these rules need to be applied consistently within each State and Territory.

In most cases, reference to the code guide of permissible values will be adequate to map a hospital's clinics to the data domain. If not, general principles for mapping existing clinics to the data domain should take account of (a) the nature of the specialty, (b) patient characteristics, e.g. age, and (c) the field of practice of the service provider.

Where the patient characteristics have determined that a paediatric clinic type is appropriate, then further differentiation between surgical and medical is determined by (a) the nature of the specialty, and (b) the field of practice of the service provider. That is, paediatric medical would include any investigations, treatment(s) or services provided to a child which do not pertain to the surgical care of diseases or injuries.

In paediatric hospitals, the full range of clinic types should be used.

A guide for the permissible values of codes for the outpatient clinic types is as follows:

CODE 1 Allied Health

- Audiology.
- Clinical Pharmacology.
- Neuropsychology.
- Dietetics.
- Occupational therapy.
- Optometry.
- Orthoptics.
- Orthotics.
- Physiotherapy.

- Podiatry.
- Prosthetics.
- Psychology.
- Social work.
- Speech pathology.

Includes clinics specified in mapping list above run solely by these Allied Health (AH) professionals. Example: A speech Pathologist conducting a clinic with booked patients for speech pathology services.

Excludes services provided by AH professionals in clinics classified in codes 2-23. Example: a physiotherapist running a cardiac rehabilitation clinic is classified to the Cardiology Clinic (see code 5).

CODE 2 Dental

- Dental.

CODE 3 Gynaecology

- Gynaecology.
- Gynaecological oncology (excluding chemotherapy).
- Menopause.
- Assisted reproduction, infertility.
- Family planning.

CODE 4 Obstetrics

- Obstetrics.
- Childbirth education.
- Antenatal.
- Postnatal.

Excludes gestational diabetes (see code 6).

CODE 5 Cardiology

- Cardiac rehabilitation.
- ECG.
- Doppler.
- Cardiac stress test.
- Hypertension.
- Pacemaker.

Excludes cardiac catheterisation (see code 22).

CODE 6 Endocrinology

- Endocrine.
- Gestational diabetes.
- Thyroid.
- Metabolic.
- Diabetes.
- Diabetes education.

CODE 7 Oncology

- Oncology.
- Lymphoedema.
- Radiation oncology.

Excludes chemotherapy (see code 20).

Excludes gynaecological oncology (see code 3).

CODE 8 Respiratory

- Asthma.
- Asthma education.
- Respiratory; excludes tuberculosis (see code 10).
- Cystic Fibrosis.
- Sleep.
- Pulmonary.

CODE 9 Gastroenterology

- Gastroenterology.

Excludes endoscopy (see code 13).

CODE 10 Medical

- Aged care, geriatric, gerontology.
- Allergy.
- Anti-coagulant.
- Clinical Measurement; include with relevant specialty clinic type where clinical measurement services are specific to a specialty (see codes 1-23) e.g. urodynamic analysis is counted with Urology (see code 15).
- Dementia.
- Dermatology.
- Development disability.
- Epilepsy.
- Falls.
- General medicine.
- Genetic.
- Haematology, haemophilia.
- Hepatobiliary.
- Hyperbaric medicine.
- Immunology, HIV.
- Infectious diseases; Communicable diseases; Hep B, C; includes tuberculosis.
- Men’s Health.
- Metabolic bone.
- Excludes Nephrology (see code 24); excludes renal (see code 24); excludes dialysis (see code 21).
- Neurology, neurophysiology.
- Occupational medicine.

- Other.
- Pain management
- Palliative.
- Refugee clinic.
- Rehabilitation; excludes cardiac rehabilitation (see code 5).
- Rheumatology.
- Sexual Health.
- Spinal.
- Stoma therapy.
- Transplants (excludes kidney transplants see code 24).
- Wound, Dressing clinic.

CODE 11 General practice/primary care

- General Practice, Primary Care.

Excludes Medicare billable patients; defined specialty general practice clinics only.

CODE 12 Paediatric Medical

- Adolescent health.
- Neonatology.
- Paediatric medicine.

In paediatric hospitals the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgery should be reported as surgery.

CODE 13 Endoscopy

Includes all occasions of service for endoscopy including cystoscopy, gastroscopy, oesophagoscopy, duodenoscopy, colonoscopy, bronchoscopy, laryngoscopy and sigmoidoscopy.

Care must be taken to ensure procedures for admitted patients are excluded from this category.

CODE 14 Plastic surgery

- Craniofacial.
- Melanoma.
- Plastic surgery.

CODE 15 Urology

- Urology.

Includes urodynamic measurement and IVPs.

CODE 16 Orthopaedic surgery

- Fracture.
- Hand.
- Orthopaedics Surgery.
- Other.
- Scoliosis.
- Neck of femur.

CODE 17 Ophthalmology

- Ophthalmology.
- Cataract extraction.
- Lens insertion.

CODE 18 Ear, nose and throat

- Ear, nose and throat.
- Otitis media.
- Oral.

CODE 19 Pre-admission and pre-anaesthesia

- Pre-admission.
- Pre-anaesthesia.

CODE 20 Chemotherapy

Includes all forms of chemotherapy.

CODE 21 Dialysis

Dialysis and includes renal dialysis education. See code 24 for Renal medicine

CODE 22 Surgery

- Cardiac.
- Vascular.
- Cardiac catheterisation.
- Colorectal.
- Upper GI surgery.
- General surgery.
- Neurosurgery.
- Other surgery.
- Thoracic surgery.

CODE 23 Paediatric surgery

In paediatric hospitals the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgery should be reported as surgery.

CODE 24 Renal Medical

- Renal Medicine.
- Nephrology.
- Includes pre and post transplant treatment, support and education.
- Excludes dialysis and renal dialysis education. See code 21.

Source and reference attributes

Origin: National Centre for Classification in Health consultant's report to Outpatients National Minimum Data Set Development Working Group, September 2004.

Data element attributes

Collection and usage attributes

Guide for use: Does not include services provided through community health settings (such as community and child health centres).

Source and reference attributes

Submitting organisation: NAP NMDS (Phase 1) working group

Relational attributes

Implementation in Data Set Specifications: Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Outpatient clinic type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—outpatient clinic type, code N[N]
METeOR identifier:	336952
Registration status:	Health, Standard 04/07/2007
Definition:	The organisational unit or organisational arrangement through which a hospital provides healthcare services in an outpatient setting, as represented by a code.
Data Element Concept:	Establishment—outpatient clinic type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Allied Health
2	Dental
3	Gynaecology
4	Obstetrics
5	Cardiology
6	Endocrinology
7	Oncology
8	Respiratory
9	Gastroenterology
10	Medical
11	General practice/primary care
12	Paediatric medical
13	Endoscopy
14	Plastic surgery
15	Urology
16	Orthopaedic surgery
17	Ophthalmology
18	Ear, nose and throat
19	Pre-admission and pre-anaesthesia

20	Chemotherapy
21	Dialysis
22	Surgery
23	Paediatric surgery
24	Renal medical

Collection and usage attributes

Guide for use:

The rules for allocating (mapping) clinic services to the clinic codes structure is the responsibility of each State and Territory and these rules need to be applied consistently within each State and Territory.

In most cases, reference to the code guide of permissible values will be adequate to map a hospital's clinics to the data domain. If not, general principles for mapping existing clinics to the data domain should take account of (a) the nature of the specialty, (b) patient characteristics, e.g. age, and (c) the field of practice of the service provider.

Where the patient characteristics have determined that a paediatric clinic type is appropriate, then further differentiation between surgical and medical is determined by (a) the nature of the specialty, and (b) the field of practice of the service provider. That is, paediatric medical would include any investigations, treatment(s) or services provided to a child which do not pertain to the surgical care of diseases or injuries.

In paediatric hospitals, the full range of clinic types should be used.

A guide for the permissible values of codes for the outpatient clinic types is as follows:

CODE 1 Allied Health

- Audiology.
- Clinical Pharmacology.
- Neuropsychology.
- Dietetics.
- Occupational therapy.
- Optometry.
- Orthoptics.
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- Podiatry.
- Prosthetics.
- Psychology.
- Social work.
- Speech pathology.

Includes clinics specified in mapping list above run solely by these Allied Health (AH) professionals. Example: A speech Pathologist conducting a clinic with booked patients for speech pathology services.

Excludes services provided by AH professionals in clinics classified in codes 2-23. Example: a physiotherapist running a cardiac rehabilitation clinic is classified to the Cardiology Clinic (see code 5).

CODE 2 Dental

- Dental.

CODE 3 Gynaecology

- Gynaecology.
- Gynaecological oncology (excluding chemotherapy).
- Menopause.
- Assisted reproduction, infertility.
- Family planning.

CODE 4 Obstetrics

- Obstetrics.
- Childbirth education.
- Antenatal.
- Postnatal.

Excludes gestational diabetes (see code 6).

CODE 5 Cardiology

- Cardiac rehabilitation.
- ECG.
- Doppler.
- Cardiac stress test.
- Hypertension.
- Pacemaker.

Excludes cardiac catheterisation (see code 22).

CODE 6 Endocrinology

- Endocrine.
- Gestational diabetes.
- Thyroid.
- Metabolic.
- Diabetes.
- Diabetes education.

CODE 7 Oncology

- Oncology.
- Lymphoedema.
- Radiation oncology.

Excludes chemotherapy (see code 20).

Excludes gynaecological oncology (see code 3).

CODE 8 Respiratory

- Asthma.
- Asthma education.
- Respiratory; excludes tuberculosis (see code 10).
- Cystic Fibrosis.
- Sleep.
- Pulmonary.

CODE 9 Gastroenterology

- Gastroenterology.

Excludes endoscopy (see code 13).

CODE 10 Medical

- Aged care, geriatric, gerontology.
- Allergy.
- Anti-coagulant.
- Clinical Measurement; include with relevant specialty clinic type where clinical measurement services are specific to a specialty (see codes 1-23) e.g. urodynamic analysis is counted with Urology (see code 15).
- Dementia.
- Dermatology.
- Development disability.
- Epilepsy.
- Falls.
- General medicine.
- Genetic.
- Haematology, haemophilia.
- Hepatobiliary.
- Hyperbaric medicine.
- Immunology, HIV.
- Infectious diseases; Communicable diseases; Hep B, C; includes tuberculosis.
- Men's Health.
- Metabolic bone.
- Excludes Nephrology (see code 24); excludes renal (see code 24); excludes dialysis (see code 21).
- Neurology, neurophysiology.
- Occupational medicine.
- Other.
- Pain management
- Palliative.
- Refugee clinic.
- Rehabilitation; excludes cardiac rehabilitation (see code

5).

- Rheumatology.
- Sexual Health.
- Spinal.
- Stoma therapy.
- Transplants (excludes kidney transplants see code 24).
- Wound, Dressing clinic.

CODE 11 General practice/primary care

- General Practice, Primary Care.

Excludes Medicare billable patients; defined specialty general practice clinics only.

CODE 12 Paediatric Medical

- Adolescent health.
- Neonatology.
- Paediatric medicine.

In paediatric hospitals the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgery should be reported as surgery.

CODE 13 Endoscopy

Includes all occasions of service for endoscopy including cystoscopy, gastroscopy, oesophagoscopy, duodenoscopy, colonoscopy, bronchoscopy, laryngoscopy and sigmoidoscopy.

Care must be taken to ensure procedures for admitted patients are excluded from this category.

CODE 14 Plastic surgery

- Craniofacial.
- Melanoma.
- Plastic surgery.

CODE 15 Urology

- Urology.

Includes urodynamic measurement and IVPs.

CODE 16 Orthopaedic surgery

- Fracture.
- Hand.
- Orthopaedics Surgery.
- Other.
- Scoliosis.
- Neck of femur.

CODE 17 Ophthalmology

- Ophthalmology.
- Cataract extraction.

- Lens insertion.

CODE 18 Ear, nose and throat

- Ear, nose and throat.
- Otitis media.
- Oral.

CODE 19 Pre-admission and pre-anaesthesia

- Pre-admission.
- Pre-anaesthesia.

CODE 20 Chemotherapy

Includes all forms of chemotherapy.

CODE 21 Dialysis

Dialysis and includes renal dialysis education. See code 24 for Renal medicine

CODE 22 Surgery

- Cardiac.
- Vascular.
- Cardiac catheterisation.
- Colorectal.
- Upper GI surgery.
- General surgery.
- Neurosurgery.
- Other surgery.
- Thoracic surgery.

CODE 23 Paediatric surgery

In paediatric hospitals the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgery should be reported as surgery.

CODE 24 Renal Medical

- Renal Medicine.
- Nephrology.
- Includes pre and post transplant treatment, support and education.
- Excludes dialysis and renal dialysis education. See code 21.

Source and reference attributes

Origin: National Centre for Classification in Health consultant's report to Outpatients National Minimum Data Set Development Working Group, September 2004.

Data element attributes

Collection and usage attributes

Guide for use: Does not include services provided through community health settings (such as community and child health centres).

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Group, 2006

Relational attributes

Related metadata references: See also Establishment—number of occasions of service, total N[NNNNNN] Health, Standard 04/07/2007

Supersedes Establishment—outpatient clinic type, code N[N] Health, Superseded 04/07/2007

Implementation in Data Set Specifications: Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Overdue patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—overdue patient status, code N
METeOR identifier:	471710
Registration status:	Health, Standard 13/12/2011
Definition:	Whether or not a patient is an overdue patient, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—overdue patient status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Overdue patient
2	Other

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item is required for patients in all *'Elective surgery waiting list episode – clinical urgency, code N'* categories. Overdue patients are those for whom the hospital system has failed to provide timely care and whose wait may have an adverse effect on the outcome of their care. They are identified by a comparison of *'Elective surgery waiting list episode – waiting time (at removal), total days N[NNN]'* or *'Elective surgery waiting list episode – waiting time (at a census date), total days N[NNN]'* and the maximum desirable time limit for the *'Elective surgery waiting list episode – clinical urgency, code N'* classification.

A patient is classified as overdue if ready for care and waiting time at admission or waiting time at a census date is longer than 30 days for patients in *'Elective surgery waiting list episode – clinical urgency, code N'* category 1, 90 days for patients in *'Elective surgery waiting list episode –*

clinical urgency, code N' category 2, or 365 days for patients in *'Elective surgery waiting list episode-clinical urgency, code N'* category 3.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

See also Elective surgery waiting list episode—clinical urgency, code N Health, Standard 01/03/2005

Supersedes Elective surgery waiting list episode—overdue patient status, code N Health, Superseded 13/12/2011

Is formed using Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Superseded 13/12/2011

Is formed using Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Superseded 13/12/2011

Implementation in Data Set Specifications:

Elective surgery waiting times (census data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 30/09/2012

Elective surgery waiting times (removals data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 01/07/2012

Elective surgery waiting times cluster Health, Standard 07/12/2011

Palliative care agency service delivery setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—service delivery setting, palliative care agency code N
METeOR identifier:	297661
Registration status:	Health, Standard 05/12/2007
Definition:	The setting in which a **palliative care agency** delivers palliative care services, as represented by a code.
Data Element Concept:	Service provider organisation—service delivery setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Private residence
2	Residential - aged care setting
3	Residential - other setting
4	Non-residential setting
5	Inpatient - designated palliative care unit or hospice
6	Inpatient - other than a designated palliative care unit
7	Outpatient - in a hospital/hospice

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Private residence

This may include a caravan, a mobile home, a houseboat or a unit in a retirement village.

CODE 2 Residential - aged care setting

Includes high and low care residential aged care facilities. Does not include units in a retirement village.

CODE 3 Residential - other setting

Includes a residential facility other than an aged care facility; a prison; or a community living environment including a group home. This code does not include inpatient settings e.g. hospitals and hospices.

CODE 4 Non-residential setting

Includes day respite centres and day centres. It does not include hospital outpatient departments.

CODE 5 Inpatient - designated palliative care unit or hospice

A dedicated ward or unit that receives identified funding for palliative care and/or primarily delivers palliative care. The unit may be a standalone unit (i.e. a hospice).

CODE 6 Inpatient - other than designated palliative care unit

Includes all beds not in a unit designated for palliative care. These are usually located in acute hospital wards. Excludes designated palliative care units.

CODE 7 Outpatient - in a hospital/hospice

Includes palliative care services provided at a hospital/hospice in an outpatient setting. Excludes all inpatient settings.

Collection methods: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Parity

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Female—parity, total N[N]

METeOR identifier: 302013

Registration status: Health, Standard 29/11/2006

Definition: The total number of previous pregnancies experienced by the woman that have resulted in a live birth or a stillbirth.

Data Element Concept: Female—parity

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[N]

Maximum character length: 2

Supplementary values:

Value	Meaning
99	Not stated

Unit of measure: Pregnancy

Data element attributes

Collection and usage attributes

Guide for use: This is to be recorded for each pregnancy.

This data element includes live births and stillbirths of 20 weeks gestation or 400 grams birthweight.

This data element excludes:

- the current pregnancy;
- pregnancies resulting in spontaneous or induced abortions before 20 weeks gestation; and
- ectopic pregnancies.

A primigravida (a woman pregnant for the first time) has a parity of 0.

Collection methods: A pregnancy with multiple fetuses is counted as one pregnancy.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Partner organisation type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—partner organisation type, palliative care code N[N]
METeOR identifier:	290715
Registration status:	Health, Standard 05/12/2007
Definition:	The type of organisation with which a palliative care service provider organisation has formal working partnership(s) in place, as represented by a code.
Data Element Concept:	Service provider organisation—partner organisation type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Palliative care services
2	Hospitals
3	Community nursing agencies
4	Residential aged care facilities
5	Allied health services
6	Aboriginal health services
7	Medical practices
8	Integrated health centres
9	Universities/research centres
10	Volunteer support services
99	Other

Data element attributes

Collection and usage attributes

Guide for use: A formal working partnership involves arrangements between a service provider organisation and other service providers and organisations, aimed at providing integrated and seamless care, so that clients are able to move smoothly between services and service settings.

A formal working partnership is a verbal or written agreement between two or more parties. It specifies the roles and responsibilities of each party, including the expected outcomes of the agreement.

Key elements of a formal working partnership are that it is organised, routine, collaborative, and systematic. It excludes ad hoc arrangements. Examples of formal working partnerships include the existence of: written service agreements; formal liaison; referral and discharge planning processes; formal and routine consultation; protocols; partnership working groups; memoranda of understanding with other providers; and case conferencing.

Where partnerships exist for case conferencing purposes, record all partners involved.

CODE 1 Palliative care services

Includes services whose substantive work is with patients who have a life-limiting illness. These palliative care services may provide services in the community and/or in admitted patient settings (including hospices).

CODE 2 Hospitals

Includes emergency departments. Excludes hospices/designated palliative care units in a hospital, and other palliative care agencies as defined under Code 1. Also excludes hospital-based allied health services and individual medical practitioners.

CODE 7 Medical practices

Includes practices of general practitioners and individual specialist physicians such as specialists in palliative care, oncologists, urologists and neurologists.

CODE 8 Integrated health centres

Includes multipurpose centres, aged care centres and specialist care centres such as cancer centres.

CODE 9 Universities/research centres

Includes universities that may undertake research and development projects.

CODE 99 Other

Includes organisations based in the community such as schools, clubs, workplaces, organisations that provide respite care or pastoral care and 'Meals on wheels'.

Collection methods: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:

Palliative care performance indicators DSS Health, Standard 05/12/2007

> *Conditional obligation:*
>
> Recorded when the data element *Service provider organisation—working partnerships indicator, yes/no code N* is 'yes' (code 1).

Patient days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of patient days, total N[N(7)]
METeOR identifier:	270045
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period.
Data Element Concept:	Establishment—number of patient days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N(7)]
Maximum character length:	8
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

A day is measured from midnight to 2359 hours.

The following basic rules are used to calculate the number of patient days for **overnight stay patients**:

- The day the patient is admitted is a patient day
- If the patient remains in hospital from midnight to 2359 hours count as a patient day
- The day a patient goes on leave is counted as a leave day
- If the patient is on leave from midnight to 2359 hours count as a leave day
- The day the patient returns from leave is counted as a patient day
- The day the patient is separated is not counted as a patient day.

The following additional rules cover special circumstances and in such cases, override the basic rules:

- Patients admitted and separated on the same date (**same-day patients**) are to be given a count of one patient day

- If the patient is admitted and goes on leave on the same day, count as a patient day
- If the patient returns from leave and goes on leave on the same date, count as a leave day.
- If the patient returns from leave and is separated, it is not counted as either a patient day or a leave day.
- If a patient goes on leave the day they are admitted and does not return from leave until the day they are discharged, count as one patient day (the day of admission is counted as a patient day, the day of separation is not counted as a patient day).

When calculating total patient days for a specified period:

- Count the total patient days of those patients separated during the specified period including those admitted before the specified period
- Do not count the patient days of those patients admitted during the specified period who did not separate until the following reference period
- Contract patient days are included in the count of total patient days. If it is a requirement to distinguish contract patient days from other patient days, they can be calculated by using the rules contained in the data element: total contract patient days.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is formed using Episode of admitted patient care (newborn)—number of qualified days, total N[NNNN] Health, Standard 01/03/2005

Supersedes Patient days, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)

Patient listing status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—patient listing status, readiness for care code N
METeOR identifier:	269996
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the person's readiness to begin the process leading directly to being admitted to hospital for the awaited procedure, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—patient listing status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Ready for care
2	Not ready for care

Data element attributes

Collection and usage attributes

Guide for use:

A patient may be 'ready for care' or 'not ready for care'. Ready for care patients are those who are prepared to be admitted to hospital or to begin the process leading directly to admission. These could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests. Not ready for care patients are those who are not in a position to be admitted to hospital. These patients are either:

- staged patients whose medical condition will not require or be amenable to surgery until some future date; for example, a patient who has had internal fixation of a fractured bone and who will require removal of the fixation device after a suitable time; or
- deferred patients who for personal reasons are not yet prepared to be admitted to hospital; for example,

patients with work or other commitments which preclude their being admitted to hospital for a time.

Not ready for care patients could be termed staged and deferred waiting list patients, although currently health authorities may use different terms for the same concepts.

Staged and deferred patients should not be confused with patients whose operation is postponed for reasons other than their own unavailability, for example; surgeon unavailable, operating theatre time unavailable owing to emergency workload. These patients are still ‘ready for care’.

Periods when patients are not ready for care should be excluded in determining ‘Waiting time (at removal)’ and ‘Waiting time (at a census date)’.

Comments: Only patients ready for care are to be included in the National Minimum Data Set - Elective surgery waiting times. The dates when a patient listing status changes need to be recorded. A patient’s classification may change if he or she is examined by a clinician during the waiting period, i.e. undergoes **clinical review**. The need for clinical review varies with the patient’s condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (metadata item Category reassignment date).

At the Waiting Times Working Group meeting on 9 September 1996, it was agreed to separate the metadata items Patient listing status, readiness for care and Clinical urgency as the combination of these items had led to confusion.

Source and reference attributes

Submitting organisation: Hospital Access Program Waiting Lists Working Group

Waiting Times Working Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Superseded 13/12/2011

Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 22/12/2011

Supersedes Patient listing status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.7 KB)

Patient present status (non-admitted patient)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Non-admitted patient service event—patient present status, code N

METeOR identifier: 270081

Registration status: Health, Standard 01/03/2005

Definition: The presence or absence of a patient at a service event, as represented by a code.

Data Element Concept: Non-admitted patient service event—patient present status

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Patient present with or without carer(s)/relative(s)
2	Carer(s)/relative(s) of the patient only

Data element attributes

Collection and usage attributes

Guide for use: A service event is regarded as having occurred when a consultation occurs between their carer/relative and a service provider at an appointment when the patient is not present, provided that the carer/relative is not a patient in their own right for the service contact. Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

Relational attributes

Related metadata references: Supersedes Non-admitted patient service event - patient present status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Patient relationship to health-care service provider

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—relationship to health-care service provider, code N
METeOR identifier:	330338
Registration status:	Health, Standard 07/12/2011
Definition:	The relationship of the patient to the health-care service provider, as represented by a code.
Data Element Concept:	Patient—relationship to health-care service provider

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Public admitted hospital patient
	2	Private admitted hospital patient
	3	Resident
	8	Other
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Public admitted hospital patient

'Public admitted hospital patient' includes persons enrolled in Medicare who, on admission to a recognised hospital or soon after, receive or elect to receive a public hospital service free of charge. This includes patients for whom treatment is contracted to a private hospital. It does not include Department of Veterans' Affairs patients and compensable patients. Code 1 also includes patients who were admitted to a private hospital as public patients.

CODE 2 Private admitted hospital patient

'Private admitted hospital patient' includes persons who on admission to a recognised hospital or soon after elect to be private patients treated by a medical practitioner of their choice; or elect to occupy a bed in a single room and are responsible for meeting certain hospital charges as well as the professional charges raised by a treating medical or dental practitioner. Private admitted hospital patients also includes persons who are eligible for Medicare who choose to be admitted to a private hospital and are responsible for meeting all hospital charges as well as the professional charges raised by any treating medical or dental practitioner.

Private admitted hospital patient also includes:

- Department of Veterans' Affairs patients (eligible persons whose charges for their hospital admission are met by the Department of Veterans' Affairs); and
- Compensable patients (persons who are entitled to receive or have received a compensation payment with respect to an injury or disease). Compensable patients are persons who are entitled to claim damages under motor vehicle third party insurance, worker's compensation, public liability or common law.

Whether patients are admitted patients will depend on administrative practices within particular jurisdictions. If the patients were considered to be admitted patients by the relevant health-service provider at the time of the health-care incident then Code 1 or 2 should be recorded (as appropriate). Code 1 or 2 should also be used for patients receiving long-term nursing or respite care in a hospital, if they are considered admitted hospital patients.

CODE 3 Resident

'Resident' should be recorded where, at the time of the incident, a patient was a resident in a residential aged care or mental health care establishment, or in a similar residential health-care setting. Some hospitals (particularly in rural areas) use hospital beds to provide long-term nursing or respite care. However, where patients receiving such care are admitted hospital patients this code should not be recorded.

CODE 8 Other

'Other' should be recorded where, at the time of the incident, the patient was attending an outpatient clinic, general practice surgery, Emergency department, or similar non-admitted, non-residential service.

CODE 9 Not stated/inadequately described

'Not stated/inadequately described' should be used when the information is not currently available.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Comments: The coding category definitions were developed with reference to the following metadata items in the National Health Data Dictionary Version 15: Admitted patient election status; Compensable status; Funding source for hospital patient; and Medicare eligibility status (AIHW 2010).

This data element distinguishes between public and private admitted hospital patients only as it is difficult to distinguish between public and private non-admitted hospital patients, and the relevant NHDD data elements all apply to hospital patients only. Also, national data on numbers of hospital separations for public and private patients are available, whereas similar denominator data are not readily available for non-admitted patients.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: AIHW (Australian Institute of Health and Welfare) 2010. National health data dictionary. Version 15. National health data dictionary series. Cat. no. HWI 107. Canberra: AIHW

Relational attributes

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Patients in residence at year end

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—patients/clients in residence at year end, total N[NNN]

METeOR identifier: 270046

Registration status: Health, Standard 01/03/2005

Definition: A headcount of all formally admitted patients/clients in residence in long-stay facilities.

Data Element Concept: Establishment—patients/clients in residence at year end

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNN]

Maximum character length: 4

Unit of measure: Person

Data element attributes

Collection and usage attributes

Collection methods: For public psychiatric hospitals and alcohol and drug hospitals, all states have either an annual census or admission tracking that would enable a statistical census. The Commonwealth Department of Health and Ageing is able to carry out a statistical census from its residential aged care service databases.

A headcount snapshot could be achieved either by census or by the admission/discharge derivation approach.

There are difficulties with the snapshot in view of both seasonal and day of the week fluctuations. Most of the traffic occurs in a small number of beds.

Any headcount should avoid the problems associated with using 31 December or 1 January. The end of the normal financial year is probably more sensible (the Wednesday before the end of the financial year was suggested, but probably not necessary). This should be qualified by indicating that the data does not form a time series in its own right.

Comments: The number of separations and bed days for individual long-stay establishments is often a poor indication of the services provided. This is because of the relatively small number of separations in a given institution. Experience has shown that the number of patients/clients in residence can often give a more reliable picture of the levels of services being provided.

Source and reference attributes

Submitting organisation: Morbidity working party

Relational attributes

Related metadata references: Supersedes Patients in residence at year end, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Percutaneous coronary intervention procedure type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—percutaneous coronary intervention procedure type, code N
Synonymous names:	PCI procedure type
METeOR identifier:	359751
Registration status:	Health, Standard 01/10/2008
Definition:	The type of procedure performed during a percutaneous coronary intervention (PCI), as represented by a code.
Data Element Concept:	Person—percutaneous coronary intervention procedure type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	N	
Permissible values:	Value	Meaning
	1	Balloon angioplasty only
	2	Bare metal stent implantation
	3	Drug-eluting stent implantation
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1   Balloon angioplasty only

Use this code where only balloon angioplasty has been performed during a percutaneous coronary intervention.

CODE 2   Bare metal stent implantation

Use this code where a bare metal stent has been implanted during a percutaneous coronary intervention.

CODE 3   Drug-eluting stent implantation

Use this code where at least one drug-eluting stent has been implanted during a percutaneous coronary intervention (i.e. if more than one stent has been placed during the procdure and at least one stent is a drug-eluting stent).

CODES 2 and 3 include the performance of balloon angioplasty.

Data element attributes

Source and reference attributes

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications: Coronary artery cluster Health, Standard 01/10/2008

Conditional obligation:

Record when a percutaneous coronary intervention is performed. This includes those performed for primary, rescue or revascularisation reasons.

Perineal status

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Female (mother)—postpartum perineal status, code N

METeOR identifier: 269939

Registration status: Health, Standard 01/03/2005

Definition: The state of the perineum following birth, as represented by a code.

Context: Perinatal

Data Element Concept: Female (mother)—postpartum perineal status

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Intact
	2	1st degree laceration/vaginal graze
	3	2nd degree laceration
	4	3rd degree laceration
	5	Episiotomy
	6	Combined laceration and episiotomy
	7	4th degree laceration
	8	Other
Supplementary values:	9	Not stated

Collection and usage attributes

Guide for use: Vaginal tear is included in the same group as 1st degree laceration to be consistent with ICD-10-AM code. Other degrees of laceration are as defined in ICD-10-AM.

Comments: While 4th degree laceration is more severe than an episiotomy it has not been placed in order of clinical significance within the data domain. Instead it has been added to the data domain as a new code rather than modifying the existing order of data domain code values. This is because information gatherers are accustomed to the existing order of the codes. Modifying the existing order may result in miscoding of data. This approach is consistent with established practice in classifications wherein a new data domain identifier (or code number) is assigned to any new value meaning that occurs, rather than assigning this new value domain meaning to an existing data domain identifier.

Data element attributes

Collection and usage attributes

Comments: Perineal laceration (tear) may cause significant maternal morbidity in the postnatal period. Episiotomy is an indicator of management during labour and, to some extent, of intervention rates.

Relational attributes

Related metadata references: Supersedes Perineal status, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

Period of residence in Australia

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—period of residence in Australia, years code NN
METeOR identifier:	270050
Registration status:	Health, Standard 01/03/2005
Definition:	Length of time in years a person has lived in Australia.
Data Element Concept:	Person—period of residence in Australia

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Permissible values:	Value	Meaning
	00	Under one year residence in Australia
	01-97	1 to 97 years residence in Australia
	98	Born in Australia
Supplementary values:	99	Unknown

Data element attributes

Collection and usage attributes

Collection methods:

This information may be obtained either from:

- a direct question with response values as specified in the data domain; or
- derived from other questions about date of birth, birthplace and year of arrival in Australia.

Comments:

This metadata item was included in the recommended second-level data set by the National Committee on Health and Vital Statistics (1979) to allow analyses relating to changes in morbidity patterns of ethnic subpopulations related to length of stay in host country; for example, cardiovascular disease among Greek immigrants in Australia.

This item was not considered a high priority by the Office of Multicultural Affairs (1988) and to date only the country of birth and Indigenous status are considered by the National Health Data Committee to be justified for

	inclusion in the National Minimum Data Set - Admitted patient care.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Period of residence in Australia, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Peripheral neuropathy (status)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—peripheral neuropathy indicator, code N

METeOR identifier: 302457

Registration status: Health, Standard 21/09/2005

Definition: Whether peripheral neuropathy is present, as represented by a code.

Data Element Concept: Person—peripheral neuropathy indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes: Record if peripheral neuropathy is present in the person.

CODE 2 No: Record if peripheral neuropathy is not present in the person.

Record whether or not peripheral neuropathy is present determined by clinical judgement following assessment using pinprick and vibration (using perhaps a Biothesiometer) or Monofilament.

Collection methods: Examine for neuropathy by testing reflexes and sensation preferably using tuning fork (standard vibration fork 128 hz), pinprick, 10g monofilament and/or biothesiometer.

The preferred assessment methods are monofilament and biothesiometer. These two non-invasive tests provide more objective and repeatable results than testing sensation with pinprick or a tuning fork, which are very difficult to standardise.

1 The 'Touch-Test' Sensory Evaluation (Semmens-Weinstein Monofilaments) application guidelines:

- Occlude the patient's vision by using a shield or by having the patient look away or close his or her eyes.
- Instruct the patient to respond when a stimulus is felt by saying 'touch' or 'yes'.
- Prepare to administer the stimulus to the foot (dorsal or plantar surface).
- Press the filament of the Touch
- Test at a 90 degree angle against the skin until it bows. Hold in place for approximately 1.5 seconds and then remove.

To assure the validity of the sensory test findings:

- The patient must not be able to view the administration of the stimuli so that false indications are avoided.
- The nylon filament must be applied at a 90 degree angle against the skin until it bows for approximately 1.5 second before removing.
- If the patient does not feel the filament, then protective pain sensation has been lost.

2 Testing vibration sensation with a biothesiometer - application guidelines:

- The biothesiometer has readings from 0 to 50 volts. It can be made to vibrate at increasing intensity by turning a dial.
- A probe is applied to part of the foot, usually on the big toe.
- The person being tested indicates as soon as he/she can feel the vibration and the reading on the dial at that point is recorded.

The reading is low in young normal individuals (i.e. they are very sensitive to vibration). In older individuals, the biothesiometer reading becomes progressively higher. From experience, it is known that the risk of developing a neuropathic ulcer is much higher if a person has a biothesiometer reading greater than 30-40 volts.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary
Reference documents:	1997 North Coast Medical, INC. San Jose, CA 95125; 800

821 - 9319

Duffy MD, John C and Patout MD, Charles A. 1990. ‘Management of the Insensitive Foot in Diabetes: Lessons from Hansen’s Disease’. Military Medicine, 155:575-579

Bell- Krotovski OTR, FAOT, FAOTA, Judith and Elizabeth Tomancik LOTR. 1987.The Repeatability of testing with Semmens-Weinstein Monofilaments. ‘The Journal of Hand Surgery,’ 12A: 155 - 161

Edmonds M, Boulton A, Buckenham T, et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27 - 42

Foot Examination -an interactive guide; Aust Prescr 2002; 25:8 - 10

Relational attributes

Related metadata references: Supersedes Person—peripheral neuropathy status, code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Peripheral vascular disease in feet (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—peripheral vascular disease indicator (foot), code N
METeOR identifier:	302459
Registration status:	Health, Standard 21/09/2005
Definition:	Whether peripheral vascular disease is present in either foot, as represented by a code.
Data Element Concept:	Person—peripheral vascular disease indicator (foot)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes: Record if peripheral vascular disease is present in either foot.

CODE 2 No: Record if peripheral vascular disease is not present in either foot.

Collection methods:

If it is mild, peripheral vascular disease can be completely without symptoms. However, compromised blood supply in the long term could cause claudication (pain in the calf after walking for a distance or up an incline or stairs), rest pain or vascular ulceration.

Physical examination is necessary to assess the peripheral vascular circulation. Purplish colour and cold temperature of feet are indications to suspect that the circulation may be impaired.

Palpate pulses:

The simplest method to estimate blood flow and to detect ischaemia to the lower extremities is palpation of the foot pulses (posterior tibial and dorsalis pedis arteries) in both feet. Note whether pulses are present or absent. If pulses in the foot can be clearly felt, the risk of foot ulceration due to vascular disease is small.

Test capillary return:

A helpful confirmation sign of arterial insufficiency is pallor of the involved feet after 1 - 2 min of elevation if venous filling time is delayed beyond the normal limit of 15 sec.

Doppler probe:

If pulses cannot be palpated, apply a small hand-held Doppler, placed over the dorsalis pedis or posterior tibial arteries to detect pulses, quantify the vascular supply and listen to the quality of the signal.

When the foot pulses are very weak or not palpable, the risk assessment could be completed by measuring the ankle brachial index (ankle pressure/ brachial pressure). Normal ankle brachial index is 0.9 - 1.2. An ankle brachial index less than 0.6 indicates compromised peripheral circulation.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Person—peripheral vascular disease status (foot), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Person identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—person identifier, XXXXXX[X(14)]
METeOR identifier:	290046
Registration status:	Community Services, Standard 25/08/2005 Health, Standard 04/05/2005
Definition:	Person identifier unique within an establishment or agency.
Data Element Concept:	Person—person identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	XXXXXX[X(14)]
Maximum character length:	20

Data element attributes

Collection and usage attributes

Guide for use:

Individual agencies, establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems.

Field cannot be blank.

Source and reference attributes

Reference documents:

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes Person—person identifier (within establishment/agency), XXXXXX[X(14)] Community Services, Superseded 25/08/2005, Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Cancer (clinical) DSS Health, Standard 07/12/2011

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Prison clinic contact DSS Health, Standard 25/08/2011

Prison entrants DSS Health, Standard 25/08/2011

Prisoners in custody repeat medications DSS Health, Standard 25/08/2011

Radiotherapy waiting times DSS 2012- Health, Standard

07/12/2011

Implementation start date: 01/07/2012

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Person identifier type—health care (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (identifier)—identifier type, geographic/administrative scope code A
METeOR identifier:	270053
Registration status:	Health, Standard 01/03/2005
Definition:	A code based on the geographical or administrative breadth of applicability of Person identifier.
Data Element Concept:	Person (identifier)—identifier type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
L	Local
A	Area/region/district
S	State or territory

Collection and usage attributes

Guide for use:

CODE L Local

This code is for an identifier that is applicable only inside the issuing health care establishment

CODE A Area/region/district

This code is for an identifier that is applicable to:

- all the area/region/district health care services but not across all services in the state or territory; or
- all of a specific health care service (e.g. community mental health) in an area/region/district health care services but not across all those services in the state or territory

CODE S State or territory

This code is for identifiers that are applicable across all state or territory health care services.

Data element attributes

Collection and usage attributes

Guide for use: A person can have more than one person identifier. Each Person identifier must have an appropriate person identifier type code recorded.

Use this field to record only identifier type. It must not be used to record any other person related information.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS5017 Health Care Client Identification

Relational attributes

Related metadata references: Supersedes Person identifier type - health care, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Pneumococcal disease immunisation indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—pneumococcal disease immunisation indicator, yes/no code N
METeOR identifier:	460017
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a person is immunised against pneumococcal disease, as represented by a code.
Data Element Concept:	Person—pneumococcal disease immunisation indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A person is immunised against pneumococcal disease.

CODE 2 No

A person is not immunised against pneumococcal disease.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Pharmacotherapy type prescribed for acute coronary syndrome in hospital

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—pharmacotherapy type prescribed in hospital, code N[N]
Synonymous names:	ACS pharmacotherapy type prescribed
METeOR identifier:	344344
Registration status:	Health, Standard 01/10/2008
Definition:	The type of pharmacotherapy prescribed to a person in hospital for the treatment of acute coronary syndrome, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—pharmacotherapy type prescribed in hospital

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:	Value	Meaning
	1	Aspirin
	2	Angiotensin converting enzyme (ACE) inhibitor
	3	Angiotensin II receptor blocker
	4	Antithrombin
	5	Beta-blocker
	6	Clopidogrel
	7	Fibrinolytic
	8	Glycoprotein IIb/IIIa receptor antagonist
	9	Statin
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Aspirin

Includes: aspirin, astrix, cardiprin, cartia, aspro, disprin and solprin

CODE 2 Angiotensin converting enzyme (ACE) inhibitor

Includes: captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril and trandolapril

CODE 3 Angiotensin II receptor blocker

Includes: candesartan, eprosartan, irbesartan, losartin and temisartan

CODE 4 Antithrombin

Includes: dalteparin, danaparoid, enoxaparin, heparin, phenindione, warfarin, bivalirudin, fondaparinux, lepirudin

CODE 5 Beta-blocker

Includes: atenolol, bisoprolol, carvedilol, esmolol, labetolol, metoprolol, oxprenolol, pindolol, propranolol and sotalol

CODE 6 Clopidogrel

Includes: iscover and plavix

CODE 7 Fibrinolytic

Includes: streptokinase, tissue plasminogen activator (t-PA) (alteplase), reteplase (r-PA) and tenecteplase (TNK t-PA)

CODE 8 Glycoprotein IIb/IIIa receptor

Includes: abciximab, eptifibatide and tirofiban

CODE 9 Statin

Includes: atorvastatin, fluvastatin, pravastatin and simvastatin

Data element attributes

Collection and usage attributes

Guide for use: A person may be prescribed one or more type of medication for acute coronary syndromes. Therefore more than one code may be recorded.

Collection methods: This information should be recorded at the end of the person's hospital stay involving the treatment of acute coronary syndromes.

Comments: The purpose of this data element is to collect information on the prescription of pharmacotherapy recommended for the treatment of acute coronary syndromes in the national guidelines. Additional information on the specific drug types prescribed is not required for this quality purpose.

The health service may choose to collect additional information on the specific drug types prescribed within each of the core pharmacotherapies.

Source and reference attributes

Reference documents: National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Pharmacotherapy type taken for acute coronary syndrome post discharge

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—pharmacotherapy type taken post discharge from hospital, code N[N]
METeOR identifier:	344822
Registration status:	Health, Standard 01/10/2008
Definition:	The type of pharmacotherapy being taken by a person for the treatment of acute coronary syndrome following discharge from hospital, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—pharmacotherapy type taken post discharge from hospital

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Permissible values:	Value	Meaning
	1	Aspirin
	2	Angiotensin converting enzyme (ACE) inhibitor
	3	Angiotensin II receptor blocker
	4	Beta-blocker
	5	Clopidogrel
	6	Statin
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Aspirin

Includes: aspirin, astrix, cardiprin, cartia, aspro, disprin and solprin

CODE 2 Angiotensin converting enzyme (ACE) inhibitor

Includes: captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril and trandolapril

CODE 3 Angiotensin II receptor blocker

Includes: candesartan, eprosartan, irbesartan, losartin and temisartan

CODE 4 Beta-blocker

Includes: atenolol, bisoprolol, carvedilol, esmolol, labetolol, metoprolol, oxprenolol, pindolol, propranolol and sotalol

CODE 5 Clopidogrel

Includes: iscover and plavix

CODE 6 Statin

Includes: atorvastatin, fluvastatin, pravastatin and simvastatin

Data element attributes

Collection and usage attributes

Guide for use: A person may be taking one or more type of medication for acute coronary syndromes (ACS). Therefore more than one code may be recorded.

Collection methods: Following a person's hospital stay for ACS, follow-up consultations with a clinician may occur at various intervals, such as 3, 6 or 12 months after discharge from hospital. The medications being taken by the person at the time of each follow-up consultation should be recorded.

Comments: The pharmacotherapies for the treatment of ACS that could be taken post discharge from hospital are different from the types that could be taken during the hospital stay as not all of the pharmacotherapies used for the treatment of ACS are for out of hospital use.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome pharmacotherapy data cluster
Health, Standard 01/10/2008

Physical activity sufficiency status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—physical activity sufficiency status, code N
METeOR identifier:	270054
Registration status:	Health, Standard 01/03/2005
Definition:	Sufficiency of moderate or vigorous physical activity to confer a health benefit, as represented by a code.
Data Element Concept:	Person—physical activity sufficiency status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	1	Sufficient
	2	Insufficient
	3	Sedentary
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

The clinician makes a judgment based on assessment of the person's reported physical activity history for a usual 7-day period where:

CODE 1:

Sufficient physical activity for health benefit for a usual 7-day period is calculated by summing the total minutes of walking, moderate and/or vigorous physical activity.

Vigorous physical activity is weighted by a factor of two to account for its greater intensity. Total minutes for health benefit need to be equal to or more than 150 minutes per week.

CODE 2:

Insufficient physical activity for health benefit is where the sum of the total minutes of walking, moderate and/or vigorous physical activity for a usual 7-day period is less than 150 minutes but more than 0 minutes.

CODE 3:

Sedentary is where there has been no moderate and/or vigorous physical activity during a usual 7-day period.

CODE 9:

There is insufficient information to more accurately define the person's physical activity sufficiency status or the information is not known.

Note: The National Heart Foundation of Australia and the National Physical Activity Guidelines for Australians describes moderate-intensity physical activity as causing a slight but noticeable, increase in breathing and heart rate and suggests that the person should be able to comfortably talk but not sing. Examples of moderate physical activity include brisk walking, low pace swimming, light to moderate intensity exercise classes. Vigorous physical activity is described as activity, which causes the person to 'huff and puff', and where talking in a full sentence between breaths is difficult.

Examples of vigorous physical activity include jogging, swimming (freestyle) and singles tennis.

Comments:

The above grouping subdivides a population into three mutually exclusive categories.

A sufficiently physically active person is a person who is physically active on a regular weekly basis equal to or in excess of that required for a health benefit. Sufficient physical activity for health results from participation in physical activity of adequate duration and intensity. Although there is no clear absolute threshold for health benefit, the accrual of 150 minutes of moderate (at least) intensity physical activity over a period of one week is thought to confer health benefit. Walking is included as a moderate intensity physical activity. Note that the 150 minutes of moderate physical activity should be made up of 30 minutes on most days of the week and this can be accumulated in 10 minute bouts (National Physical Activity Guidelines for Australians).

Health benefits can also be obtained by participation in vigorous physical activity, in approximate proportion to the total amount of activity performed, measured either as energy expenditure or minutes of physical activity (Pate et al. 1995).

Physical activity - health benefit for vigorous physical activity is calculated by:

- incorporating a weighted factor of 2, to account for its greater intensity
- summing the total minutes of walking, moderate

and/or vigorous physical activity will then give an indication if a health benefit is likely.

Insufficient physical activity describes a person who engages in regular weekly physical activity but not to the level required for a health benefit through either moderate or vigorous physical activity.

A sedentary person is a person who does not engage in any regular weekly physical activity.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: The National Heart Foundation of Australia's Physical Activity Policy, April 2001. National Physical Activity Guidelines For Australians, developed by the University of Western Australia & the Centre for Health Promotion

Relational attributes

Related metadata references: Supersedes Physical activity sufficiency status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.5 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Place of occurrence of external cause of injury (ICD-10-AM)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Injury event—place of occurrence, code (ICD-10-AM 7th edn) ANN{.N[N]}

METeOR identifier: 391334

Registration status: Health, Standard 22/12/2009

Definition: The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.

Data Element Concept: Injury event—place of occurrence

Value domain attributes

Representational attributes

Classification scheme: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition

Representation class: Code

Data type: String

Format: ANN{.N[N]}

Maximum character length: 6

Data element attributes

Collection and usage attributes

Guide for use: Admitted patient:

External cause codes in the range V00 to Y89 must be accompanied by a place of occurrence code.

External cause codes V00 to Y34 must be accompanied by an activity code.

Comments: Enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Source and reference attributes

Origin: National Centre for Classification in Health

AIHW National Injury Surveillance Unit

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: Supersedes Injury event—place of occurrence, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Implementation in Data Set Specifications: Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Injury surveillance DSS Health, Standard 14/12/2009

Place of occurrence of external cause of injury (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—place of occurrence, non-admitted patient code N[N]
METeOR identifier:	268949
Registration status:	Health, Standard 01/03/2005
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.
Data Element Concept:	Injury event—place of occurrence

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Permissible values:	Value	Meaning
	0	Home
	1	Residential Institution
	2	School, other institution and public administration area
	21	School
	22	Health service area
	23	Building used by general public or public group
	3	Sports and athletics area
	4	Street and highway
	5	Trade and service area
	6	Industrial and construction area
	7	Farm
	8	Other specified places
Supplementary values:	9	Unspecified place

Data element attributes

Collection and usage attributes

Guide for use: To be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterises the type of place where the person was situated when the injury occurred on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.

Source and reference attributes

Origin:

National Centre for Classification in Health

AIHW National Injury Surveillance Unit

National Data Standards for Injury Surveillance Advisory Group

National Health Data Committee

Relational attributes

Related metadata references: Supersedes Place of occurrence of external cause of injury, version 6, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.1 KB)

Implementation in Data Set Specifications: Injury surveillance DSS Health, Standard 14/12/2009

Planned hospital transfer indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment (prison)—planned hospital transfer indicator, yes/no code N

METeOR identifier: 402779

Registration status: Health, Standard 25/08/2011

Definition: An indicator of whether a transfer from a prison to a hospital is planned or unplanned, as represented by a code.

Data Element Concept: Establishment (prison)—planned hospital transfer indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes

Select this code if the transfer was planned.

CODE 2 No

Select this code if the transfer was unplanned.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Establishment (prison)—number of hospital transfers, number N[NN] Health, Standard 25/08/2011

Implementation in Data Set Specifications: Hospital transfer cluster Health, Standard 25/08/2011

Postal delivery point identifier (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—postal delivery point identifier, {N(8)}
Synonymous names:	Australian delivery point identifier
METeOR identifier:	287220
Registration status:	Community Services, Superseded 06/02/2012 Health, Standard 04/05/2005
Definition:	A unique number assigned to a person's postal address as recorded on the Australia Post Postal Address File (PAF).
Data Element Concept:	Person (address)—postal delivery point identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	{N(8)}
Maximum character length:	8

Source and reference attributes

Origin:	Customer Barcoding Technical Specifications, 1998: Australia Post
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Guide for use:

Australia Post maintains a Postal Address File (PAF) database which contains Australian postal delivery addresses and their corresponding eight (8) character unique identification number known as a Delivery Point Identifier (DPID). While the PAF is concerned with postal address, for many persons' a postal address will be the same as their residential address. The PAF can be used to improve the recording of address data at the time of data collection.

The Postal Address File may be used at the time of data collection to confirm that the combined metadata items of address line, suburb/town/locality, Australian state/territory identifier and postcode - Australian are accurately recorded.

Collection methods: The Delivery Point Identifier (DPID) is assigned electronically to recognised Australia Post delivery addresses following reference to the Postal Address File (PAF) database.

Comments: In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Agencies or establishments can use software to improve the quality of person address data it collects and records and, at the same time, receive financial benefits by reducing its postage expenses.

The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-franking machine (e.g. as used by most major hospitals), the postage cost is reduced. Every three months, Australia Post provides updates to the PAF database. For more information, contact Australia Post.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Standards Committee

National Community Services Data Committee

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Reference documents: AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references: Supersedes Person (address)—postal delivery point identifier, {N(8)} Community Services, Superseded 25/08/2005, Health, Superseded 04/05/2005

Is formed using Person (address)—suburb/town/locality name, text [A(50)] Community Services, Superseded 06/02/2012, Housing assistance, Standard 23/08/2010, Health, Superseded 07/12/2011, Early Childhood, Superseded 09/03/2012, Homelessness, Standard 23/08/2010, Tasmanian Health, Proposed 28/09/2011

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Postal delivery point identifier (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—postal delivery point identifier, {N(8)}
METeOR identifier:	290141
Registration status:	Community Services, Superseded 06/02/2012 Health, Standard 04/05/2005
Definition:	A unique number assigned to a service provider organisation's postal address as recorded on the Australia Post Postal Address File (PAF).
Data Element Concept:	Service provider organisation (address)—postal delivery point identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	{N(8)}
Maximum character length:	8

Source and reference attributes

Origin:	Customer Barcoding Technical Specifications, 1998: Australia Post
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Collection methods:	The Delivery Point Identifier (DPID) is assigned electronically to recognised Australia Post delivery addresses following reference to the Postal Address File (PAF) database.
Comments:	In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Agencies or establishments can use software to improve the quality of

person address data it collects and records and, at the same time, receive financial benefits by reducing its postage expenses.

The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-franking machine (e.g. as used by most major hospitals), the postage cost is reduced. Every three months, Australia Post provides updates to the PAF database. For more information, contact Australia Post.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Standards Committee

National Community Services Data Committee

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references: Is formed using Service provider organisation (address)—suburb/town/locality name, text [A(50)] Community Services, Superseded 06/02/2012, Housing assistance, Recorded 13/10/2011, Health, Superseded 07/12/2011, Early Childhood, Superseded 09/03/2012, Tasmanian Health, Proposed 28/09/2011

Implementation in Data Set Specifications: Health care provider identification DSS Health, Standard 03/12/2008

Postal delivery service number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—postal delivery service type identifier, [X(11)]
METeOR identifier:	270032
Registration status:	Health, Standard 01/03/2005
Definition:	An identifier for the postal delivery service where a person is located.
Data Element Concept:	Person (address)—postal delivery service type identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[X(11)]
Maximum character length:	11

Data element attributes

Collection and usage attributes

Guide for use:

The identification of a postal delivery service may be composed of a prefix, a number, and a suffix as per the following format:

Prefix A(3)

Number N(5)

Suffix A(3)

May optionally include a prefix and suffix which are non-numeric.

The identification may also not be required for certain services.

Examples:

PO BOX C96

CARE PO

RMB 123

GPO BOX 1777Q

Collection methods:

To be collected in conjunction with Postal delivery service type - abbreviation.

Source and reference attributes

Origin: Health Data Standards Committee
AS4590 Interchange of client information

Relational attributes

Related metadata references: Supersedes Postal delivery service number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)

Postal delivery service type - abbreviation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—postal delivery service type, code AA[A(9)]
METeOR identifier:	270027
Registration status:	Health, Standard 01/03/2005
Definition:	Type of postal delivery service for a person, as represented by a code.
Data Element Concept:	Person—postal delivery service type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AA[A(9)]
Maximum character length:	11

Permissible values:

Value	Meaning
CARE PO	Care-of Post Office (also known as Poste Restante)
CMA	Community Mail Agent
CMB	Community Mail Bag
GPO BOX	General Post Office Box
LOCKED BAG	Locked Mail Bag Service
MS	Mail Service
PO BOX	Post Office Box
PRIVATE BAG	Private Mail Bag Service
RSD	Roadside Delivery
RMB	Roadside Mail Box/Bag
RMS	Roadside Mail Service

Source and reference attributes

Origin: AS4590 Interchange of client information

Data element attributes

Source and reference attributes

Origin: Health Data Standards Committee

Relational attributes

Related metadata references: Supersedes Postal delivery service type - abbreviation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)

Postcode—international (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—international postcode, text [X(10)]
Synonymous names:	International postcode
METeOR identifier:	288985
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	The code for a postal delivery area, aligned with locality, suburb or place for the address of a person, as defined by the postal service of a country other than Australia, as represented by text.
Data Element Concept:	Person (address)—international postcode

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(10)]
Maximum character length:	10

Data element attributes

Collection and usage attributes

Collection methods:

This is a self-reported code from a person and may be non-verifiable without reference to the specific country's coding rules.

May be collected as part of Address or separately. Postal addresses may be different from where a person actually resides.

Source and reference attributes

Submitting organisation:	Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard

03/12/2008

Postcode—international (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—international postcode, text [X(10)]
METeOR identifier:	288987
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	The code for a postal delivery area, aligned with locality, suburb or place for the address of an organisation, as defined by the postal service of a country other than Australia.
Data Element Concept:	Service provider organisation (address)—international postcode

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(10)]
Maximum character length:	10

Data element attributes

Collection and usage attributes

Collection methods:

This is a self-reported code from an organisation and may be non-verifiable without reference to the specific country's coding rules.

May be collected as part of Address or separately. Postal addresses may be different from where a service is actually located.

Source and reference attributes

Submitting organisation:	Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Standard 03/12/2008

Postpartum complication

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Birth event—complication (postpartum), code (ICD-10-AM 7th edn) ANN{.N[N]}

METeOR identifier: 391336

Registration status: Health, Standard 22/12/2009

Definition: Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care, as represented by a code.

Data Element Concept: Birth event—complication (postpartum)

Value domain attributes

Representational attributes

Classification scheme: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition

Representation class: Code

Data type: String

Format: ANN{.N[N]}

Maximum character length: 6

Collection and usage attributes

Guide for use: Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

Guide for use: There is no arbitrary limit on the number of conditions specified.

Comments: Examples of such conditions include postpartum haemorrhage, retained placenta, puerperal infections, puerperal psychosis, essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease.

Complications of the puerperal period may cause maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalisation after childbirth.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Origin: International Classification of Diseases - 10th Revision, Australian Modification (7th Edition 2010) National Centre for Classification in Health, Sydney.

Relational attributes

Related metadata references: Supersedes Birth event—complication (postpartum), code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Preferred language

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—preferred language, code (ASCL 2011) NN{NN}
METeOR identifier:	460123
Registration status:	Community Services, Standard 13/10/2011 Housing assistance, Standard 13/10/2011 Health, Standard 13/10/2011 Homelessness, Standard 13/10/2011
Definition:	The language (including sign language) most preferred by the person for communication, as represented by a code.
Data Element Concept:	Person—preferred language

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Languages 2011
Representation class:	Code
Data type:	Number
Format:	NN{NN}
Maximum character length:	4

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Languages (ASCL) has a three-level hierarchical structure. The most detailed level of the classification consists of base units (languages) which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow group level), identified by the first two digits. The most general level of the classification consists of broad groups of languages (the Broad group level) and is identified by the first digit. The classification includes Australian Indigenous languages and sign languages.

For example, the Lithuanian language has a code of 3102. In this case 3 denotes that it is an Eastern European language, while 31 denotes that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denotes that it is an Australian Indigenous language and 87 denotes that the language is a Western Desert language.

Language data may be output at the Broad group level, Narrow group level or base level of the classification. If necessary, significant languages within a Narrow group can be presented separately while the remaining languages in the Narrow group are aggregated. The same principle can be adopted to highlight significant Narrow groups within a Broad group.

Data element attributes

Collection and usage attributes

Guide for use: This may be a language other than English even where the person can speak fluent English.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: ABS cat. no. 1267.0. Australian Standard Classification of Languages (ASCL), 2011. Canberra: Australian Bureau of Statistics

Relational attributes

Related metadata references: See also Person—main language other than English spoken at home, code (ASCL 2005) NN{NN} Community Services, Superseded 13/10/2011, Housing assistance, Standard 10/02/2006, Health, Superseded 13/10/2011

See also Person—main language other than English spoken at home, code (ASCL 2011) NN{NN} Community Services, Standard 13/10/2011, Housing assistance, Standard 13/10/2011, Health, Standard 13/10/2011, Homelessness, Standard 13/10/2011

Supersedes Person—preferred language, code (ASCL 2005) NN{NN} Community Services, Superseded 13/10/2011, Health, Superseded 13/10/2011, Tasmanian Health, Proposed 28/09/2011

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Pregnancy duration at the first antenatal care visit

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Pregnancy—estimated duration (at the first visit for antenatal care), completed weeks N[N]

Synonymous names: Estimated pregnancy gestation in completed weeks at the first visit for antenatal care.

METeOR identifier: 379597

Registration status: Health, Standard 02/12/2009

Definition: The total number of completed weeks of a pregnancy's estimated duration on the day of the first visit for antenatal care.

Data Element Concept: Pregnancy—estimated duration

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[N]

Maximum character length: 2

Supplementary values:

Value	Meaning
99	Not stated/unknown

Unit of measure: Completed weeks

Data element attributes

Collection and usage attributes

Guide for use: The day of the first visit for antenatal care is the day of the first contact with a midwife, medical practitioner, or other recognised health professional where antenatal care was provided. It does not include a contact if it was to confirm the pregnancy only or those contacts that occurred during the pregnancy that related to other non pregnancy related issues. It does not include a first contact after the onset of labour.

Antenatal care visits are attributed to the pregnant woman. The duration of the pregnancy on that day is the same as the gestational age of the fetus or baby on that day.

Collection methods: To be collected at any time during the pregnancy or birth episode after the best estimate of gestational age has been determined.

The method of data collection will usually be from health records of pregnancy and/or birth.

The valid range of completed weeks for Pregnancy duration at the first visit for antenatal care is 3-46.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also Product of conception—gestational age, completed weeks N[N] Health, Standard 02/12/2009

Implementation in Data Set Specifications: Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Pregnancy—current status

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Female—pregnancy indicator (current), code N

METeOR identifier: 302817

Registration status: Health, Standard 21/09/2005

Definition: Whether the female person is currently pregnant, as represented by a code.

Data Element Concept: Female—pregnancy indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes: Record if the female individual currently pregnant.

CODE 2 No: Record if the female individual not currently pregnant.

Collection methods: Ask the individual if she is currently pregnant.

Source and reference attributes

Submitting organisation: National diabetes data working group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references: Supersedes Female—current pregnancy status, code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Premature cardiovascular disease family history (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—premature cardiovascular disease family history status, code N
METeOR identifier:	359398
Registration status:	Health, Standard 01/10/2008
Definition:	Whether a person has a first degree relative (father, mother or sibling) who has had a vascular event or condition diagnosed before the age of 60 years, as represented by a code.
Data Element Concept:	Person—premature cardiovascular disease family history status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
	3	Family history status not known
Supplementary values:	9	Not recorded

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1: Yes, the person has a first-degree relative under the age of 60 years who has had a vascular disease/condition diagnosed.

CODE 2: No, the person does not have a first-degree relative under the age of 60 years who has had a vascular disease/condition diagnosed.

CODE 3: Family history status not known, the existence of a premature family history for cardiovascular disease cannot be determined.

CODE 9: Not recorded, the information as to the existence of a premature family history for cardiovascular disease has not been recorded.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: Guidelines Subcommittee of the World Health Organization/International Society of Hypertension (WHO-ISH): 1999 WHO-ISH guidelines for management of hypertension. J Hypertension 1999; 17: 151 - 83.

Relational attributes

Related metadata references: Supersedes Person—premature cardiovascular disease family history status, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Presentation at birth

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Birth event—birth presentation, code N

METeOR identifier: 299992

Registration status: Health, Standard 06/09/2006

Definition: The presenting part of the fetus at birth, as represented by a code.

Data Element Concept: Birth event—birth presentation

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Vertex
	2	Breech
	3	Face
	4	Brow
	8	Other
Supplementary values:	9	Not stated/inadequately described

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use: Compound presentations (where an extremity prolapses simultaneously alongside the presenting part) should be coded to ‘8 Other’.

All other malpresentations, including for example, cord, shoulder or hand, should be coded to ‘8 Other’.

Collection methods: In the case of multiple births, presentation should be recorded for each baby born.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Birth event—birth presentation, code N Health, Superseded 06/09/2006
Implementation in Data Set Specifications:	Perinatal NMDS 2012-2013 Health, Standard 07/03/2012 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Previous opioid pharmacotherapy treatment program indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—previous opioid pharmacotherapy treatment program indicator, yes/no code N
Synonymous names:	Opiate replacement program
METeOR identifier:	404739
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of a person's previous participation in a drug-based opioid dependence treatment program, as represented by a code.
Data Element Concept:	Person—previous opioid pharmacotherapy treatment program indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data elements: *Person – current opioid pharmacotherapy treatment program indicator, yes/no code N* and *Person – type of opioid pharmacotherapy treatment, code N* to provide information on a person's opioid pharmacotherapy treatment history.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Dolan KA, Hall W & Wodak A 1996. Methadone maintenance reduces injecting in prison. British Medical Journal 312:1162

Kastelic A, Pont J & Stover H 2008. Opioid substitution treatment in custodial settings: a practical guide. Oldenburg: BIS-Verlag.

Relational attributes

Related metadata references:

See also Person—current opioid pharmacotherapy treatment program indicator, yes/no code N Health, Standard 25/08/2011

See also Person—type of opioid pharmacotherapy treatment, code N Health, Standard 25/08/2011

Implementation in Data Set Specifications:

Opioid pharmacotherapy treatment cluster Health, Standard 25/08/2011

Previous pregnancies—ectopic

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Female—number of previous pregnancies (ectopic), total N[N]

METeOR identifier: 269936

Registration status: Health, Standard 01/03/2005

Definition: The total number of previous pregnancies of a female resulting in ectopic pregnancy.

Data Element Concept: Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[N]

Maximum character length: 2

Supplementary values:

Value	Meaning
99	Not stated

Unit of measure: Pregnancy

Data element attributes

Collection and usage attributes

Guide for use: A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Comments: The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Previous pregnancies—induced abortion

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Female—number of previous pregnancies (induced abortion), total NN

METeOR identifier: 269935

Registration status: Health, Standard 01/03/2005

Definition: The total number of previous pregnancies of a female resulting in induced abortion (termination of pregnancy before 20 weeks' gestation).

Data Element Concept: Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[N]

Maximum character length: 2

Supplementary values:

Value	Meaning
99	Not stated

Unit of measure: Pregnancy

Data element attributes

Collection and usage attributes

Guide for use: A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Comments: The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.

A previous history of induced abortion may increase the risk of some outcomes in subsequent pregnancies.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Previous pregnancies—live birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (live birth), total NN
METeOR identifier:	269931
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in **live birth**.
Data Element Concept:	Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Not stated

Unit of measure: Pregnancy

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Comments: The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Previous pregnancies—spontaneous abortion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (spontaneous abortion), total NN
METeOR identifier:	269934
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in spontaneous abortion (less than 20 weeks' gestational age, or less than 400 g **birthweight** if gestational age is unknown).
Data Element Concept:	Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2
Supplementary values:	Value Meaning 99 Not stated
Unit of measure:	Pregnancy

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic

	pregnancy), depending on the outcome.
Comments:	The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes. A previous history of spontaneous abortion identifies the mother as high risk for subsequent pregnancies.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Previous pregnancies—stillbirth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (stillbirth), total N[N]
METeOR identifier:	269933
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in stillbirth (- at least 20 weeks' gestational age or 400 g **birthweight**).
Data Element Concept:	Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Not stated

Unit of measure: Pregnancy

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Comments: The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.

A previous history of stillbirth identifies the mother as high risk for subsequent pregnancies.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Previous specialised treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—previous specialised treatment, code N
METeOR identifier:	270374
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a patient has had a previous **admission** or service contact for treatment in the specialty area within which treatment is now being provided, as represented by a code.
Data Element Concept:	Patient—previous specialised treatment

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided
	2	Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided
	3	Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided
	4	Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided
Supplementary values:	5	Unknown/not stated

Collection and usage attributes

Guide for use:

CODE 1 Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided

Use this code for admitted patients, whose only prior specialised treatment contact was the service contact that referred the patient for admission.

CODES 2-4 These codes include patients who have been seen at any time in the past within the speciality within which the patient is currently being treated (mental health or palliative care), regardless of whether it was part of the current episode or a previous admission/service contact many years in the past. Use these codes regardless of whether the previous treatment was provided within the service in which the person is now being treated, or another equivalent specialised service (either institutional or community-based).

CODE 2 Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided

CODE 3 Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided

CODE 4 Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided

Data element attributes

Collection and usage attributes

Comments: This metadata item was originally developed in the context of mental health institutional care data development (originally metadata item Problem status and later First admission for psychiatric treatment). More recent data development work, particularly in the area of palliative care, led to the need for this item to be re-worded in more generic terms for inclusion in other data sets.

For palliative care, the value of this data element is in its use in enabling approximate identification of the number of new palliative care patients receiving specialised treatment. The use of this data element in this way would be improved by the reporting of this data by community-based services.

Source and reference attributes

Submitting organisation: National Mental Health Information Strategy Committee

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Previous specialised treatment, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)

Implementation in Data Set Specifications: Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Primary body function or structure of patient affected

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—primary body function or structure affected, body function or structure code N[N]
METeOR identifier:	330176
Registration status:	Health, Standard 07/12/2011
Definition:	The primary body function or structure of the patient alleged to have been affected, as represented by a code.
Data Element Concept:	Patient—primary body function or structure affected

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Permissible values:	Value	Meaning
	1	Mental functions or structures of the nervous system
	2	Sensory functions and pain of the eye, ear and related structures
	3	Voice and speech functions or structures involved in voice and speech
	4	Functions or structures of the cardiovascular, haematological, immunological and respiratory systems
	5	Functions or structures of the digestive, metabolic and endocrine systems
	6	Genitourinary or reproductive functions and structures
	7	Neuromusculoskeletal or movement-related functions and structures
	8	Functions and structures of the skin and related structures
	9	Death
Supplementary values:	97	Not applicable

99	Not stated/inadequately described

Collection and usage attributes

Comments: The coding categories for this value domain are based on the chapter headings for body functions and body structures in the Body component of the World Health Organization's International Classification of Functioning, Disability and Health (ICF 2.1a) (WHO 2003).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: WHO (World Health Organization) 2003. International Classification of Functioning, Disability and Health (ICF). Geneva: WHO

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data element: *Patient—additional body function or structure affected, body function or structure code N[N]* to provide information on the nature of the harm alleged to have resulted from a health-care incident.

Only one primary body function or structure may be selected.

The primary body function or structure affected should be that which has the greatest impact on the patient.

Where this impact is psychological it should be recorded as Code 1 'Mental functions or structures of the nervous system'.

Where the patient experiences pain as a result of the health-care incident, record the code for the body structure with which the pain is most closely associated. Where the pain experienced by the patient as a result of the health-care incident is deemed to be more disabling than the associated physical or mental damage to the patient, then record Code 2 'Sensory functions and pain of the eye, ear and related structures'.

In the case of cancer primarily affecting a single organ or body part, the appropriate code for that organ or body part should be recorded. Where the cancer has progressed and affects major body systems, Code 4 'Functions or structures of the cardiovascular, haematological, immunological and respiratory systems' should be recorded. This rule should also be followed for other conditions affecting major body systems.

Comments: This data element is fully aligned with the Australian Prudential Regulation Authority (2006) National Claims and Policies Database, data item 16. 'Body functions or structures affected'.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: APRA (Australian Prudential Regulation Authority) 2006. Data Specifications National Claims and Policies Database document number 3.1. Canberra: APRA

Relational attributes

Related metadata references: See also Patient—additional body function or structure affected, body function or structure code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Primary incident or allegation type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim—primary incident or allegation type, health-care code NN[N]
METeOR identifier:	329724
Registration status:	Health, Standard 07/12/2011
Definition:	The high level description of the main event or circumstance that led to the medical indemnity claim, as represented by a code.
Data Element Concept:	Medical indemnity claim—primary incident or allegation type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN[N]
Maximum character length:	3
Permissible values:	

Value	Meaning
10	Diagnosis
20	Medication-related: type and dosage
21	Medication-related: method of administration
22	Medication-related: other or not further defined
30	Anaesthetic
40	Blood or blood product-related (includes blood transfusions)
50	Procedure—failure to perform
51	Procedure—wrong procedure
52	Procedure—wrong body site
53	Procedure—post-operative complications
54	Procedure—failure of procedure
56	Procedure—post-operative infection
57	Procedure—intra-operative complications
59	Procedure—other or not further defined
60	Treatment—delayed

	61	Treatment—not provided
	62	Treatment—complications
	63	Treatment—failure of treatment
	64	Treatment—other or not further defined
	70	Consent (includes failure to warn)
	80	Infection control (includes instrument sterilisation)
	90	Device failure (includes problems with implanted devices)
	100	Other general duty of care issues
	888	Other
Supplementary values:	999	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 10 Diagnosis

'Diagnosis' includes missed, delayed or incorrect diagnosis.

'Medication-related' is defined to cover the use of drugs and other medicines in the delivery of health services, including immunisations; excludes 'anaesthetic' and 'blood or blood product-related'.

CODE 20 Medication-related: type and dosage

'Medication-related: type and dosage' includes issues related to type of medication or its dosage.

CODE 21 Medication-related: method of administration

'Medication-related: method of administration' includes issues related to method of administration of medication.

CODE 22 Medication-related: other or not further defined

'Medication-related: other or not further defined' includes any medication-related issues other than type, dosage or method of administration. Examples include medication not provided and a patient's reaction to a correctly prescribed and administered medication.

CODE 30 Anaesthetic

'Anaesthetic' includes all issues related to epidural, anaesthetic substances, equipment, monitoring or resuscitation and patient awareness.

'Procedure' is defined as an invasive clinical intervention, where there is an incision and/or the body cavity is entered; procedures may be therapeutic or diagnostic. A vaginal delivery is also considered a procedure for the purposes of this metadata item.

CODE 51 Procedure—wrong procedure

'Procedure—wrong procedure' includes unnecessary procedures, for example, removal of a healthy appendix.

CODE 53 Procedure—post-operative complications

'Procedure—post-operative complications' includes incidents involving unintentionally retained objects following a procedure.

CODE 56 Procedure—post-operative infection

'Procedure—post-operative infection' includes wound infection due to a procedure; excludes hospital-acquired infections, for example, post-operative sepsis, needlestick injuries and claims involving failure to properly sterilise equipment.

CODE 57 Procedure—intra-operative complications

'Procedure—intra-operative complications' includes complications that arise during the course of a procedure, for example unintended perforations of adjacent organs.

CODE 59 Procedure—other or not further defined

'Procedure—other or not further defined' includes alleged negligent procedure (where no further information is available).

'Treatment' refers to health-care acts other than 'medication-related', 'anaesthetic', 'blood or blood product-related (includes blood transfusions)' or 'procedure'. Examples of treatment include applying a dressing to a wound, setting a broken bone, physiotherapy services and psychiatric counselling for mental health patients.

CODE 61 Treatment—not provided

'Treatment—not provided' includes, for example, where an ambulance is called to attend but does not arrive, where a patient's condition deteriorates after the patient elects to leave or is turned away from a medical facility, or where a patient is not provided with the diet required by the patient's condition.

CODE 62 Treatment—complications

'Treatment—complications' includes, for example, developing ulcers under a plaster or dressing or a bone fractured during physiotherapy treatment, or where the failure to clean a wound sustained from an injury results in infection.

CODE 63 Treatment—failure of treatment

'Treatment—failure of treatment' includes incorrectly setting a broken bone.

CODE 64 Treatment—other or not further defined

'Treatment—other or not further defined' includes any incident or allegation of treatment as defined here, which does not fall under the treatment subcategories listed above.

CODE 70 Consent (includes failure to warn)

‘Consent (includes failure to warn)’ includes no valid consent and failure to warn, cessation or continuation of treatment without consent or against patient’s stated wishes, and disposing of a fetus without the consent of the parents.

CODE 80 Infection control (includes instrument sterilisation)

‘Infection control (includes instrument sterilisation)’ includes hospital-acquired infections, for example, post-operative sepsis, needlestick injuries and claims involving failure to properly sterilise equipment, but excluding post-operative infection.

CODE 90 Device failure (includes problems with implanted devices)

‘Device failure (includes problems with implanted devices)’ includes device failure during insertion and the insertion procedure is consequently aborted. Excludes problems due to the surgical implantation procedure.

CODE 100 Other general duty of care issues

‘Other general duty of care issues’ includes falls, administrative errors, for example, placing a ‘nil by mouth’ sign on the bed of the wrong patient, and patient monitoring and follow-up issues.

CODE 888 Other

‘Other’ includes medico-legal reports, disciplinary enquiries and other legal issues, breach of confidentiality, record keeping or loss of documents, and harassment and discrimination.

CODE 999 Not stated/inadequately described

‘Not stated/inadequately described’ should be used when the information is not currently available.

Comments: The definition of ‘Procedure’ used in the Medical indemnity data set specification was agreed to by the MIDWG during the data development phase of the MINC. This definition is narrower than the definition of ‘Procedure’ used in the National Health Data Dictionary METeOR identifier 391349.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: National Centre for Classification in Health (NCCH) 2010. The Australian Classification of Health Interventions (ACHI) – Seventh Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney

Data element attributes

Collection and usage attributes

Guide for use:

Only one code may be selected for this data element.

The code recorded as the primary incident or allegation type should be that which best reflects the main, dominant or primary cause giving rise to a medical indemnity claim.

Where a series of events contributed to the incident that gave rise to a medical indemnity claim, and it is difficult to identify the primary incident or allegation type the first event in the series should be coded.

Comments:

The coding categories for this data element have been developed with reference to a range of classifications currently in use, among which there is a high degree of commonality in terms of the categories identified. At the time of developing this data element a list of 46 categories of ‘clinical incident category alleged in claim’ was used in New South Wales to record this information. This list was also adopted for use in Tasmania. In Western Australia eight broad ‘incident type’ categories were used to collect this information on clinical incident notification forms. Two studies of the epidemiology of adverse events (one Australian and one from the United States of America) used similar, broad categories of the nature of adverse events to analyse data (Thomas et al. 2000; Wilson et al. 1995).

There is concordance between the Australian Prudential Regulation Authority (2006) National Claims and Policies Database claims data item 15 ‘Cause of loss’ and the Medical Indemnity National Collection data item (AIHW 2011).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents:

AIHW 2011. Public and private sector medical indemnity claims in Australia 2008–09. Safety and quality of health care series no. 10. Cat. no. HSE 112. Canberra: AIHW

APRA (Australian Prudential Regulation Authority) 2006. Data specifications National Claims and Policies Database document number 3.1. Canberra: APRA

Thomas EJ, Studdert DM, Burstin HR, Orav EJ, Zeena T, Williams EJ, et al. 2000. Incidence and types of adverse events and negligent care in Utah and Colorado. Medical Care 38: 261–71

Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L & Hamilton JD 1995. The quality in Australian health care study. Medical Journal of Australia 163: 458–471

Relational attributes

Related metadata references: See also Medical indemnity claim—additional incident or allegation type, health-care code NN[N] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Primary site of cancer (ICD-10-AM code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—primary site of cancer, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391340
Registration status:	Health, Standard 22/12/2009
Definition:	The site of origin of the tumour, as opposed to the secondary or metastatic sites, as represented by an ICD-10-AM code.
Data Element Concept:	Person with cancer—primary site of cancer

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use: Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer.

Source and reference attributes

Reference documents: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)

Data element attributes

Collection and usage attributes

Collection methods: In a hospital setting, primary site of cancer should be recorded on the patient's medical record by the patient's attending clinician or medical practitioner, and coded by the hospital's medical records department.

Hospitals use Diagnosis codes from ICD-10-AM (7th edition). Valid codes must start with C or D.

In hospital reporting, the diagnosis code for each separate primary site cancer will be reported as a Principal diagnosis or an Additional diagnosis as defined in the current edition of the Australian Coding Standards. In death reporting, the Australian Bureau of Statistics uses ICD-10.

Some ICD-10-AM (7th edition) diagnosis codes e.g. mesothelioma and Kaposi's sarcoma, are based on morphology and not site alone, and include tumours of these types even where the primary site is unknown.

Source and reference attributes

Origin: World Health Organization

Relational attributes

Related metadata references: Supersedes Person with cancer—primary site of cancer, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Implementation in Data Set Specifications: Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Conditional obligation:
This data element should be provided for all patients receiving services for a cancer-related diagnosis.

Primary site of cancer (ICD-O-3 code)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person with cancer—primary site of cancer, topography code (ICD-O-3) ANN.N

METeOR identifier: 396090

Registration status: Health, Standard 07/12/2011

Definition: The site in which the tumour originated in a person with cancer, as opposed to the secondary or metastatic sites, as represented by a code.

Data Element Concept: Person with cancer—primary site of cancer

Value domain attributes

Representational attributes

Classification scheme: International Classification of Diseases for Oncology 3rd edition

Representation class: Code

Data type: String

Format: ANN.N

Maximum character length: 5

Collection and usage attributes

Guide for use: Record all four alphanumeric characters of the topography code. The number after the decimal point represents the subsite or subcategory.

Data element attributes

Collection and usage attributes

Guide for use: Record the primary site of cancer, if known, for patients who have been diagnosed with cancer. When the primary site is unknown, record C80.9.

The primary site of the tumour is the site of origin, as opposed to the secondary or metastatic site.

Record all four alphanumeric characters of the topography code. The number after the decimal point represents the subsite or subcategory.

Refer to the coding guidelines for topography in ICD-O-3, pp 23-26.

Refer to the coding guidelines for multiple tumours in ICD-O-3, pp 35-37.

If the patient is diagnosed with more than one primary tumour, record the site of each primary separately.

If the primary site differs on multiple pathology or other notification reports for the same tumour, use the most specific value. For example, one report may state the breast (C50.9) is the site of the primary while another report records the lower-inner quadrant of the breast (C50.3) as the primary site; record C50.3 here as the primary site.

Collection methods: This information should be obtained from the patient's medical record.

Comments: The information is collected so that tumours can be classified into clinically relevant groups based on their primary site and histological type. This provides a basis for staging and the determination of treatment options. The primary site of the cancer also affects the course of the disease and prognosis.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: World Health Organization

Reference documents: Fritz A et al. 2000. International Classification of Diseases for Oncology (ICD-O), 3rd edition. Geneva: World Health Organization

Relational attributes

Related metadata references: Supersedes Person with cancer—primary site of cancer, code (ICDO-3) ANN{.N[N]} Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Principal clinician specialty involved in health-care incident

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health-care incident—principal clinician specialty involved in health-care incident, clinical specialties code N[N]
METeOR identifier:	330143
Registration status:	Health, Standard 07/12/2011
Definition:	The clinical specialty of the health-care provider who played the most prominent role in the health-care incident, as represented by a code.
Data Element Concept:	Health-care incident—principal clinician specialty involved in health-care incident

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
3	Cardiology
4	Cardio-thoracic surgery
5	Chiropractics
6	Clinical genetics
7	Haematology (clinical)
8	Immunology and allergy (clinical)
9	Clinical pharmacology (excluding pharmacy)
11	Cosmetic surgery
13	Dentistry
14	Dermatology
15	Diagnostic radiology
16	Otolaryngology
17	Emergency medicine
18	Endocrinology
21	Gastroenterology and hepatology

22	General medicine
23	General practice–non-procedural
24	General practice–procedural
25	General surgery
26	Geriatric medicine
27	Gynaecology only
28	Infectious diseases
29	Intensive care medicine
30	Medical oncology
31	Midwifery
32	Neurology
33	Neurosurgery
34	Neonatal or perinatal medicine
35	Nuclear medicine
36	Nursing–general
37	Nursing–nurse practitioner
38	Nutrition or dietician
39	Obstetrics and gynaecology
40	Obstetrics only
41	Occupational and environmental medicine
42	Ophthalmology
44	Orthopaedic surgery
45	Osteopathy
46	Paediatrics
47	Paediatric surgery
48	Paramedical and ambulance staff
49	Pathology
50	Pharmacy (excluding clinical pharmacology)
51	Physiotherapy
52	Plastic and reconstructive surgery
53	Podiatry
54	Psychiatry
55	Psychology
56	Public health
57	Rehabilitation medicine
58	Nephrology
59	Respiratory and sleep medicine
60	Rheumatology

	62	Sports and exercise medicine
	63	Radiation oncology (therapeutic radiology)
	65	Urology
	66	Vascular surgery
	67	Other allied health (including complementary medicine)
	68	Other hospital-based medical practitioner
	71	Anaesthesia
	72	Maternal-fetal medicine
	73	Medical administration
	75	Oral and maxillofacial surgery
	76	Palliative medicine
	77	Urogynaecology
	78	Reproductive endocrinology and infertility
	79	Addiction medicine
	80	Paediatric emergency medicine
	81	Sexual health medicine
	82	Pain medicine
Supplementary values:	97	Not applicable
	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 13 Dentistry

'Dentistry' excludes oral and maxillofacial surgery.

CODE 15 Diagnostic radiology

'Diagnostic radiology' includes diagnostic ultrasound.

CODE 16 Otolaryngology

'Otolaryngology' includes ear, nose, throat, head and neck surgeons.

CODE 22 General medicine

'General medicine' includes general and internal medicine physicians and endoscopy.

CODE 25 General surgery

'General surgery' includes surgical procedures, including colorectal surgery.

CODE 27 Gynaecology only

'Gynaecology only' includes gynaecologists who only diagnose, treat and aid in the prevention of disorders of the female reproductive system (RANZCOG 2011).

CODE 31 Midwifery

'Midwifery' includes registered midwives only.

CODE 35 Nuclear medicine

'Nuclear medicine' includes radiotherapy and radiation oncology.

CODE 36 Nursing–general

'Nursing-general' includes enrolled and registered nurses.

CODE 37 Nursing–nurse practitioner

'Nursing–nurse practitioner' includes registered nurse practitioners only.

CODE 39 Obstetrics and gynaecology

'Obstetrics and gynaecology' includes specialists who carry out gynaecological examinations, diagnosis and operations on women; provide medical care before, during and after childbirth; and treat infertility by chemical or operative measures (RANZCOG 2011).

CODE 40 Obstetrics only

'Obstetrics only' includes obstetricians who only provide medical care before, during and after childbirth (RANZCOG 2011).

CODE 41 Occupational and environmental medicine

'Occupational and environmental medicine' should be used for doctors only; occupational therapists should be recorded at Code 67.

CODE 46 Paediatrics

'Paediatrics' excludes neonatal or perinatal medicine and paediatric surgery.

CODE 49 Pathology

'Pathology' includes general pathology, anatomical pathology, chemical pathology, pathological haematology, pathological immunology and clinical microbiology.

CODE 59 Respiratory and sleep medicine

'Respiratory and sleep medicine' includes thoracic medicine.

CODE 67 Other allied health (including complementary medicine)

'Other allied health (including complementary medicine)' includes: acupuncturist, allergy and asthma consultant, alternative health services, audiologist, audiometrist, Chinese medicine therapist, chiropodist, dental hygienist, dental technician, drug and alcohol counsellor, hygiene consultant, naturopath, occupational health and safety practitioner, occupational therapist, optometrist, social worker, speech pathologist, speech therapist and therapeutic masseur.

CODE 68 Other hospital-based medical practitioners

'Other hospital-based medical practitioners' includes junior doctors, resident doctors, house officers, interns, and other clinicians who do not have a specialty.

CODE 71 Anaesthesia

‘Anaesthesia’ includes general anaesthesia, paediatric anaesthesia and intensive care anaesthesia.

CODE 82 Pain medicine

‘Pain medicine’ includes specialists in managing severe pain problems in the areas of acute pain, cancer pain and chronic pain (Faculty of Pain Medicine 2003).

CODE 97 Not applicable

‘Not applicable’ should be used where no clinical or medical administration staff were involved in the incident.

CODE 99 Not stated/inadequately described

‘Not stated/inadequately described’ should be used when the information is not currently available. Not stated/inadequately described should not be used when a claim is closed.

Comments: The general aim of this list is to include all categories that might be of relevance to medical indemnity claims. The medical specialties included in this value domain are taken from the List of Australian Recognised Medical Specialties, a list approved by the Minister for Health and Ageing (AMC 2009) and from the lists of clinical specialties developed by various health authorities for use in their medical indemnity data collections.

The categories of medical specialists align well between the Australian Prudential Regulation Authority (2006) National Claims and Policies Database (NCPD) and the Medical Indemnity National Collection (MINC). The NCPD specifications have separate codes for several allied health and complementary fields which are subsumed within the MINC category ‘Other allied health (including complementary medicine)’. In the NCPD, ‘student practitioner or intern’ is a separate category. The MINC codes students based on the speciality they are training in, and classifies interns with ‘Other hospital-based medical practitioners’ (AIHW 2011).

Recording the specialty of the individual clinician at this data element does not imply that the individual was ‘at fault’. These individuals may or may not be defendants in the medical indemnity claim.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: AIHW (Australian Institute of Health and Welfare) 2011. Public and private sector medical indemnity claims in Australia 2008–09. Safety and quality of health care series no.10. Cat. no. HSE 112. Canberra: AIHW

AMC (Australian Medical Council) 2009. The List of Australian Recognised Medical Specialties. Canberra. Viewed 16 November 2010, <http://www.amc.org.au/images/Recognition/AMC-list-of-specialties.pdf>

APRA (Australian Prudential Regulation Authority) 2006. Data specifications National Claims and Policies Database Document Number 3.1. Canberra: APRA

Faculty of Pain Medicine 2003. Application for specialty recognition by the Faculty of Pain Medicine to the Australian Medical Council. Melbourne: Australian and New Zealand College of Anaesthetists. Viewed 25 May 2011, <http://www.anzca.edu.au/fpm/news-and-reports/FPM_AMCSub.pdf>

RANZCOG (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists) 2011. About the specialty. Viewed 20 October 2011, <http://www.ranzcog.edu.au/the-ranzcog/about-specialty.html>

Data element attributes

Collection and usage attributes

Guide for use:

This data element should record the specialty of the clinician who played the most prominent role in the incident that gave rise to the medical indemnity claim; that is, the individual whose actions or omissions are directly implicated in 'what went wrong'. The individual may or may not be a defendant in the medical indemnity claim.

Only one code may be selected for this data element.

The principal clinician specialty should usually relate to the primary incident or allegation type.

For a particular clinician, the specialty recorded should be the main clinical area in which that clinician has formal qualifications (or, in the case of a specialist-in-training, is working towards gaining formal qualifications), and/or in which that clinician primarily practices. The specialty recorded may not be the area in which the clinician was working at the time of the incident. For example, if a clinician involved in the incident was a general surgeon, but was working in the Emergency department when the incident occurred, Code 25 'General surgery' should be recorded.

Where a private doctor was closely involved in the incident, the specialty of the private doctor should be recorded.

This data element should be completed on the basis of available information about the specialty of clinicians closely involved in the incident; specialty should not be assumed based on other information. For example, if the incident occurred in the course of repair to an aortic abdominal aneurysm, Code 66 'Vascular surgery' should only be recorded where there is information to confirm that a vascular surgeon was among the clinicians involved.

Where a registrar was closely involved in the incident, the specialty for which the registrar was training at the time of the incident should be recorded.

Where no clinical staff were involved in the incident (for example where the medical indemnity claim relates to actions of hospital administrative staff) Code 97 'Not applicable' should be recorded.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Health-care incident—additional clinician specialty involved in health-care incident, clinical specialties code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Principal diagnosis—episode of care

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of care—principal diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]}

METeOR identifier: 391326

Registration status: Health, Standard 22/12/2009
Tasmanian Health, Proposed 28/09/2011

Definition: The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code.

Data Element Concept: Episode of care—principal diagnosis

Value domain attributes

Representational attributes

Classification scheme: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition

Representation class: Code

Data type: String

Format: ANN{.N[N]}

Maximum character length: 6

Data element attributes

Collection and usage attributes

Guide for use: The principal diagnosis must be determined in accordance with the Australian Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.

As a minimum requirement the Principal diagnosis code must be a valid code from the current edition of ICD-10-AM.

For episodes of admitted patient care, some diagnosis codes are too imprecise or inappropriate to be acceptable as a principal diagnosis and will group to an error DRG in the Australian Refined Diagnosis Related Groups.

Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as principal diagnosis.
Diagnosis codes which are morphology codes cannot be used as principal diagnosis.

Collection methods: A principal diagnosis should be recorded and coded upon **separation**, for each episode of admitted patient care or episode of residential care or attendance at a health care establishment. The principal diagnosis is derived from and must be substantiated by clinical documentation.

Comments: The principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.

Source and reference attributes

Origin: National Centre for Classification in Health

National Data Standard for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Supersedes Episode of care—principal diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Implementation in Data Set Specifications: Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Principal diagnosis—patient

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Patient—principal diagnosis, (ICD-10-AM 7th edn) ANN{.N[N]}

METeOR identifier: 433356

Registration status: Health, Standard 07/12/2011

Definition: The diagnosis established after study to be chiefly responsible for occasioning a patient's service event or episode, as represented by a code.

Data Element Concept: Patient—principal diagnosis

Value domain attributes

Representational attributes

Classification scheme: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition

Representation class: Code

Data type: String

Format: ANN{.N[N]}

Maximum character length: 6

Data element attributes

Relational attributes

Implementation in Data Set Specifications: Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Principal drug of concern

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—drug of concern (principal), (ASCDC 2011 extended) code NNNN
METeOR identifier:	467699
Registration status:	Health, Standard 07/12/2011
Definition:	The main drug, as stated by the client, that has led a person to seek treatment from the service, as represented by a code.
Context:	Required as an indicator of the client's treatment needs.
Data Element Concept:	Episode of treatment for alcohol and other drugs—drug of concern

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Drugs of Concern 2011
Representation class:	Code
Data type:	String
Format:	NNNN
Maximum character length:	4

Supplementary values:

Value	Meaning
0005	Opioid analgesics not further defined
0006	Psychostimulants not further defined

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Drugs of Concern (ASCDC) provides a number of supplementary codes that have specific uses and these are detailed within the ASCDC, e.g. 0000 = inadequately described.

Other supplementary codes that are not already specified in the ASCDC may be used in National Minimum Data Sets (NMDS) when required. In the Alcohol and other drug treatment service NMDS, two additional supplementary codes have been created which enable a finer level of detail to be captured:

CODE 0005 Opioid analgesics not further defined

This code is to be used when it is known that the client's principal drug of concern is an opioid but the specific opioid used is not known. The existing code 1000 combines opioid analgesics and non-opioid analgesics together into Analgesics nfd and the finer level of detail, although known, is lost.

CODE 0006   Psychostimulants not further defined

This code is to be used when it is known that the client's principal drug of concern is a psychostimulant but not which type. The existing code 3000 combines stimulants and hallucinogens together into Stimulants and hallucinogens nfd and the finer level of detail, although known, is lost.

Psychostimulants refer to the types of drugs that would normally be coded to 3100-3199, 3300-3399 and 3400-3499 categories plus 3903 and 3905.

Data element attributes

Collection and usage attributes

Guide for use: The principal drug of concern should be the main drug of concern to the client and is the focus of the client's treatment episode. If the client has been referred into treatment and does not nominate a drug of concern, then the drug involved in the client's referral should be chosen.

Collection methods: To be collected on commencement of the treatment episode.

For clients whose treatment episode is related to the alcohol and other drug use of another person, this metadata item should not be collected.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Episode of treatment for alcohol and other drugs—drug of concern (principal), code (ASCDC 2000 extended) NNNN Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Principal role - health profession

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—principal role, health profession code N
METeOR identifier:	375557
Registration status:	Health, Standard 10/12/2009
Definition:	The role in which the registered health professional spent the most time in the profession, in the week before registration, as represented by a code.
Data Element Concept:	Registered health professional—principal role

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Clinician
	2	Administrator
	3	Teacher/educator
	4	Researcher
	5	Other
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 CLINICIAN

A clinician is a person mainly involved in the area of clinical practice. That is the diagnosis, care and treatment, including recommended preventative action, to patients or clients. Clinical practice may involve direct client contact or may be practised indirectly through individual case material (as in radiology and laboratory medicine).

CODE 2 ADMINISTRATOR

An administrator in a health profession is a person whose main job is in an administrative capacity in the profession, such as directors of nursing, medical superintendents, medical advisers in government health authorities and health profession union administrators.

CODE 3 TEACHER/EDUCATOR

A teacher/educator in a health profession is a person whose main job is employment by tertiary institutions or health institutions to provide education and training in the profession.

CODE 4 RESEARCHER

A researcher in a health profession is a person whose main job is to conduct research in the field of the profession, especially in the area of clinical activity. Researchers are employed by tertiary institutions, medical research bodies, health institutions, health authorities, drug companies and other bodies.

CODE 5 OTHER

Other roles include Public health/health promotion, Occupational health, Environmental health, and all other roles not covered by codes 1-4 above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: This data element is applicable to health professionals who were employed in the registered profession in Australia.

The health professional may be employed or self-employed in the profession.

Registered health professionals on leave at the time of registration are asked to report their usual principal role.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Health professional—principal role, code N Health, Superseded 10/12/2009

Implementation in Data Set Specifications: Main job of registered chiropractor cluster Health, Standard 10/12/2009

Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Main job of registered medical professional cluster Health, Standard 10/12/2009

Main job of registered midwife cluster Health, Standard 10/12/2009

Main job of registered nursing professional cluster Health, Standard 10/12/2009

Main job of registered optometrist cluster Health, Standard 10/12/2009

Main job of registered osteopath cluster Health, Standard 10/12/2009

Main job of registered pharmacist cluster Health, Standard 10/12/2009

Main job of registered physiotherapist cluster Health, Standard 10/12/2009

Main job of registered podiatrist cluster Health, Standard 10/12/2009

Main job of registered psychologist cluster Health, Standard 10/12/2009

Second job of registered chiropractor cluster Health, Standard 10/12/2009

Second job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Second job of registered medical professional cluster Health, Standard 10/12/2009

Second job of registered midwife cluster Health, Standard 10/12/2009

Second job of registered nursing professional cluster Health, Standard 10/12/2009

Second job of registered optometrist cluster Health, Standard 10/12/2009

Second job of registered osteopath cluster Health, Standard 10/12/2009

Second job of registered pharmacist cluster Health, Standard 10/12/2009

Second job of registered physiotherapist cluster Health, Standard 10/12/2009

Second job of registered podiatrist cluster Health, Standard 10/12/2009

Second job of registered psychologist cluster Health, Standard 10/12/2009

Principal source of funding

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—principal source of funding, code NN
METeOR identifier:	400680
Registration status:	Health, Standard 01/12/2010
Definition:	The principal source of funds for a non-admitted patient service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—principal source of funding

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Health service budget (not covered elsewhere)
02	Health service budget (due to eligibility for Reciprocal Health Care Agreement)
03	Health service budget (no charge raised due to hospital decision)
04	Department of Veterans' Affairs
05	Department of Defence
06	Correctional facility
07	Medicare Benefits Scheme
08	Other hospital or public authority (contracted care)
09	Private health insurance
10	Worker's compensation
11	Motor vehicle third party personal claim
12	Other compensation (e.g. public liability, common law, medical negligence)
13	Self-funded
14	Other funding source

Supplementary values: 99 Not known

Collection and usage attributes

Guide for use:

CODE 01 Health service budget (not covered elsewhere)

Health service budget (not covered elsewhere) should be recorded as the funding source for Medicare eligible patients presenting at a public hospital outpatient department for whom there is no other funding arrangement.

CODE 02 Health service budget (due to eligibility for Reciprocal Health Care Agreement)

Patients who are overseas visitors from countries covered by Reciprocal Health Care Agreements.

CODE 03 Health service budget (no charge raised due to hospital decision)

Patients who are Medicare ineligible and receive public hospital services free of charge at the discretion of the hospital or the state/territory. Also includes patients for whom a charge is raised but is subsequently waived.

CODE 07 Medicare Benefits Scheme

Medicare eligible non-admitted patients presenting at a public hospital outpatient department for whom services are billed to Medicare. Includes both bulk-billed and patients with out-of-pocket expenses.

CODE 08 Other hospital or public authority (contracted care)

Patients receiving treatment under contracted care arrangements (inter-hospital contracted patient).

CODE 09 Private health insurance

Patients who are funded by private health insurance, including travel insurance for Medicare eligible patients.

Excludes: Overseas visitors for whom travel insurance is the major funding source.

CODE 13 Self-funded

This code includes funded by the patient, by the patient's family or friends, or by other benefactors.

CODE 14 Other funding source

This code includes overseas visitors for whom travel insurance is the major funding source.

Data element attributes

Collection and usage attributes

Guide for use: The principal source of funding should be assigned based on a best estimate of where the majority of funds come from. This data element is not designed to capture information on out-of-pocket expenses to patients (e.g. fees only partly covered by the Medicare Benefits Schedule).

Source and reference attributes

Submitting organisation: NAP NMDS (Phase 1) Working Group

Relational attributes

Related metadata references: See also Episode of care—principal source of funding, hospital code NN Health, Standard 29/11/2006

See also Episode of care—source of funding, patient funding source code NN Health, Standard 11/04/2012

Implementation in Data Set Specifications: Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Prison entrant age at first detention

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Prison entrant—age at first detention, total years NN
Synonymous names:	Prison entrant age at first incarceration
METeOR identifier:	376069
Registration status:	Health, Standard 25/08/2011
Definition:	A prison entrant's age (in years) at the time of their first detention within a corrective services facility.
Data Element Concept:	Prison entrant—age at first detention

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

Comments:

Individuals who experience detention at a younger age often experience multiple periods of detention (AIHW 2008).

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Reference documents:

AIHW (Australian Institute of Health and Welfare) 2008. Juvenile justice in Australia 2006-07. Juvenile justice series no. 4. Cat no. JUV 4. Canberra:AIHW

Relational attributes

Related metadata references:

See also Incarceration history cluster Health, Standard 25/08/2011

Implementation in Data Set Specifications:

Prison entrants DSS Health, Standard 25/08/2011

Conditional obligation:
Conditional on the prison entrant being previously

detained in a prison or juvenile justice centre.

Prison entrant number of times in prison or juvenile detention

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Prison entrant—number of times in prison or juvenile detention, total number N[N]

Synonymous names: Number of times in prison; number of times in detention

METeOR identifier: 399014

Registration status: Health, Standard 25/08/2011

Definition: The total number of times a prison entrant has been imprisoned in a prison and/or in a **juvenile detention centre**.

Data Element Concept: Prison entrant—number of times in prison or juvenile detention

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[N]

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: The total number of times in an adult prison includes the current imprisonment.

This data element should be used in conjunction with the data element: *Prison entrant—type of corrective services facility, code N* to provide information on the prison entrant's incarceration history.

Comments: Commonly, prisoners have been in prison or juvenile detention numerous times (AIHW 2010).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: AIHW (Australian Institute of Health and Welfare) 2010. The health of Australia's prisoners 2009. Cat. no. PHE 123. Canberra: AIHW

Relational attributes

Related metadata references: See also Prison entrant—type of corrective services facility, code N Health, Standard 25/08/2011

Implementation in Data Set Specifications: Incarceration history cluster Health, Standard 25/08/2011

Prison establishment identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (prison)—organisation identifier, NNN
Synonymous names:	Correctional facility identifier
METeOR identifier:	365725
Registration status:	Health, Standard 25/08/2011
Definition:	A numeric sequence of characters that identifies a prison.
Data Element Concept:	Establishment (prison)—organisation identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	NNN
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:

The organisation identifier includes components that identify the state/territory (character position one) and the prison (character positions two and three).

Each prison included in the National Prisoner Health Census will have a unique identifier at the national level. Allocation of the prison identifier is undertaken by the Australian Institute of Health and Welfare (the organisation responsible for the National Prisoner Health Census).

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Prison entrants DSS Health, Standard 25/08/2011 Prison establishments DSS Health, Standard 25/08/2011

Prison health worker type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (prison)—health worker type, occupation code (ANZSCO 1st edition) N[NNN]{NN}
METeOR identifier:	412999
Registration status:	Health, Standard 25/08/2011
Definition:	The type of health worker that delivers healthcare in a prison, as represented by a code.
Data Element Concept:	Establishment (prison)—health worker type

Value domain attributes

Representational attributes

Classification scheme:	Australian and New Zealand Standard Classification of Occupations, First edition, 2006
Representation class:	Code
Data type:	Number
Format:	N[NNN]{NN}
Maximum character length:	6

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Full-time equivalent prison staff cluster Health, Standard 25/08/2011

Prisoner health discharge summary indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—prisoner health discharge summary indicator, yes/no code N
METeOR identifier:	411257
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether a **prisoner** has a health-related discharge summary on their file when released from prison, as represented by a code.
Data Element Concept:	Person—prisoner health discharge summary indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Establishment (prison)—number of prisoners released, number N[NN] Health, Standard 25/08/2011 See also Person—legal status of prisoner, code N Health, Standard 25/08/2011
Implementation in Data Set Specifications:	Prisoner health discharge summary cluster Health, Standard 25/08/2011

Prisoner location when service provider utilised

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—prisoner location, code N
METeOR identifier:	418641
Registration status:	Health, Standard 25/08/2011
Definition:	The physical location of a prisoner when they utilised a health service, as represented by a code.
Data Element Concept:	Health service event—prisoner location

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	In the community
2	In prison

Collection and usage attributes

Guide for use:	Respondents must have indicated that they were in prison in the previous 12 months for a Code 2 response to be valid.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	This data element should be used in conjunction with the data elements: *Prison entrant—individual service provider consulted indicator, yes/no code N* and *Prison entrant—type of service provider consulted, occupation code (ANZSCO 1st edition) N[NNN]{NN}* to gain a greater understanding of the health seeking behaviours of prison entrants.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Prison entrant—individual service provider consulted indicator, yes/no code N Health, Standard 25/08/2011

See also Prison entrant—type of service provider consulted, occupation code (ANZSCO 1st edition) N[NNN]{NN} Health, Standard 25/08/2011

Implementation in Data Set Specifications:

Health service utilisation cluster Health, Standard 25/08/2011

Conditional obligation:

Conditional on the prisoner consulting a service provider for their own health in the last 12 months.

Prisoner location when service provider was needed, but not utilised

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—prisoner location when service provider was needed, but not utilised, prisoner location code N
METeOR identifier:	402799
Registration status:	Health, Standard 25/08/2011
Definition:	The location of a prisoner when they needed to engage with a service provider for their health, but did not, as represented by a code.
Data Element Concept:	Health service event—prisoner location when service provider was needed, but not utilised

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	In the community
2	In prison

Collection and usage attributes

Guide for use: Respondents must have indicated that they were in prison in the previous 12 months for a Code 2 response to be valid.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data elements: *Prison entrant – service provider needed but not utilised indicator, yes/no code N and Prison entrant – type of service provider needed but not utilised, occupation code*

(ANZSCO 1st edition) N[NNN]{NN} to gain a greater understanding of the health seeking behaviours of prison entrants.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Prison entrant—reason for non-utilisation of health service, code NN Health, Standard 25/08/2011

See also Prison entrant—service provider needed but not utilised indicator, yes/no code N Health, Standard 25/08/2011

See also Prison entrant—type of service provider needed but not utilised, occupation code (ANZSCO 1st edition) N[NNN]{NN} Health, Standard 25/08/2011

Implementation in Data Set Specifications:

Health service non-utilisation cluster Health, Standard 25/08/2011

Conditional obligation:

Conditional on the prison entrant indicating that he or she needed to consult with a service provider for their own health but did not.

Procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—procedure, code (ACHI 7th edn) NNNNN-NN
METeOR identifier:	391349
Registration status:	Health, Standard 22/12/2009 Tasmanian Health, Proposed 28/09/2011

Definition:

A clinical intervention represented by a code that:

- is surgical in nature, and/or
- carries a procedural risk, and/or
- carries an anaesthetic risk, and/or
- requires specialised training, and/or
- requires special facilities or equipment only available in an acute care setting.

Data Element Concept: Episode of admitted patient care—procedure

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 7th edition
Representation class:	Code
Data type:	Number
Format:	NNNNN-NN
Maximum character length:	7

Data element attributes

Collection and usage attributes

Collection methods: Record and code all procedures undertaken during the episode of care in accordance with the ACHI (7th edition). Procedures are derived from and must be substantiated by clinical documentation.

Comments: The National Centre for Classification in Health advises the National Health Information Standards and Statistics Committee of relevant changes to the ACHI.

Source and reference attributes

Origin: National Centre for Classification in Health

National Health Information Standards and Statistics

Committee

Relational attributes

Related metadata references:

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Supersedes Episode of admitted patient care—procedure, code (ACHI 6th edn) NNNNN-NN Health, Superseded 22/12/2009

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Proficiency in spoken English

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—proficiency in spoken English, code N
METeOR identifier:	270203
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006 Health, Standard 01/03/2005
Definition:	A person's self-assessed level of ability to speak English, as represented by a code.
Data Element Concept:	Person—proficiency in spoken English

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	0	Not applicable (persons under 5 years of age or who speak only English)
	1	Very well
	2	Well
	3	Not well
	4	Not at all
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 0 Not applicable (persons under 5 years of age or who speak only English)

Not applicable, is to be used for people under 5 year of age and people who speak only English.

CODE 9 Not stated/inadequately described

Not stated/inadequately described, is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Comments:

The ABS advises that the most useful information provided by this metadata item is in the distinction between the two category groups of Very well/Well and Not well/Not at all.

Source and reference attributes

Reference documents: Standards for Statistics on Cultural and Language Diversity 1999. Cat. no. 1289.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

Collection methods: This metadata item is only intended to be collected if a person has a main language other than English spoken at home; and/or first language spoken is not English.

Recommended question:

How well do you speak English? (tick one)

1. Very well
2. Well
3. Not well
4. Not at all

Generally this would be a self-reported question, but in some circumstances (particularly where a person does not speak English well) assistance will be required in answering this question. It is important that the person's self-assessed proficiency in spoken English be recorded wherever possible. This metadata item does not purport to be a technical assessment of proficiency but is a self-assessment in the four broad categories outlined above.

This metadata item is not relevant to and should not be collected for persons under the age of five years.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, this standard should be used wherever practically possible.

Comments: This metadata item identifies those people who may suffer disadvantage in terms of their ability to access services due to lack of ability in the spoken English language. This information can be used to target the provision of services to people whose lack of ability in spoken English is potentially a barrier to gaining access to government programs and services.

In conjunction with Indigenous status, the main language other than English spoken at home and the country of birth, this metadata item forms the minimum core set of cultural and language indicators recommended by the

Australian Bureau of Statistics.

Source and reference attributes

Origin:

National Health Data Committee
National Community Services Data Committee

Relational attributes

Related metadata references:

See also Person—country of birth, code (SACC 1998) NNNN Community Services, Superseded 02/06/2008, Housing assistance, Superseded 24/11/2008, Health, Superseded 01/10/2008

See also Person—first language spoken, code (ASCL 2005) NN{NN} Community Services, Superseded 13/10/2011, Housing assistance, Standard 10/02/2006, Health, Superseded 13/10/2011

See also Person—first language spoken, code (ASCL 2011) NN{NN} Community Services, Standard 13/10/2011, Housing assistance, Standard 13/10/2011, Health, Standard 13/10/2011, Homelessness, Standard 13/10/2011

See also Person—main language other than English spoken at home, code (ASCL 2005) NN{NN} Community Services, Superseded 13/10/2011, Housing assistance, Standard 10/02/2006, Health, Superseded 13/10/2011

Supersedes Proficiency in spoken English, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (18.6 KB)

Progesterone receptor assay results

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—progesterone receptor assay results, code N
METeOR identifier:	291341
Registration status:	Health, Standard 13/06/2004
Definition:	The results of progesterone receptor assay at the time or diagnosis of the primary breast tumour, as represented by a code.
Data Element Concept:	Person with cancer—progesterone receptor assay results

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Test done, results positive (progesterone receptor positive)
	2	Test done, results negative (Progesterone receptor negative)
Supplementary values:	0	Test not done (test not ordered or not performed)
	8	Test done but results unknown
	9	Unknown

Data element attributes

Collection and usage attributes

Collection methods:

The Australian Cancer Network Working Party established to develop guidelines for the pathology reporting of breast cancer recommends that hormone receptor assays be performed on all cases of invasive breast carcinoma. The report should include:

- the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high), and
- a conclusion as to whether the assay is positive or

negative.

Source and reference attributes

Origin:

Royal College of Pathologists of Australasia

Australian Cancer Network

Commission on Cancer American College of Surgeons

Reference documents:

Royal College of Pathologists of Australasia Manual of Use and Interpretation of Pathology Tests: Third Edition Sydney (2001)

Australian Cancer Network Working Party The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001)

Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:

Supersedes Progesterone receptor assay status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Proteinuria status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—proteinuria status, code N{.N}
METeOR identifier:	270346
Registration status:	Health, Standard 01/03/2005
Definition:	Whether there is a presence of excessive protein in the urine of the person, as represented by a code.
Data Element Concept:	Person—proteinuria status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N{.N}
Maximum character length:	2

Permissible values:	Value	Meaning
	1	Negative for protein
	1.1	Microalbuminuria present
	1.2	Microalbuminuria not present
	1.3	Microalbuminuria not tested
	2	Proteinuria
	3	Not tested
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Negative for protein

Negative for proteinuria - less than 1 plus on dipstick-testing or excretion of 300 mg or less of protein from 24-hour urine collection.

CODE 1.1 Microalbuminuria present

Microalbuminuria present

CODE 1.2 Microalbuminuria not present

Microalbuminuria not present

CODE 1.3 Microalbuminuria not tested

Microalbuminuria not tested

CODE 2 Proteinuria

Proteinuria - one or more pluses of protein in dipstick urinalysis or for a 24-hour urine collection, where the patient excretes more than 300 mg/per day of protein.

CODE 3 Not tested

Not tested - no urinalysis for proteinuria was taken.

Collection methods: Where laboratory testing is used to determine Proteinuria status the categorisation must be substantiated by clinical documentation such as an official laboratory report.

Data element attributes

Collection and usage attributes

Collection methods: Dipstick testing can be used to test for protein in a urine specimen. Proteinuria (i.e. excessive protein in the urine) on dipstick urinalysis is described as one or more pluses of protein and for a 24-hour urine collection where the patient excretes more than 300 mg/day of protein.

Microalbuminuria can be determining using any one of the following tests: spot urine, timed urine (24-hour collection) or albumin/creatinine ratio. Although the presence of microalbuminuria does not warrant categorisation as proteinuria, it is clinically significant in the diagnosis and treatment of diabetes.

Comments: In settings where the monitoring of a person's health is ongoing and where a measure can change over time (such as general practice), the Patient—diagnosis date, DDMMYYYY should be recorded.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references: Supersedes Proteinuria - status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Provider occupation category (self-identified) (ANZSCO 1st edition)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Individual service provider—occupation (self-identified), code (ANZSCO 1st edition) N[NNN]{NN}

Synonymous names: Health care provider field of practice

METeOR identifier: 350896

Registration status: Community Services, Standard 27/03/2007
Health, Standard 04/07/2007

Definition: A health care occupation that an individual provider identifies as being one in which they provide a significant amount of services, as represented by a code.

Data Element Concept: Individual service provider—occupation (self-identified)

Value domain attributes

Representational attributes

Classification scheme: Australian and New Zealand Standard Classification of Occupations, First edition, 2006

Representation class: Code

Data type: Number

Format: N[NNN]{NN}

Maximum character length: 6

Data element attributes

Collection and usage attributes

Guide for use: The following is a list of the more common health care occupations, however, it is not intended to represent all the possible health care occupations:

Aboriginal and Torres Strait Islander Health Worker (ANZSCO code 411511)

Acupuncturist (ANZSCO code 252211)

Aged or disabled carer (ANZSCO code 423111)

Ambulance officer (ANZSCO code 411111)

Anaesthetist (ANZSCO code 253211)

Audiologist (ANZSCO code 252711)

Chiropractor (ANZSCO code 252111)

Clinical psychologist (ANZSCO code 272311)

Complementary Health Therapists n.e.c. (ANZSCO code

252299)
Dental assistant (ANZSCO code 423211)
Dental hygienist (ANZSCO code 411211)
Dental specialist (ANZSCO code 252311)
Dental technician (ANZSCO code 411213)
Dental therapist (ANZSCO code 411214)
Dentist (ANZSCO code 252312)
Dermatologist(ANZSCO code 253911)
Dietician (ANZSCO code 251111)
Drug and Alcohol Counsellor (ANZSCO code 272112)
Enrolled nurse (ANZSCO code 411411)
General medical practitioner (ANZSCO code 253111)
Health professionals (ANZSCO code 25)
Hospital pharmacist (ANZSCO code 251511)
Intensive care ambulance paramedic (AUS) / ambulance paramedic (NZ) (ANZSCO code 411112)
Massage therapist (ANZSCO code 411611)
Medical diagnostic radiographer (ANZSCO code 251211)
Medical practitioners n.e.c. (ANZSCO code 253999)
Medical radiation therapist (ANZSCO code 251212)
Midwife (ANZSCO code 254111)
Naturopath (ANZSCO code 252213)
Nuclear medicine technologist (ANZSCO code 251213)
Nurse educator (ANZSCO code 254211)
Nurse manager (ANZSCO code 254311)
Nurse practitioner (ANZSCO code 254411)
Nurse researcher (ANZSCO code 254212)
Nursing assistant support worker (ANZSCO code 423312)
Occupational therapist (ANZSCO code 252411)
Ophthalmologist (ANZSCO code 253914)
Optometrist (ANZSCO code 251411)
Orthoptist (ANZSCO code 251412)
Orthotist or Prosthetist (ANZSCO code 251912)
Osteopath (ANZSCO code 252112)
Paediatrician (ANZSCO code 253321)
Pathologist (ANZSCO code 253915)
Physiotherapist (ANZSCO code 252511)
Podiatrist (ANZSCO code 252611)
Psychiatrist (ANZSCO code 253411)
Psychologists n.e.c. (ANZSCO code 272399)
Radiologist (ANZSCO code 253916)
Registered nurse (developmental disability)(ANZSCO code 254416)

Registered nurse (mental health)(ANZSCO code 254422)

Registered Nurses n.e.c. (ANZSCO code 254499)

Rehabilitation counsellor (ANZSCO code 272114)

Retail pharmacist (ANZSCO code 251513)

Social worker (ANZSCO code 272511)

Sonographer (ANZSCO code 251214)

Specialist physician (general medicine) (ANZSCO code 253311)

Speech pathologist (AUS) / speech language therapist (NZ) (ANZSCO code 252712)

Surgeon (general) (ANZSCO code 253511)

Therapy aide (ANZSCO code 423314)

Collection methods: Data is collected at the time a health care provider identification record is created.

Multiple instances of health care occupation may be collected where the individual provides a significant amount of services in more than one category. For example, a dentist who is also a medical practitioner may practice as both.

Record as many as apply.

Accurate data are best achieved using computer assisted coding. A computer assisted coding system is available from the ABS to assist in coding occupational data to ANZSCO codes.

Data coded at the 4-digit and 6-digit level will provide more detailed information than that collected at the higher levels and may be more useful. However, the level at which data are coded and reported will depend on the purpose of collecting this information.

Comments: ANZSCO defines ‘occupation’ as ‘a set of jobs with similar sets of tasks’. Operationally this is defined as ‘a collection of jobs which are sufficiently similar in their main tasks to be grouped together for purposes of the classification’. Job is defined as ‘a set of tasks designed to be performed by one individual for a wage or salary’.

Source and reference attributes

Origin: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia.

Reference documents: AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia.

Relational attributes

Related metadata references: Supersedes Individual service provider—occupation (self-identified), code (ASCO 2nd edn) N[NNN]{-NN} Community Services, Superseded 27/03/2007, Health, Superseded 04/07/2007

Implementation in Data Set Specifications: Health care provider identification DSS Health, Standard 03/12/2008

Provider occupation end date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Individual service provider—occupation end date, DDMMYYYY

Synonymous names: Health care provider field of practice end date

METeOR identifier: 289053

Registration status: Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Definition: The date on which an individual health care provider ceased practising in an identified occupation.

Data Element Concept: Individual service provider—occupation end date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: Enter the date using day, month and year.

In the AS4846 Health Care Provider Identification, the Australian Standard Health Care Provider Field of Practice End Date mandates the use of a Date Accuracy Indicator. This is not compulsory with the use of this data element.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references: See also Date—accuracy indicator, code AAA Community Services, Standard 30/09/2005, Housing assistance, Standard 23/08/2010, Health, Standard 04/05/2005, Early

	Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Standard 03/12/2008

Provider occupation start date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Individual service provider—occupation start date, DDMMYYYY

Synonymous names: Health care provider field of practice start date

METeOR identifier: 289059

Registration status: Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Definition: The date on which an individual health care provider commenced practising in an identified occupation.

Data Element Concept: Individual service provider—occupation start date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: Enter the date using day, month and year.

In the AS4846 Health Care Provider Identification, the Australian Standard Health Care Provider Field of Practice Start Date mandates the use of a Date Accuracy Indicator. This is not compulsory with the use of this data element.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references: See also Date—accuracy indicator, code AAA Community Services, Standard 30/09/2005, Housing assistance, Standard 23/08/2010, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard

	23/08/2010
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Standard 03/12/2008

Purchase of goods and services

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Organisation—purchase of goods and services, total Australian currency NNNNN.N

METeOR identifier: 359935

Registration status: Health, Standard 05/12/2007

Definition: Expenses of an organisation consisting mainly of purchases of goods and services, in Australian currency.

Data Element Concept: Organisation—purchase of goods and services

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: NNNNN.N

Maximum character length: 6

Unit of measure: Australian currency (AU$)

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use: Expenses relating to purchases of goods and services are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).

Includes:

- administrative expenses (excluding workers compensation premiums and payouts)
- domestic services
- drug supplies
- food supplies
- grants
- medical and surgical supplies

- patient transport
- payments to visiting medical officers
- repairs and maintenance
- social benefits
- subsidy expenses
- other expenses (includes contracted care services purchased from private hospitals)

Collection methods: Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Expenses relating to purchases of goods and services are to be reported for the *Health industry relevant organisation type* and *Type of health and health related functions* data elements.

Health industry relevant organisation type

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments: In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Origin: Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.aasb.com.au>

Relational attributes

Related metadata references:	Is used in the formation of Organisation—expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007
Implementation in Data Set Specifications:	Government health expenditure organisation expenditure data element cluster Health, Standard 01/04/2009 Government health expenditure organisation expenditure purchase of goods and services data element cluster Health, Standard 01/04/2009

Quality accreditation/certification standard—Quality Improvement Council

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—quality accreditation/certification standard indicator (Quality Improvement Council), code N
METeOR identifier:	302379
Registration status:	Health, Standard 14/09/2005
Definition:	Whether the Quality Improvement Council standard has been met by the hospital establishment as a whole, as represented by a code.
Data Element Concept:	Establishment—quality accreditation/certification standard indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Report the status code as at 30 June.

Code 1 Yes

Record if the hospital establishment is accredited or compliant with the standard.

Code 2 No

Record if the hospital establishment is not accredited or compliant with the standard.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—quality accreditation/certification standard status (Quality Improvement Council), code N Health, Superseded 14/09/2005

Radiation dose administered

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Cancer treatment—radiation dose administered, total Gray N[NN.NN]

METeOR identifier: 408039

Registration status: Health, Standard 07/12/2011

Definition: The largest prescribed dose of radiation administered during the initial course of treatment for cancer, measured in Gray (Gy).

Data Element Concept: Cancer treatment—radiation dose administered

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NN.NN]

Maximum character length: 5

Supplementary values:

Value	Meaning
999.97	Not applicable-radiotherapy was not administered
999.98	Unknown whether radiotherapy was administered
999.99	Radiotherapy was administered but the dose is not stated/inadequately described

Unit of measure: Gray (Gy)

Collection and usage attributes

Guide for use: One gray is equivalent to 100 centigray (cGy). For example, a radiation dose of 5040 cGy equates to 50.40 Gy. This would be recorded as 50.40.

Data element attributes

Collection and usage attributes

Guide for use: The gray (Gy) is the SI (International System of Units) unit of absorbed radiation dose of ionizing radiation (for example, X-rays), and is defined as the absorption of one joule of ionizing radiation by one kilogram of matter (usually human tissue).

The radiation dose administered records the largest prescribed dose to the target. This means that for patients that have a boost treatment, the largest prescribed dose is the addition of the boost to the other phases of treatment.

Record the largest prescribed dose to the target site for all courses of **radiotherapy** delivered to the patient during the initial course of treatment. The initial course of treatment is treatment administered to the patient from diagnosis and before disease progression or recurrence.

The patient may receive more than one course of radiotherapy during the initial course of treatment. For example, radiotherapy may be administered to the primary site and the site of a distant metastasis. Record the radiation dose received for each course of treatment.

The radiation dose administered is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of treatment.

The International Commission on Radiation Units and Measurements (ICRU) develops internationally acceptable recommendations regarding quantities and units of radiation and radioactivity, procedures suitable for the measurement and application of these quantities in clinical radiology and radiobiology, and physical data needed in the application of these procedures to support uniformity in reporting.

The ICRU recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pairs and so on). The ICRU50 reference dose should be recorded for photon therapy if available, otherwise a description of the received dose at the centre of the planning target volume. The ICRU58 should be recorded for brachytherapy. For maximum consistency in this field, the ICRU recommendations should be followed whenever possible.

Do not include treatment with unsealed radioisotopes.

Collection methods: The radiation dose will typically be found in the radiation oncologist's summary letter for the initial course of treatment or in the radiotherapy treatment summary in the patient's medical record.

Determining the total dose may require assistance from the radiation oncologist for consistent coding.

Comments: The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome. Patient outcomes are strongly related to the radiotherapy dose delivered.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references:

Supersedes Cancer treatment—radiation dose received, total Gray N[NNNN] Health, Superseded 13/10/2011

See also Cancer treatment—radiotherapy completion date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy fractions administered, total fractions N[N] Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy start date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy target site, code N[N] Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy treatment type, code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Radiotherapy for cancer cluster Health, Standard 07/12/2011

Radiotherapy completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiotherapy completion date, DDMMYYYY
METeOR identifier:	394464
Registration status:	Health, Standard 07/12/2011
Definition:	The completion date of the **radiotherapy** administered during the initial course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—radiotherapy completion date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

The completion date for radiotherapy is the date the last dose was administered. Record the completion date of radiotherapy for all courses administered during the initial course of treatment for cancer. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The patient may receive more than one course of radiotherapy during the initial course of treatment. For example, radiotherapy may be administered to the primary site and the site of a distant metastasis. Record the completion date for each course of treatment.

The completion date of radiotherapy is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of treatment.

Record the completion date for radiotherapy administered as external beam radiotherapy or brachytherapy. Do not include radiotherapy with unsealed radioisotopes.

Dates of surgery, systemic agent therapies and systemic therapy procedures are collected as separate items.

Collection methods: The radiotherapy completion date will typically be found in the radiation oncologist's summary letter for the initial course of treatment or in the radiotherapy treatment summary in the patient's medical record.

Comments: Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references:

See also Cancer treatment—radiation dose administered, total Gray N[NN.NN] Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy fractions administered, total fractions N[N] Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy start date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy target site, code N[N] Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy treatment type, code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Radiotherapy for cancer cluster Health, Standard 07/12/2011

Radiotherapy fractions administered

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiotherapy fractions administered, total fractions N[N]
METeOR identifier:	393512
Registration status:	Health, Standard 07/12/2011
Definition:	The total number of **radiotherapy** sessions (fractions) administered during the initial course of treatment for cancer.
Data Element Concept:	Cancer treatment—radiotherapy fractions administered

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
97	Not applicable-no radiotherapy was administered
98	Unknown whether radiotherapy was administered
99	Radiotherapy administered but the number of fractions not stated/inadequately described

Collection and usage attributes

Guide for use: Valid values are 1 to 96.

Data element attributes

Collection and usage attributes

Guide for use: A total dose of radiation is delivered to the patient in a number of even parts or treatment sessions (fractions). Although a treatment session may include several treatment portals delivered within a confined period of time, usually a few minutes, it is still considered one fraction.

Record the number of fractions of radiotherapy treatment for all courses delivered to the patient during the initial course of treatment for cancer. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The patient may receive more than one course of radiotherapy during the initial course of treatment. For example, radiotherapy may be administered to the primary site and the site of a distant metastasis. Record the total radiation dose for each course of treatment.

The number of fractions administered is recorded regardless of whether the course of treatment is completed as intended and regardless of the intent or timing of treatment.

The number of radiotherapy fractions recorded should include any boost.

Brachytherapy (or implants) may be delivered more than once, each treatment is recorded as a fraction.

Do not include treatment with unsealed radioisotopes.

Collection methods: The number of radiotherapy fractions delivered will typically be found in the radiation oncologist's summary letter for the initial course of treatment or in the radiotherapy treatment summary in the patient's medical record.

Determining the number of fractions may require assistance from the radiation oncologist for consistent coding.

Comments: The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references: See also Cancer treatment—radiation dose administered, total Gray N[NN.NN] Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy completion date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy start date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy target site, code N[N] Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy treatment type, code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Radiotherapy for cancer cluster Health, Standard 07/12/2011

Radiotherapy start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—radiotherapy start date, DDMMYYYY
METeOR identifier:	448147
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which a patient commences a **course of radiotherapy treatment**, expressed as DDMMYYYY.
Data Element Concept:	Patient—radiotherapy start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

This item should be used when collecting information about service volumes for the purpose of calculating radiotherapy waiting times. If collecting radiotherapy start date to examine cancer patient care for safety and quality monitoring and other public health purposes use Cancer treatment—radiotherapy start date, DDMMYYYY.

Relational attributes

Related metadata references:

See also Cancer treatment—radiotherapy start date, DDMMYYYY Health, Standard 07/12/2011

Implementation in Data Set Specifications:

Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Conditional obligation:
Every record must contain either this item or Health service event—first service contact date, DDMMYYYY.

Radiotherapy start date—cancer treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiotherapy start date, DDMMYYYY
METeOR identifier:	393497
Registration status:	Health, Standard 07/12/2011
Definition:	The start date of the **radiotherapy** administered during the initial course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—radiotherapy start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

Record the first or earliest date radiotherapy commenced for all courses of radiotherapy administered during the initial course of treatment. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The patient may receive more than one course of radiotherapy during the initial course of treatment. For example, in the treatment of cancer, radiotherapy may be administered to the primary site and the site of a distant metastasis. Record the start date for each course of treatment.

The start date of radiotherapy is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of treatment.

Record the start date for radiotherapy administered as external beam radiotherapy or brachytherapy. Do not include radiotherapy with unsealed radioisotopes.

This item should be used when collecting information about cancer patient care for safety and quality monitoring and other public health purposes. If collecting radiotherapy start date to examine service volumes for the purpose of calculating radiotherapy waiting times use *Patient—radiotherapy start date, DDMMYYYY*.

Collection methods: The radiotherapy commencement date(s) will typically be found in the radiation oncologist's summary letter for the initial course of treatment or in the radiotherapy treatment summary in the patient's medical record.

Comments: Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references:

See also Cancer treatment—radiation dose administered, total Gray N[NN.NN] Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy completion date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy fractions administered, total fractions N[N] Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy target site, code N[N] Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy treatment type, code N[N] Health, Standard 07/12/2011

See also Patient—radiotherapy start date, DDMMYYYY Health, Standard 07/12/2011

Implementation in Data Set Specifications: Radiotherapy for cancer cluster Health, Standard 07/12/2011

Radiotherapy target site

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiotherapy target site, code N[N]
METeOR identifier:	393422
Registration status:	Health, Standard 07/12/2011
Definition:	The target site of **radiotherapy** administered during the initial course of treatment for cancer, as represented by a code.
Data Element Concept:	Cancer treatment—radiotherapy target site

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

	Value	Meaning
Permissible values:	1	Primary site only
	2	Regional nodes only
	3	Distant metastases only
	4	Primary site and regional nodes
	5	Primary site and distant metastases
	6	Primary site, regional nodes and distant metastases
	7	Regional nodes and distant metastases
Supplementary values:	97	Not applicable-radiotherapy was not administered
	98	Unknown whether radiotherapy was administered
	99	Radiotherapy was administered but the site not stated/inadequately described

Collection and usage attributes

Guide for use:	More than one site may be targeted for radiotherapy during the initial course of treatment; select the appropriate code value.

Source and reference attributes

Submitting organisation: Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use:

The target site is collected for all courses of radiotherapy administered to the patient during the initial course of treatment. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The target site for radiotherapy is recorded regardless of whether the course of treatment is completed as intended, the intent or timing of the radiotherapy, and the radiation therapy treatment modality.

Record the value representing all the sites targeted for radiotherapy during the initial course of treatment. There may be more than one site targeted for treatment. For example, the primary tumour site and the site of a distant metastasis may receive radiotherapy as part of the initial course of treatment. In this case code "5" would be recorded.

The target site for surgery is collected as a separate data item.

Collection methods:

This information should be obtained from the patient’s radiotherapy records.

Determining the target site of radiotherapy may require assistance from the radiation oncologist for consistent coding.

Comments:

This is collected to identify which sites are targeted by radiotherapy and is useful in evaluating patterns of care and patient outcomes.

Source and reference attributes

Submitting organisation: Cancer Australia

Relational attributes

Related metadata references:

See also Cancer treatment—radiation dose administered, total Gray N[NN.NN] Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy completion date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy fractions administered, total fractions N[N] Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy start date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy treatment type,

	code N[N] Health, Standard 07/12/2011
Implementation in Data Set Specifications:	Radiotherapy for cancer cluster Health, Standard 07/12/2011

Radiotherapy treatment type

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Cancer treatment—radiotherapy treatment type, code N[N]

Synonymous names: Radiotherapy treatment modality

METeOR identifier: 399526

Registration status: Health, Standard 07/12/2011

Definition: The type of **radiotherapy** administered during the initial course of treatment for cancer, as represented by a code.

Data Element Concept: Cancer treatment—radiotherapy treatment type

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N[N]

Maximum character length: 2

	Value	Meaning
Permissible values:	1	External beam radiotherapy only
	2	Brachytherapy only
	3	Unsealed radioisotopes only
	4	External beam radiotherapy and brachytherapy
	5	External beam radiotherapy and unsealed radioisotopes
	6	Brachytherapy and unsealed radioisotopes
	7	External beam radiotherapy, brachytherapy and unsealed radioisotopes
Supplementary values:	97	Not applicable-radiotherapy was not administered
	98	Unknown whether radiotherapy was administered
	99	Radiotherapy was administered but the treatment type not stated/inadequately described

Collection and usage attributes

Guide for use: More than one radiotherapy treatment type may be delivered during the initial course of treatment; select the appropriate code value.

The difference between the types of radiotherapy relates to the position of the radiation source:

- External beam radiotherapy (EBRT) is delivered by directing the radiation at the tumour from outside the body.
- Brachytherapy or sealed source radiotherapy is delivered by placing the radiation source in close proximity to the tumour site.
- Unsealed radioisotopes or systemic radioisotope therapy is delivered by infusion into the bloodstream or by ingestion and is a form of targeted therapy.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: DeVita VT, Hellman S, Rosenberg SA 2005. Cancer: Principles and practice of oncology, 7th edition. Philadelphia: Lippincott Williams & Wilkins

Data element attributes

Collection and usage attributes

Guide for use: External beam radiotherapy (EBRT) is delivered by directing the radiation at the tumour from outside the body. Types of external beam radiotherapy include conventional EBRT, intensity modulated radiation therapy (IMRT) and 3-dimensional conformal radiotherapy (3D-CRT).

Brachytherapy is delivered by placing the radiation source in close proximity to the tumour site. The radioactive isotopes are sealed in tiny pellets or “seeds” which are placed in the body using delivery devices such as needles or catheters. Types include interstitial brachytherapy, which uses a source placed within tumour tissue, for example, within a prostate tumour; and intracavitary brachytherapy, whereby the source is placed within a surgical cavity or a body cavity. Brachytherapy can involve the temporary or permanent placement of radioactive sources.

Unsealed radioisotopes or systemic radioisotope therapy is delivered by infusion into the bloodstream or by ingestion and is a form of targeted therapy. Targeting can be due to the chemical properties of the isotope, for example, radioiodine is specifically absorbed by the thyroid gland. It can also be achieved by attaching the radioisotope to another molecule or antibody to guide it to the target tissue. Examples of treatment with unsealed radioisotopes include the infusion of metaiodobenzylguanidine (MIBG) to treat neuroblastoma and of oral iodine-131 to treat thyroid cancer.

Radiotherapy treatment type is collected for all courses of radiotherapy delivered to the patient during the initial course of treatment. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The radiotherapy treatment type is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of treatment.

More than one radiotherapy treatment type may be administered during the initial course of treatment; select the appropriate code value.

If external beam radiotherapy and/or brachytherapy were administered, the radiation dose received and number of fractions should also be collected as well as the start and finish dates of the radiotherapy.

Most external beam radiotherapy is delivered on an outpatient basis.

Brachytherapy is likely to be delivered to admitted patients.

Collection methods: The radiotherapy treatment modality will typically be found in the radiation oncologist's summary letter for the initial course of treatment or in the radiotherapy treatment summary in the patient's medical record.

Determining the treatment modality may require assistance from the radiation oncologist for consistent coding.

Comments: To evaluate patterns of radiotherapy care and analyse patient outcomes, it is necessary to know which treatment modalities were employed in the delivery of treatment.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

New South Wales Health Department

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Cancer Institute NSW 2006. NSW Clinical Cancer Registration: Minimum Data Set Data Dictionary, version

1.9 draft

Relational attributes

Related metadata references:

See also Cancer treatment—radiation dose administered, total Gray N[NN.NN] Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy completion date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy fractions administered, total fractions N[N] Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy start date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—radiotherapy target site, code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specifications:

Radiotherapy for cancer cluster Health, Standard 07/12/2011

Ready-for-care date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Patient—ready-for-care date, DDMMYYYY

METeOR identifier: 448141

Registration status: Health, Standard 07/12/2011

Definition: The date, in the opinion of the treating clinician, on which a patient is ready to commence treatment, expressed as DDMMYYYY.

Data Element Concept: Patient—ready-for-care date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Relational attributes

Implementation in Data Set Specifications: Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Conditional obligation:
This item must be completed if Patient—radiotherapy start date, DDMMYYYY.

Reason for cessation of treatment episode for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—cessation reason, code N[N]
METeOR identifier:	270011
Registration status:	Health, Standard 01/03/2005
Definition:	The reason for the client ceasing to receive a treatment episode from an alcohol and other drug treatment service, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—cessation reason

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Treatment completed
2	Change in main treatment type
3	Change in the delivery setting
4	Change in the principal drug of concern
5	Transferred to another service provider
6	Ceased to participate against advice
7	Ceased to participate without notice
8	Ceased to participate involuntary (non-compliance)
9	Ceased to participate at expiation
10	Ceased to participate by mutual agreement
11	Drug court and /or sanctioned by court diversion service
12	Imprisoned, other than drug court sanctioned
13	Died
98	Other

Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

To be collected on cessation of a treatment episode. Codes 1 to 12 listed above are set out as follows to enable a clearer picture of which codes are to be used for what purpose:

Treatment completed as planned:

CODE 1 Treatment completed

Client ceased to participate:

CODE 6 Ceased to participate against advice

CODE 7 Ceased to participate without notice

CODE 8 Ceased to participate involuntary (non-compliance)

CODE 9 Ceased to participate at expiation

Ceased to participate at expiation:

CODE 11 Drug court and /or sanctioned by court diversion service

CODE 12 Imprisoned, other than drug court sanctioned

Treatment not completed (other):

CODE 2 Change in main treatment type

CODE 3 Change in the delivery setting

CODE 4 Change in the principal drug of concern

CODE 5 Transferred to another service provider

Treatment ceased by mutual agreement:

CODE 10 Ceased to participate by mutual agreement

CODE 1 Treatment completed

This code is to be used when all of the immediate goals of the treatment have been completed as planned. Includes situations where the client, after completing this treatment, either does not commence any new treatment, commences a new treatment episode with a different main treatment or principal drug, or is referred to a different service provider for further treatment.

CODE 2 Change in main treatment type

A treatment episode will end if, prior to the completion of the existing treatment, there is a change in the main treatment type for alcohol and other drugs. See also Code 10.

CODE 3 Change in the delivery setting

A treatment episode may end if, prior to the completion of the existing treatment, there is a change in the treatment delivery setting for alcohol and other drugs. See also Code 10 and the Guide for use section in metadata item Episode of treatment for alcohol and other drugs.

CODE 4 Change in the principal drug of concern

A treatment episode will end if, prior to the completion of the existing treatment, there is a change in the principal drug of concern. See also Code 10.

CODE 5 Transferred to another service provider

This code includes situations where the service provider is no longer the most appropriate and the client is transferred/referred to another service. For example, transfers could occur for clients between non-residential and residential services or between residential services and a hospital. Excludes situations where the original treatment was completed before the client transferred to a different provider for other treatment (use Code 1).

CODE 6 Ceased to participate against advice

This code refers to situations where the service provider is aware of the client's intention to stop participating in treatment, and the client ceases despite advice from staff that such action is against the client's best interest.

CODE 7 Ceased to participate without notice

This code refers to situations where the client ceased to receive treatment without notifying the service provider of their intention to no longer participate.

CODE 8 Ceased to participate involuntary (non-compliance)

This code refers to situations where the client's participation has been ceased by the service provider due to non-compliance with the rules or conditions of the program.

CODE 9 Ceased to participate at expiation

This code refers to situations where the client has fulfilled their obligation to satisfy expiation requirements (e.g. participate in a treatment program to avoid having a criminal conviction being recorded against them) as part of a police or court diversion scheme and chooses not to continue with further treatment.

CODE 10 Ceased to participate by mutual agreement

This code refers to situations where the client ceases participation by mutual agreement with the service provider even though the treatment plan has not been completed. This may include situations where the client has moved out of the area. Only to be used when Code 2, 3 or 4 is not applicable.

CODE 11 Drug court and/or sanctioned by court diversion service

This code applies to drug court and/or court diversion service clients who are sanctioned back into jail for non-compliance with the program.

CODE 12 Imprisoned, other than drug court sanctioned

This code applies to clients who are imprisoned for reasons other than Code 11.

Data element attributes

Collection and usage attributes

Comments: Given the levels of attrition within alcohol and other drug treatment programs, it is important to identify the range of different reasons for ceasing treatment with a service.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Reason for cessation of treatment episode for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.4 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Reason for health clinic attendance

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—reason for health clinic attendance, code NN
METeOR identifier:	365291
Registration status:	Health, Standard 25/08/2011
Definition:	The reason or health issue that prompts a person to visit a health clinic, as represented by a code.
Data Element Concept:	Person—reason for health clinic attendance

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Health check
02	Diabetes
03	Mental health condition
04	Pathology
05	Skin condition (excluding cancer and communicable diseases)
06	Drug and alcohol issue
07	Medication
08	Vaccination
09	Musculoskeletal injury
10	Musculoskeletal condition (excluding arthritis, injury or cancer)
11	Cardiovascular disease
12	Respiratory condition (excluding asthma, cancer or communicable diseases)
13	Communicable disease
14	Dental
15	Digestive condition (excluding cancer)
16	Wound care
17	Asthma

	18	Sensory conditions (ear and eye conditions)
	19	Neurological condition
	20	Malignancy (cancer, excluding non-melanoma skin cancer)
	21	Arthritis
	22	Women's health
	25	Other
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

More than one code may be recorded if there are multiple reasons for visiting the health clinic.

CODE 1 Health check

Record this code if the person attended the clinic for a general health check.

CODE 2 Diabetes

Record this code if the person attended the clinic for treatment of Type 1, Type 2 or gestational diabetes.

CODE 3 Mental health condition

Record this code if the person attended the clinic for treatment of a mental health condition.

CODE 4 Pathology

Record this code if the person attending the clinic was having blood or urine tested or receiving results from a blood or urine test.

CODE 5 Skin condition (excludes cancer and communicable diseases)

Record this code if the person attended the clinic for a skin condition (excludes cancer and communicable diseases).

CODE 6 Drug and alcohol issue

Record this code if the person attended the clinic for a drug and alcohol issue.

CODE 7 Medication

Record this code if the person attended the clinic for medication.

CODE 8 Vaccination

Record this code if the person attended the clinic for a vaccination.

CODE 9 Musculoskeletal injury

Record this code if the person attended the clinic for a musculoskeletal injury. Musculoskeletal conditions are recorded separately.

CODE 10 Musculoskeletal condition (excluding arthritis, injury or cancer)

Record this code if the person attended the clinic for a musculoskeletal condition. This excludes arthritis, cancer or injury.

CODE 11 Cardiovascular disease

Record this code if person attended the clinic for treatment of cardiovascular disease (includes coronary heart disease, heart failure, rheumatic fever, rheumatic heart disease, congenital heart disease, stroke and peripheral vascular disease).

CODE 12 Respiratory condition (excludes asthma, cancer or communicable diseases)

Record this code if the person attended the clinic for treatment of a respiratory condition.

CODE 13 Communicable disease

Communicable diseases are those which are capable of being transmitted between individuals and include infectious and parasitic disease (Healey 2004). Record this code if person attended the clinic for treatment of a communicable disease (includes blood-borne diseases, gastrointestinal diseases, quarantinable diseases, sexually transmitted infections, vaccine preventable diseases, vector-borne diseases, zoonoses and other bacterial infections.

CODE 14 Dental

Record this code if the person attended the clinic for dental referral, dental procedures or dental pain.

CODE 15 Digestive condition (excluding cancer)

Record this code if the person attended the clinic for treatment of a digestive condition. This excludes cancers which are recorded separately.

CODE 16 Wound care

Record this code if the person attended the clinic for wound care for example dressings or review.

CODE 17 Asthma

Record this code if the person attended the clinic for the treatment of asthma.

CODE 18 Sensory conditions (ear and eye conditions)

Record this code if the person attended the clinic for the treatment of ear or eye conditions.

CODE 19 Neurological condition

Record this code if the person attended the clinic for neurological conditions for example epilepsy, Parkinson disease, motor neurone disease.

CODE 20 Malignancy (cancer, excludes non-melanoma skin cancer)

Record this code if the reason for attending the clinic was a malignancy (cancer), excludes non-melanoma skin cancer.

CODE 21 Arthritis

Record this code if the person attended the clinic for treatment of arthritis (includes gout, rheumatism, osteoarthritis, rheumatoid arthritis, other type, arthritis type unknown).

CODE 22 Women's health

Record this code if the person attended the clinic for women's health issues for example cervical screening, contraceptives.

CODE 25 Other

Record this code if the person attended the clinic for a reason not specified above.

CODE 99 Not stated/inadequately described

Record this code when the reason is unknown.

Comments: The list of reasons for attendance at the health clinic was initially guided by the most common categories reported in a number of relevant surveys, for example the 2001 NSW Inmate Health Survey, Queensland Women Prisoners' Health Survey and the *General Practice Activity in Australia 2007-08* (Britt et al. 2008). Following the 2009 National Prisoner Health Census, the list was amended to include the reasons recorded in the 'Other' category on the National Prisoner Health Census Clinic form.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Centre for Classification in Health 2010. The International statistical classification of diseases and related health problems, tenth revision, Australian modification (7th edn). Sydney: National Centre for Classification in Health, Faculty of Health Sciences, The University of Sydney

Reference documents: Australian Institute of Health and Welfare 2010. The health of Australia's prisoners 2009. Cat. no. PHE 123. Canberra: AIHW.

Britt H, Miller G, Charles J, Henderson J, Bayram C, Harrison C et al. 2008. General practice activity in Australia 2007-08. General practice series no. 22. Cat. no. GEP 22. Canberra: AIHW.

Butler T & Milner L 2003. The 2001 New South Wales Inmate Health Survey. Sydney: Corrections Health Service.

Healey J 2004. Communicable diseases. Thirroul, New South Wales: Spinney Press.

Hockings BA, Young M, Falconer A & O'Rourke PK 2002. Queensland Women Prisoners' Health Survey. Brisbane: Department of Corrective Services.

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Prison clinic contact DSS Health, Standard 25/08/2011

Reason for non prescription of pharmacotherapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—reason for non prescription of pharmacotherapy, code N
METeOR identifier:	347222
Registration status:	Health, Standard 01/10/2008
Definition:	The reason a pharmacotherapy was not prescribed for a person, as represented by a code.
Data Element Concept:	Person—reason for non prescription of pharmacotherapy

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Not indicated
	2	Contraindicated
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Not indicated

Record this code when a pharmacotherapy was not prescribed because it was not necessary to the treatment of the person.

CODE 2 Contraindicated

Record this code when a pharmacotherapy was not prescribed because of a condition or factor that increases the risks involved in using the pharmacotherapy. Examples of contraindications are allergy, intolerance, medical condition.

Collection methods:

For each type of pharmacotherapy not prescribed for the person, record whether it was not indicated or contraindicated.

Relational attributes

Related metadata references:

See also Person with acute coronary syndrome—pharmacotherapy type prescribed in hospital, code N[N] Health, Standard 01/10/2008

Implementation in Data Set Specifications:

Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:

To be provided for each of the pharmacotherapies listed in the data element *'Pharmacotherapy type prescribed for acute coronary syndrome in hospital'* not prescribed.

Reason for non-utilisation of health service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Prison entrant—reason for non-utilisation of health service, code NN
METeOR identifier:	376304
Registration status:	Health, Standard 25/08/2011
Definition:	The reason as to why a prison entrant did not use a health service when it was needed, as represented by a code.
Data Element Concept:	Prison entrant—reason for non-utilisation of health service

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

	Value	Meaning
Permissible values:	01	Cost
	02	Discrimination
	03	Cultural inappropriateness
	04	Indifference or unwillingness
	05	Difficulty in attending health service
	06	Waiting time too long or service not available at time required
	07	Required service not available in a specific location
	08	Too busy
	09	Legal reasons
	10	Intoxication
	20	Other reasons
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

More than one reason may be selected.

CODE 1 Cost

Includes all cases where a health service was not sought because it was likely to be unaffordable.

CODE 2 Discrimination

Includes all cases of perceived discrimination at a health service, on the basis of factors such as age, sex, disability, religion or culture, etc.

CODE 3 Cultural inappropriateness

Includes cases where a health service was not sought because of a perceived lack of cultural consideration e.g. lack of appropriate interpreter services, or no service provider of similar cultural background available.

CODE 4 Indifference or unwillingness

Includes cases where a health service was not sought because a person either felt that seeking a health service was unnecessary, a person did not want to seek a health service, or a person lacked motivation to seek a health service.

CODE 5 Difficulty in attending health service

Includes cases where a health service was not sought either due to lack of available transport to attend the service or the distance required to attend a health service was perceived as being too great.

CODE 6 Waiting time too long or service not available at time required

Includes cases where the waiting time for a health service (either expected or actual) was too long, or the health service was not available at the required time.

CODE 7 Required service not available in a specific location

Includes cases where a health service was not available in the person's location e.g. local community area, prison etc.

CODE 8 Too busy

Includes cases where the person was too busy to seek a health service e.g. work, personal or family responsibilities.

CODE 9 Legal reasons

Includes cases where the person did not seek a health service for legal reasons e.g. likely arrest, actual arrest, appearance in court or being in custody.

CODE 10 Intoxication

Includes cases where the person did not seek a health service because they were intoxicated as a result of drug use, alcohol consumption or other causes.

CODE 20 Other reasons

Includes all reasons not elsewhere included.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used in conjunction with the data elements: *Prison entrant—service provider needed but not utilised indicator, yes/no code N; Prison entrant—type of service provider needed but not utilised, occupation code (ANZSCO 1st edition) N[NNN]{NN}* and *Health service event—prisoner location when service provider was needed, but not utilised, prisoner location code N* to provide information on the health seeking behaviours of prison entrants.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Health service event—prisoner location when service provider was needed, but not utilised, prisoner location code N Health, Standard 25/08/2011

See also Prison entrant—service provider needed but not utilised indicator, yes/no code N Health, Standard 25/08/2011

See also Prison entrant—type of service provider needed but not utilised, occupation code (ANZSCO 1st edition) N[NNN]{NN} Health, Standard 25/08/2011

Implementation in Data Set Specifications:

Prison entrants DSS Health, Standard 25/08/2011

Conditional obligation:

Conditional on the prison entrant not seeing a health professional during the last 12 months, when required.

Reason for readmission—acute coronary syndrome

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—reason for readmission following acute coronary syndrome episode, code N[N]
METeOR identifier:	359404
Registration status:	Health, Standard 01/10/2008
Definition:	The main reason for the **admission**, to any hospital, of a person within 28 days of discharge from an episode of admitted patient care for acute coronary syndrome, as represented by a code.
Data Element Concept:	Person—reason for readmission following acute coronary syndrome episode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

	Value	Meaning
Permissible values:	1	ST-segment-elevation myocardial infarction
	2	non-ST-segment-elevation ACS with high-risk features
	3	non-ST-segment-elevation ACS with intermediate-risk features
	4	non-ST-segment-elevation ACS with low-risk features
	5	Percutaneous coronary intervention (PCI)
	6	Coronary artery bypass graft (CABG)
	7	Heart Failure (without MI)
	8	Arrhythmia (without MI)
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 ST-segment-elevation myocardial infarction

This code is used when the reason for admission is persistent ST elevation of >=1mm in two contiguous limb leads, or ST elevation of >=2mm in two contiguous chest leads, or with new left bundle-branch block (BBB) pattern on the ECG.

CODE 2 Non-ST-segment-elevation ACS with high-risk features

This code is used when the reason for admission is clinical features consistent with an acute coronary syndrome with high-risk features which include any of the following:

- repetitive or prolonged (> 10 minutes) ongoing chest pain or discomfort;
- elevated level of at least one cardiac biomarker (troponin or creatine kinase-MB isoenzyme);
- persistent or dynamic ECG changes of ST segment depression >= 0.5mm or new T wave >= 2mm;
- transient ST-segment elevation (>= 0.5 mm) in more than 2 contiguous leads;
- haemodynamic compromise: Blood pressure < 90 mmHg systolic, cool peripheries, diaphoresis, Killip Class > 1, and/or new onset mitral regurgitation;
- sustained ventricular tachycardia;
- syncope;
- left ventricular systolic dysfunction (left ventricular ejection fraction < 0.40);
- prior percutaneous coronary intervention within 6 months or prior coronary artery bypass surgery;
- presence of known diabetes (with typical symptoms of ACS); or
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with typical symptoms of ACS).

CODE 3 Non-ST-segment-elevation ACS with intermediate-risk features

This code is used when the reason for admission is clinical features consistent with an acute coronary syndrome and any of the following intermediate-risk features AND NOT meeting the criteria for high-risk ACS:

- chest pain or discomfort within the past 48 hours that occurred at rest, or was repetitive or prolonged (but currently resolved);
- age greater than 65yrs;
- known coronary heart disease: prior myocardial infarction with left ventricular ejection fraction >= 0.40, or known coronary lesion more than >50% stenosed;
- no high-risk changes on electrocardiography (see high-risk features);
- two or more of the following risk factors: of known hypertension, family history, active smoking or

hyperlipidaemia;

- presence of known diabetes (with atypical symptoms of ACS);
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with atypical symptoms of ACS); or
- prior aspirin use.

CODE 4 Non-ST-segment-elevation ACS with low-risk features

This code is used when the reason for admission is clinical features consistent with an acute coronary syndrome without intermediate or high-risk features of non-ST-segment-elevation ACS. This includes onset of anginal symptoms within the last month, or worsening in severity or frequency of angina, or lowering of anginal threshold.

CODE 5 Percutaneous coronary intervention (PCI)

This code is used when the reason for admission is for a PCI, where the PCI is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated PCI undertaken, one of codes 1-4 should be coded.

CODE 6 Coronary artery bypass graft (CABG)

This code is used when the reason for admission is for a CABG, where the CABG is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated CABG undertaken, one of codes 1-4 should be coded.

CODE 7 Heart failure (without MI)

This code is used when the reason for admission is for the treatment of heart failure, where heart failure is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission, one of codes 1-4 should be coded.

CODE 8 Arrhythmia (without MI)

This code is used when the reason for admission is for the treatment of an arrhythmia, where the arrhythmia is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission, one of codes 1-4 should be coded.

Data element attributes

Collection and usage attributes

Guide for use: To determine if this item should be collected ask the person being admitted if they have been discharged from an episode of admitted patient care for acute coronary syndrome within the last 28 days.

Comments: This metadata item is designed to identify recurrent admissions following an initial presentation with acute coronary syndromes (ACS), not necessarily to the hospital responsible for the index admission.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Person—reason for readmission following acute coronary syndrome episode, code N[N] Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Reason for removal from elective surgery waiting list

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—reason for removal from a waiting list, code N
METeOR identifier:	471735
Registration status:	Health, Standard 13/12/2011
Definition:	The reason why a patient is removed from the elective surgery waiting list, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—reason for removal from a waiting list

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Admitted as an elective patient for awaited procedure by or on behalf of this hospital or the state/territory
	2	Admitted as an emergency patient for awaited procedure by or on behalf of this hospital or the state/territory
	3	Could not be contacted (includes patients who have died while waiting, whether or not the cause of death was related to the condition requiring treatment)
	4	Treated elsewhere for awaited procedure, but not on behalf of this hospital or the state/territory
	5	Surgery not required or declined
	6	Transferred to another hospital's waiting list
Supplementary values:	9	Not known

Collection and usage attributes

Guide for use:

CODE 1 Admitted as an elective patient for awaited procedure by or on behalf of this hospital or the state/territory

Patients undergoing the awaited procedure whilst admitted for another reason are to be coded this code.

CODE 2 Admitted as an emergency patient for awaited procedure by or on behalf of this hospital or the state/territory

This code identifies patients who were admitted ahead of their normal position in the queue because the condition requiring treatment deteriorated whilst waiting. Admission as an emergency patient could also be due to other causes such as inappropriate urgency rating, delays in the system, or unpredicted biological variation.

CODES 3 - 5

CODE 3 Could not be contacted (includes patients who have died while waiting, whether or not the cause of death was related to the condition requiring treatment)

CODE 4 Treated elsewhere for awaited procedure, but not on behalf of this hospital or the state/territory

This code would be used where surgery was undertaken other than by or on behalf of this hospital or the state/territory; for example, the patient has accessed surgery as a private patient in a private hospital.

CODE 5 Surgery not required or declined

These codes provide an indication of the amount of clerical audit of the waiting lists. Code 4 gives an indication of patients treated other than as a patient of the hospital's waiting list. The awaited procedure may have been performed as an emergency or as an elective procedure.

CODE 6 Transferred to another hospital's waiting list

This code identifies patients who were transferred from one hospital's elective surgery waiting list to that of another hospital. The waiting time on the waiting lists at the initial hospital and subsequent hospitals should be combined for national reporting.

CODE 9 Not known

This code identifies patients removed from the waiting list for reasons unknown.

Data element attributes

Source and reference attributes

Submitting organisation: Hospital Access Program Waiting Lists Working Group
Waiting Times Working Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Elective surgery waiting list episode—reason for removal from a waiting list, code N Health, Superseded 13/12/2011

Implementation in Data Set Specifications:

Elective surgery waiting times (removals data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 01/07/2012

Elective surgery waiting times cluster Health, Standard 07/12/2011

Record identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Record—identifier, X[X(14)]
Synonymous names:	State record identifier
METeOR identifier:	459234
Registration status:	Health, Standard 07/12/2011
Definition:	A record identifier that is unique to the reporting body, as represented by a code.
Data Element Concept:	Record—identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	X[X(14)]
Maximum character length:	15

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (indirect health care)— public health and monitoring services

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (indirect health care) (public health and monitoring services) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270292

Registration status: Health, Standard 01/03/2005

Definition: Expenditure on indirect health care that is related to public health and monitoring services, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: To be provided at the state level. Public or registered non-profit services and organisations with centralised, statewide or national public health or monitoring services. These include programs concerned primarily with preventing the occurrence of diseases and mitigating their effect, and includes such activities as mass chest X-ray campaigns, immunisation and vaccination programs, control of communicable diseases, ante-natal and post-natal clinics, preschool and school medical services, infant welfare clinics, hygiene and nutrition advisory services, food and drug inspection services, regulation of standards of sanitation, quarantine services, pest control, anti-cancer, anti-drug and anti-smoking campaigns and other programs to increase public awareness of disease symptoms and health hazards, occupational health services, Worksafe Australia, the Australian Institute of Health and Welfare and the National Health and Medical Research Council.

Included here would be child dental services comprising expenditure incurred (other than by individual establishments) or dental examinations, provision of preventive and curative dentistry, dental health education for infants and school children and expenditure incurred in the training of dental therapists.

Record values up to hundreds of millions of dollars.

Comments: Resources Working Party members were concerned about the possibility of double-counting of programs at the hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (indirect health care)—central administrations

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (indirect health care) (central administrations) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270294
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure measured in Australian dollars on indirect health care related to central administrations, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	To be provided at the state level. Expenditures relating to central health administration, research and planning for central and regional offices of State, Territory and Commonwealth health authorities and related departments (e.g. the Department of Veterans' Affairs). Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar.
Comments:	Resources Working Party members were concerned about the possibility of double-counting of programs at the hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (indirect health care)—central and statewide support services

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (indirect health care) (central and statewide support services) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270293

Registration status: Health, Standard 01/03/2005

Definition: Expenditure measured in Australian dollars on indirect health care related to central and statewide support services, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: To be provided at the state level. Public or registered services which provide central or statewide support services for residential establishments within the scope of the Public hospital establishments National Minimum Data Set. These include central pathology services, central linen services and frozen food services and blood banks provided on a central or statewide basis such as Red Cross.

Record values up to hundreds of millions of dollars, rounded to the nearest whole dollar.

Comments: Resources Working Party members were concerned about the possibility that double-counting of programs at the hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.1 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Recurrent expenditure (indirect health care)—other

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (indirect health care) (other) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270295
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure in Australian dollars on health care that cannot be directly related to programs operated by a particular establishment and is not related to patient transport services, public health and monitoring services, central and statewide support services or central administrations, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	To be provided at the state level. Other: Any other indirect health care expenditure as defined above not catered for in the following categories: Patient transport services; Public health and monitoring services; Central and statewide support services; Central administrations. This might include such things as family planning and parental health counselling services and expenditure incurred in the registration of notifiable diseases and other medical information. Record values up to hundreds of millions of dollars, rounded to the nearest whole dollar.
Comments:	Resources Working Party members were concerned about the possibility that double-counting of programs at the

hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (indirect health care)—patient transport services

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (indirect health care) (patient transport services) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270291

Registration status: Health, Standard 01/03/2005

Definition: Expenditure measured in Australian dollars on indirect health care related to patient transport services, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: To be provided at the state level. Public or registered non-profit organisations which provide patient transport (or ambulance) for services associated with inpatient or residential episodes at residential establishments within the scope of this data set.

This category excludes patient transport services provided by other types of establishments (for example, public hospitals) as part of their normal services. This category includes centralised and statewide patient transport services (for example, Queensland Ambulance Transport Brigade) which operate independently of individual inpatient establishments.

Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar.

Comments: Resources Working Party members were concerned about the possibility that double-counting of programs at the hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (mental health)—non-salary operating costs

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)]

Synonymous names: Non-salary operating costs excluding depreciation

METeOR identifier: 287979

Registration status: Health, Standard 08/12/2004

Definition: Total expenditure by a mental health establishment relating to non-salary operating items.

Data Element Concept: Establishment—recurrent expenditure (non-salary operating costs)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Report all expenditure in thousands of dollars (i.e. $ 000's).

Expenditure should include both the specific costs directly associated with the service and indirect costs, for example personnel services.

Research and academic units that function as an integral part of ambulatory care should be reported against the appropriate service.

Depreciation is to be excluded from the non-salary operating costs.

Collection methods: Non-salary recurrent expenditure, excluding depreciation, is to be reported by service setting (admitted patient care, residential care, ambulatory care).

For the admitted patient care setting non-salary recurrent expenditure, excluding depreciation, is to be disaggregated by specialised mental health service program type and specialised mental health service target population, together.

The sub-components of non-salary recurrent expenditure, and depreciation, are to be reported at the organisation level for the Mental health establishments NMDS. However, if the organisation is not reporting on an accrual basis then it does not need to report depreciation.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Establishment—recurrent expenditure (administrative expenses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (domestic services) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (drug supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (food supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (interest payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (medical and surgical supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (other recurrent expenditure) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (patient transport cost) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (repairs and maintenance) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (superannuation employer contributions) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (mental health)—salaries and wages

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)]
METeOR identifier:	296577
Registration status:	Health, Standard 08/12/2004
Definition:	Total salary and wage payments to all **staff** of a mental health establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:

Is formed using Establishment—recurrent expenditure (salaries and wages) (administrative and clerical staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (carer consultants) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (salaries and wages) (consumer consultants) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (salaries and wages) (diagnostic and health professionals) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (domestic and other staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (enrolled nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (other personal care staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (registered nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (salaried medical officers) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (salaries and wages)—administrative and clerical staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (administrative and clerical staff) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270275
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **administrative and other clerical staff** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)
Implementation in Data Set Specifications:	Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013 Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012
Implementation end date: 30/06/2013

Recurrent expenditure (salaries and wages)—carer consultants

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (salaries and wages) (carer consultants) (financial year), total Australian currency N[N(8)]

METeOR identifier: 296531

Registration status: Health, Standard 08/12/2004

Definition: Salary and wage payments to **carer consultants** of an establishment, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Carer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of carers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the carer only received reimbursements of expenses or occasional sitting fees for attendance at meetings.

Collection methods: Note: This code is only to be reported for the Mental Health Establishments NMDS.

For Public hospital establishments NMDS data are to be reported in a category according to specific state and territory arrangements.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (salaries and wages)—consultant psychiatrists and psychiatrists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (consultant psychiatrists and psychiatrists) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288767
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **consultant psychiatrists** and **psychiatrists** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (salaries and wages)—consumer consultants

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (consumer consultants) (financial year), total Australian currency N[N(8)]
METeOR identifier:	296528
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **consumer consultants** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Consumer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of consumers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the consumer only received reimbursements of expenses or occasional sitting fees for attendance at meetings.
Collection methods:	Note: This code is only to be reported for the Mental Health Establishments NMDS. For Public hospital establishments NMDS data are to be reported in a category according to specific state and territory arrangements.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Recurrent expenditure (salaries and wages)—diagnostic and health professionals

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (salaries and wages) (diagnostic and health professionals) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270274

Registration status: Health, Standard 01/03/2005

Definition: Salary and wage payments measured in Australian dollars to **diagnostic and health professionals** of an establishment, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (salaries and wages)—domestic and other staff

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (salaries and wages) (domestic and other staff) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270276

Registration status: Health, Standard 01/03/2005

Definition: Salary and wage payments measured in Australian dollars to **domestic and other staff** of an establishment, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012
Implementation end date: 30/06/2013

Recurrent expenditure (salaries and wages)—enrolled nurses

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (salaries and wages) (enrolled nurses) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270270

Registration status: Health, Standard 01/03/2005

Definition: Salary and wage payments measured in Australian dollars to **enrolled nurses** of an establishment, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (salaries and wages)—occupational therapists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (occupational therapists) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288778
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **occupational therapists** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Recurrent expenditure (salaries and wages)—other diagnostic and health professionals

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (other diagnostic and health professionals) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288786
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **other diagnostic and health professionals** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Recurrent expenditure (salaries and wages)—other medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (other medical officers) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288776
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **other medical officers** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Other medical officers are those who are neither registered as psychiatrists within the State or Territory nor formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (salaries and wages)—other personal care staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (other personal care staff) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270273
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **other personal care staff** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)
Implementation in Data Set Specifications:	Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013 Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012
Implementation end date: 30/06/2013

Recurrent expenditure (salaries and wages)—psychiatry registrars and trainees

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (psychiatry registrars and trainees)(financial year), total Australian currency N[N(8)]
METeOR identifier:	288774
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **psychiatry registrars and trainees** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Recurrent expenditure (salaries and wages)—psychologists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (psychologists) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288784
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **psychologists** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (salaries and wages)—registered nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (registered nurses) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270269
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **registered nurses** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)
Implementation in Data Set Specifications:	Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013 Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012
Implementation end date: 30/06/2013

Recurrent expenditure (salaries and wages)—salaried medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (salaried medical officers) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270265
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **salaried medical officers** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:

Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (salaries and wages)—social workers

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (salaries and wages) (social workers) (financial year), total Australian currency N[N(8)]

METeOR identifier: 288780

Registration status: Health, Standard 08/12/2004

Definition: Salary and wage payments to **social workers** of an establishment, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (salaries and wages)—student nurses

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (salaries and wages) (student nurses) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270271

Registration status: Health, Standard 01/03/2005

Definition: Salary and wage payments measured in Australian dollars to **student nurses** of an establishment, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Student nurses are persons employed by the establishment currently studying in years one to three of a three year certificate course. This includes any person commencing or undertaking a three year course of training leading to registration as a nurse by the state or territory registration board. This includes full time general student nurse and specialist student nurse, such as mental deficiency nurse, but excludes practising nurses enrolled in post basic training courses.

Note: This code is not to be reported for the Mental health establishments National Minimum Data Set.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure (salaries and wages)—total

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (salaries and wages) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270470

Registration status: Health, Standard 01/03/2005

Definition: Salary and wage payments measured in Australian dollars for all employees of the establishment (including contract staff employed by an agency, provided staffing data is also available).

Data Element Concept: Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Record as currency up to hundreds of millions of dollars.

Figures should be supplied for each of the staffing categories:

C1.1 Salaried medical officers

C1.2 Registered nurses

C1.3 Enrolled nurses

C1.4 Student nurses

C1.5 Trainee / pupil nurses

C1.6 Other personal care staff

C1.7 Diagnostic and health professionals

C1.8 Administrative and clerical staff

C1.9 Domestic and other staff

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Recurrent expenditure (salaries and wages)—trainee/pupil nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (trainee/pupil nurses) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270272
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **trainee/pupil nurses** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Recurrent expenditure—administrative expenses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (administrative expenses) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270107
Registration status:	Health, Standard 01/03/2005
Definition:	The expenditure measured in Australian dollars incurred by establishments (but not central administrations) of a management expenses/administrative support nature such as any rates and taxes, printing, telephone, stationery and insurance (including workers compensation), for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (administrative expenses)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Rounded to the nearest whole dollar.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Administrative expenses, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB) Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005 Is used in the formation of Establishment (mental health)—

recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—Department of Veterans' Affairs funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (Department of Veterans' Affairs funded), total Australian currency N[N(8)]
METeOR identifier:	377992
Registration status:	Health, Standard 02/12/2009
Definition:	Total recurrent expenditure measured in Australian dollars funded by block grants or activity payments provided by the Department of Veterans' Affairs (DVA) for provision of mental health services and payments made for mental health treatment and care of DVA clients.
Data Element Concept:	Establishment—recurrent expenditure (Department of Veterans' Affairs funded)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Australian dollars. Rounded to nearest whole dollar.

Collection methods:

DVA-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure is available.

Where DVA-funded expenditure could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possibility of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—recurrent expenditure (Department of Veterans' Affairs funded), total Australian currency N[N(8)] Health, Superseded 02/12/2009

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—depreciation

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (depreciation) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270279

Registration status: Health, Standard 01/03/2005

Definition: Depreciation charges measured in Australian dollars for a financial year.

Data Element Concept: Establishment—recurrent expenditure (depreciation)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar.

Depreciation is to be reported by service setting (admitted patient care, residential care, ambulatory care).

For admitted patient care settings, depreciation is to be disaggregated by specialised mental health service program type and specialised mental health service target population, together.

Comments: With the long-term trend towards accrual accounting in the public sector, this metadata item will ultimately become significant for public sector establishments. Public sector establishments in some states have adopted modified accrual accounting identifying depreciation only, before reaching full accrual accounting. Depreciation is now reported for most public sector establishments and should be reported as a separate recurrent expenditure.

Depreciation should be identified separately from other recurrent expenditure categories.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Depreciation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—domestic services

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (domestic services) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270283

Registration status: Health, Standard 01/03/2005

Definition: The costs measured in Australian dollars of all domestic services including electricity, other fuel and power, domestic services for staff, accommodation and kitchen expenses but not including salaries and wages, food costs or equipment replacement and repair costs, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (domestic services)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar.

Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Comments: The possibility of separating fuel, light and power from domestic services which would bring the overall non-salary recurrent expenditure categories closer to the old Hospitals and Allied Services Advisory Council categories was briefly considered by the Resources Working Party but members did not hold strong views in this area.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Domestic services, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—drug supplies

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (drug supplies) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270282
Registration status:	Health, Standard 01/03/2005
Definition:	The cost measured in Australian dollars of all drugs including the cost of containers, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (drug supplies)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar.

Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Drug supplies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)

Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—food supplies

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (food supplies) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270284
Registration status:	Health, Standard 01/03/2005
Definition:	The cost measured in Australian dollars of all food and beverages but not including kitchen expenses such as utensils, cleaning materials, cutlery and crockery, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (food supplies)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Supersedes Food supplies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB)

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—interest payments

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (interest payments) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270186
Registration status:	Health, Standard 01/03/2005
Definition:	Payments in Australian dollars made by or on behalf of the establishment in respect of borrowings (e.g. interest on bank overdraft) provided the establishment is permitted to borrow, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (interest payments)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar.
Comments:	The item would not have been retained if the data set was restricted to the public sector. In some States, public hospitals may not be permitted to borrow funds or it may be entirely a State treasury matter, not identifiable by the health authority. Even where public sector establishment borrowings might be identified, this appears to be a sensitive area and also of less overall significance than in the private sector.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary

operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Supersedes Interest payments, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—medical and surgical supplies

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (medical and surgical supplies) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270358
Registration status:	Health, Standard 01/03/2005
Definition:	The cost in Australian dollars of all consumables of a medical or surgical nature (excluding drug supplies) but not including expenditure on equipment repairs, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (medical and surgical supplies)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.
Collection methods:	Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Supersedes Medical and surgical supplies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—National Mental Health Strategy funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (National Mental Health Strategy funded), total Australian currency N[N(8)]
METeOR identifier:	289502
Registration status:	Health, Standard 08/12/2004
Definition:	Total recurrent expenditure funded by monies allocated by the Commonwealth to the state or territory to assist in implementation of the National Mental Health Strategy.
Data Element Concept:	Establishment—recurrent expenditure (National Mental Health Strategy payments)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Australian dollars. Rounded to the nearest whole dollar.

Collection methods: Report only the expenditure from those funds used to resource recurrent Expenditure on services within the scope of the NMDS—Mental Health Establishments.

National Mental Health Strategy-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency

N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Recurrent expenditure—non-salary operating costs (excluding depreciation)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270297

Registration status: Health, Standard 01/03/2005

Definition: Total expenditure relating to non-salary operating items, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (non-salary operating costs)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar.

Total is calculated from expenditure including:

- Payments to visiting medical officers
- Superannuation employer contributions (including funding basis)
- Drug supplies
- Medical and surgical supplies
- Food supplies
- Domestic services
- Repairs and maintenance
- Patient transport
- Administrative expenses
- Interest payments

- Depreciation
- Other recurrent expenditure.

Expenditure should include both the specific costs directly associated with the service and indirect costs for example personnel services.

Research and academic units that function as an integral part of ambulatory care should be reported against the appropriate service.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Establishment—recurrent expenditure (administrative expenses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (depreciation) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (domestic services) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (drug supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (food supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (interest payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (medical and surgical supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (other recurrent expenditure) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (patient transport cost) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (repairs and maintenance) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (superannuation employer contributions) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Supersedes Non-salary operating costs, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.2 KB)

Recurrent expenditure—other Commonwealth Government funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (other Commonwealth Government funded expenditure), total Australian currency N[N(8)]
METeOR identifier:	288031
Registration status:	Health, Standard 08/12/2004
Definition:	Total recurrent expenditure by an organisation, region or central administration funded from other revenue paid directly by the Commonwealth Government and used to resource recurrent expenditure on services within the scope of the NMDS—Mental Health Establishments.
Data Element Concept:	Establishment—recurrent expenditure (other Commonwealth Government funded expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Australian dollars. Rounded to nearest whole dollar.

Includes expenditure where the funding is from nursing home and hostel subsidies for the care of patients in specialised mental health services, and any other special purpose grants including rural health support, education and training funds and incentive package funds made available under the Australian Health Care Agreements.

Excludes expenditure funded by the Commonwealth under grants from the Department of Veterans' Affairs or from the National Mental Health Strategy.

Collection methods:

Other Commonwealth Government-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level.

Where other Commonwealth Government-funded expenditure could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—other patient revenue funded

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (other patient revenue funded expenditure), total Australian currency N[N(8)]

METeOR identifier: 290583

Registration status: Health, Standard 08/12/2004

Definition: Recurrent expenditure funded from other revenue paid directly by patients or third parties, such as private health insurers, on behalf of patients under care of the organisation, region or central administration mental health services, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (other patient revenue funded expenditure)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Australian dollars. Rounded to the nearest whole dollar.

Collection methods: Other patient revenue funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the State, regional or organisational level.

Note: this excludes expenditure funded by Department of Veterans' Affairs payments in respect of specific patients, or funded by the Commonwealth nursing home or hostel subsidies which should be reported in Department of Veterans' Affairs funded expenditure or Commonwealth Government funded expenditure respectively.

Where other patient revenue funded expenditure could be allocated to more than one level, it is important to allocate it to the single most appropriate statistical unit level to avoid the possibility of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—other recurrent expenditure

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (other recurrent expenditure) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270126

Registration status: Health, Standard 01/03/2005

Definition: All other recurrent expenditure measured in Australian dollars not included elsewhere in any of the recurrent expenditure categories, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (other recurrent expenditure)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Submitting organisation: National Minimum Data Set Working Parties

Relational attributes

Related metadata references: Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—other revenue funded

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)]

METeOR identifier: 288071

Registration status: Health, Standard 08/12/2004

Definition: The total recurrent expenditure funded from all other revenue that was received by the organisation, region and central administration and has not been reported elsewhere.

Data Element Concept: Establishment—recurrent expenditure (other revenue funded expenditure)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Australian dollars. Rounded to nearest whole dollar.

Collection methods: Expenditure funded from all other revenue, excluding those reported separately, to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the State, regional or organisational level.

Expenditure reported separately are listed below under the Relational attributes section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: See also Establishment—recurrent expenditure (Department of Veterans' Affairs funded), total Australian currency N[N(8)] Health, Superseded 02/12/2009

See also Establishment—recurrent expenditure (National Mental Health Strategy funded), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (other Commonwealth Government funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (other patient revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (other state or territory funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (recoveries funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (state or territory health authority funded), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—other State or Territory funded

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (other state or territory funded expenditure), total Australian currency N[N(8)]

METeOR identifier: 288075

Registration status: Health, Standard 08/12/2004

Definition: The total recurrent expenditure from state or territory funding sources from government departments external to the health department portfolio which were used to support the delivery and/or administration of mental health services.

Data Element Concept: Establishment—recurrent expenditure (other state or territory funded expenditure)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: State or territory-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred, e.g. at the state, regional or organisational level.

Collection methods: Where state or territory-funded expenditure could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.

Expenditure funded from all other revenue, excluding those reported separately, to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level.

Relational attributes

Related metadata references:

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—patient transport

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (patient transport cost) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270048

Registration status: Health, Standard 01/03/2005

Definition: The direct cost in Australian dollars of transporting patients excluding salaries and wages of transport staff where payment is made by an establishment, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (patient transport cost)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Supersedes Patient transport, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—payments to visiting medical officers

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270049

Registration status: Health, Standard 01/03/2005

Definition: All payments measured in Australian dollars made by an institutional health care establishment to **visiting medical officers** for medical services provided to hospital (public) patients on an honorary, sessionally paid, or fee for service basis, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (visiting medical officer payments)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Comments: Although accepting the need to include visiting medical officer payments, the Resources Working Party decided not to include data on visiting medical officer services (whether hours or number of sessions or number of services provided) due to collection difficulties and the perception that use of visiting medical officers was purely a hospital management issue.

Source and reference attributes

Submitting organisation: National Minimum Data Set Working Parties

Relational attributes

Related metadata references:

Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Supersedes Payments to visiting medical officers, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.2 KB)

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—recoveries funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (recoveries funded expenditure), total Australian currency N[N(8)]
METeOR identifier:	288685
Registration status:	Health, Standard 08/12/2004
Definition:	Recurrent expenditure funded from revenue that is in the nature of a recovery of expenditure incurred, including income from provision of meals and accommodation, use of facilities, etc. for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (recoveries funded expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to nearest whole dollar.
Collection methods:	Expenditure funded from recoveries to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level. Where expenditure funded from recoveries could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, recoveries received through service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Recurrent expenditure—repairs and maintenance

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (repairs and maintenance) (financial year), total Australian currency N[N(8)]

METeOR identifier: 269970

Registration status: Health, Standard 01/03/2005

Definition: The costs in Australian dollars incurred in maintaining, repairing, replacing and providing additional equipment, maintaining and renovating building and minor additional works, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (repairs and maintenance)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Expenditure of a capital nature should not be included here.

Do not include salaries and wages of repair and maintenance staff. Gross expenditure should be reported with no revenue offsets (except for inter-hospital transfers).

Source and reference attributes

Submitting organisation: National Minimum Data Set Working Parties

Relational attributes

Related metadata references: Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency

N[N(8)] Health, Standard 01/03/2005

Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Supersedes Repairs and maintenance, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—State or Territory health authority funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (state or territory health authority funded), total Australian currency N[N(8)]
METeOR identifier:	288965
Registration status:	Health, Standard 08/12/2004
Definition:	The total recurrent expenditure from funds provided by the State or Territory health authority which were used to support the delivery and/or administration of mental health services reported by the organisation, region or central administration.
Data Element Concept:	Establishment—recurrent expenditure (state or territory health authority funded)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to nearest whole dollar. Includes specific mental health allocations as well as health funds appropriated for general or other specific purpose.
Collection methods:	State or Territory health authority-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level. Where State or Territory health authority-funded expenditure could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be

reported at the lowest statistical unit level possible only.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Recurrent expenditure—superannuation employer contributions

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent expenditure (superannuation employer contributions) (financial year), total Australian currency N[N(8)]

METeOR identifier: 270371

Registration status: Health, Standard 01/03/2005

Definition: Contributions paid in Australian dollars or (for an emerging cost scheme) that should be paid (as determined by an actuary) on behalf of establishment employees either by the establishment or a central administration such as a state health authority, to a superannuation fund providing retirement and related benefits to establishment employees, for a financial year.

Data Element Concept: Establishment—recurrent expenditure (superannuation employer contributions)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Comments: The definition specifically excludes employee superannuation contributions (not a cost to the establishment) and superannuation final benefit payments.

In private enterprise some superannuation schemes are partially funded but this is considered too complex a distinction for national minimum data sets.

It is noted that the emergence of salary sacrifice schemes allows employees to forego salary for higher superannuation contributions. If these become significant, national minimum data sets may have to take them into account at a future stage.

Source and reference attributes

Submitting organisation: National Minimum Data Set Working Parties

Relational attributes

Related metadata references:

Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Supersedes Superannuation employer contributions (including funding basis), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.4 KB)

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Recurrent expenditure—total

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)]
METeOR identifier:	288993
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure relating to salaries and wages, non-salary recurrent expenditure and depreciation for a financial year.
Data Element Concept:	Establishment—recurrent expenditure

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Australian dollars. Rounded to nearest whole dollar.

Total is calculated from expenditure including: salaries and wages; depreciation; and non-salary recurrent expenditure comprising: payments to visiting medical officers; superannuation employer contributions (including funding basis); drug supplies; medical and surgical supplies; food supplies; domestic services; repairs and maintenance; patient transport; administrative expenses; interest payments; and other recurrent expenditure.

Collection methods:

The total grant made to non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding. Can be reported as the total recurrent expenditure if detailed expenditure data are not available.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Is formed using Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (Department of Veterans' Affairs funded), total Australian currency N[N(8)] Health, Superseded 02/12/2009

Is formed using Establishment—recurrent expenditure (National Mental Health Strategy funded), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (administrative expenses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (domestic services) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (drug supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (food supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (interest payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (medical and surgical supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (other Commonwealth Government funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (other patient revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (other recurrent expenditure) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (other state or territory funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (patient transport cost) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (recoveries funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (repairs and maintenance) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (state or territory health authority funded), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (superannuation employer contributions) Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Referral destination to further care (from specialised mental health residential care)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—referral destination (mental health care), code N
METeOR identifier:	417658
Registration status:	Health, Standard 07/12/2011
Definition:	The type of health care the **resident** is referred to by the residential mental health care service for further care at the end of residential stay, as represented by a code.
Data Element Concept:	Episode of residential care—referral destination (mental health care)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	1	Specialised mental health admitted patient care
	2	Specialised mental health residential care
	3	Specialised mental health ambulatory care
	4	Private psychiatrist care
	5	General practitioner care
	6	Other care
	7	Not referred
	8	Not applicable (i.e. end of reference period)
Supplementary values:	9	Unknown/not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Where the **resident** is referred to two or more types of health care, the type of health care provided by the service primarily responsible for the care of the resident is to be

reported.

Relational attributes

Related metadata references: Supersedes Episode of residential care—referral destination (mental health care), code N Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Referral destination to further care (psychiatric patients)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of admitted patient care (mental health care)—referral destination, code N

METeOR identifier: 269990

Registration status: Health, Standard 01/03/2005

Definition: The type of further health service care to which a person is referred from mental health, as represented by a code.

Data Element Concept: Episode of admitted patient care—referral destination

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Not referred
2	Private psychiatrist
3	Other private medical practitioner
4	Mental health/alcohol and drug in-patient facility
5	Mental health/alcohol and drug non in-patient facility
6	Acute hospital
7	Other

Data element attributes

Source and reference attributes

Submitting organisation: National Minimum Data Set Working Parties

Relational attributes

Related metadata references: Supersedes Referral to further care (psychiatric patients), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)

Implementation in Data Set Admitted patient mental health care NMDS 2012-2013

Specifications:	Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Referred to ophthalmologist (diabetes mellitus)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—referral to ophthalmologist indicator (last 12 months), code N
METeOR identifier:	302823
Registration status:	Health, Standard 21/09/2005
Definition:	Whether the individual was referred to an **ophthalmologist** within the last 12 months, as represented by a code.
Data Element Concept:	Person—referral to ophthalmologist indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes: Record if the individual was referred to an ophthalmologist during the last 12 months.

CODE 2 No: Record if the individual was not referred to an ophthalmologist during the last 12 months.

Collection methods:

Ask the individual if he/she was referred to an ophthalmologist during the last 12 months. Alternatively, obtain this information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative

(NDOQRIN) data dictionary

Reference documents: Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

Relational attributes

Related metadata references: Supersedes Health service event—referral to ophthalmologist status (last 12 months), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Region code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—region identifier, X[X]
METeOR identifier:	269940
Registration status:	Health, Standard 01/03/2005
Definition:	An alphanumeric identifier for the location of health services in a defined geographic or administrative area.
Data Element Concept:	Establishment—region identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	X[X]
Maximum character length:	2

Data element attributes

Collection and usage attributes

Guide for use:

Domain values are specified by individual states/territories. Regions may also be known as Areas or Districts. Any valid region code created by a jurisdiction is permitted.

Relational attributes

Related metadata references:

Is used in the formation of Establishment—organisation identifier (Australian), NNX[X]NNNNN Health, Standard 01/03/2005

Supersedes Region code, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Health care client identification DSS Health, Standard

03/12/2008

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Region name

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—region name, text XXX[X(57)]

METeOR identifier: 407187

Registration status: Health, Standard 07/12/2011

Definition: The appellation by which an administrative region is known or called, as represented by text.

Data Element Concept: Establishment—region name

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: XXX[X(57)]

Maximum character length: 60

Data element attributes

Collection and usage attributes

Guide for use: The name of regions are determined by the relevant state or territory. The region refers to an administrative concept, not a geographical one, because the intent is to capture expenditure and other related data. States and territories may have one or more regions into which the state or territory is divided and to which its service organisations belong. In those cases, region should be reported using the Region identifier data element. In the smaller states or territories there may only be one or no region. In these cases, the region name would repeat the name of the state or territory.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Region of first recurrence

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person with cancer—region of first recurrence of cancer, code N

METeOR identifier: 289136

Registration status: Health, Standard 04/06/2004

Definition: The region of first recurrence of primary cancer after a disease free intermission or remission, as represented by a code.

Data Element Concept: Person with cancer—region of first recurrence of cancer

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Local
	2	Regional
	3	Both local and regional
	4	Distant
	5	Distant and either local or regional
	6	Local, regional and distant
Supplementary values:	0	None, patient is disease-free
	7	Patient was never disease-free
	8	Recurred but site unknown
	9	Unknown if recurred

Data element attributes

Collection and usage attributes

Guide for use: The region of the first recurrence following the initial diagnosis should be recorded.

The record should not be updated with subsequent recurrences.

The cancer may recur in more than one site (e.g. both regional and distant metastases).

Record the highest numbered applicable response.

Source and reference attributes

Origin: Commission on Cancer, American College of Surgeons

Reference documents: Commission on Cancer, Standards of the Commission on Cancer Volume II Registry Operations and Data Standards (ROADS) (1998)

Relational attributes

Related metadata references: Supersedes Region of first recurrence, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.0 KB)

Region of first recurrence as distant metastasis

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person with cancer—region of first recurrence as distant metastasis, topography code (ICD-O-3) ANN.N

METeOR identifier: 393854

Registration status: Health, Standard 07/12/2011

Definition: The region of first recurrence as a distant metastasis in a person with cancer, after a disease-free period, as represented by a code.

Data Element Concept: Person with cancer—region of first recurrence as distant metastasis

Value domain attributes

Representational attributes

Classification scheme: International Classification of Diseases for Oncology 3rd edition

Representation class: Code

Data type: String

Format: ANN.N

Maximum character length: 5

Collection and usage attributes

Guide for use: Record all four alphanumeric characters of the topography code. The number after the decimal point represents the subsite or subcategory.

Data element attributes

Collection and usage attributes

Guide for use: This information is collected for the site or region of first recurrence as distant metastasis.

The term recurrence refers to the return, reappearance or metastasis of cancer of the same histology after a disease-free period.

Distant metastasis refers to the spread of cancer of the same histology as the original (primary) tumour to distant organs or distant lymph nodes.

Site or region refers to the anatomical location that the cancer has spread to.

Distant metastasis may occur in more than one site; record all relevant distant metastatic sites.

The region of locoregional recurrence is collected as a separate item.

The record should not be updated with subsequent recurrences.

Collection methods: The information should be obtained from the patient's medical record.

Comments: This is collected to identify in which anatomical structures recurrence occurs, and is useful for evaluating patterns of care and patient outcomes.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references: See also Patient—diagnosis date of first recurrence as distant metastasis, DDMMYYYY Health, Standard 07/12/2011

See also Patient—diagnosis date of first recurrence as locoregional cancer, DDMMYYYY Health, Standard 07/12/2011

See also Person with cancer—most valid basis of diagnosis of the first recurrence, code N Health, Standard 07/12/2011

See also Person with cancer—region of first recurrence as locoregional cancer, topography code (ICD-O-3) ANN.N Health, Standard 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on the patient being diagnosed with recurrence of distant metastasis.

Region of first recurrence as locoregional cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—region of first recurrence as locoregional cancer, topography code (ICD-O-3) ANN.N
METeOR identifier:	393848
Registration status:	Health, Standard 07/12/2011
Definition:	The region of first recurrence as locoregional cancer in a person with cancer, after a disease-free period, as represented by a code.
Data Element Concept:	Person with cancer—region of first recurrence as locoregional cancer

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	String
Format:	ANN.N
Maximum character length:	5

Collection and usage attributes

Guide for use:

Record all four alphanumeric characters of the topography code. The number after the decimal point represents the subsite or subcategory.

Data element attributes

Collection and usage attributes

Guide for use:

This information is collected for the site or region of the first recurrence as locoregional cancer.

The term recurrence refers to the return, reappearance or metastasis of cancer of the same histology after a disease-free period.

Locoregional recurrence refers to the appearance of cancer cells at the same site as the original (primary) tumour or the regional lymph nodes. A list of those lymph nodes defined as regional lymph nodes for each cancer site can be found in the TNM Classification of Malignant Tumours International Union Against Cancer (UICC) and the

American Joint Committee on Cancer (AJCC) Cancer Staging Manual; the latest editions are recommended.

Site or region refers to the anatomical position that the cancer has reappeared, record all relevant locoregional sites.

The region of recurrence of distant metastasis is collected as a separate item.

The record should not be updated with subsequent recurrences.

Collection methods: The information should be obtained from the patient's medical record.

Comments: This is collected to identify in which anatomical structures recurrence occurs, and is useful for evaluating patterns of care and patient outcomes.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references: See also Patient—diagnosis date of first recurrence as distant metastasis, DDMMYYYY Health, Standard 07/12/2011

See also Patient—diagnosis date of first recurrence as locoregional cancer, DDMMYYYY Health, Standard 07/12/2011

See also Person with cancer—most valid basis of diagnosis of the first recurrence, code N Health, Standard 07/12/2011

See also Person with cancer—region of first recurrence as distant metastasis, topography code (ICD-O-3) ANN.N Health, Standard 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:

Conditional on the patient being diagnosed with recurrence of locoregional cancer.

Regional lymph nodes positive

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person with cancer—number of positive regional lymph nodes, total N[N]

METeOR identifier: 415959

Registration status: Health, Standard 07/12/2011

Definition: The total number of regional lymph nodes reported to contain tumour in a person with cancer.

Data Element Concept: Person with cancer—number of positive regional lymph nodes

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[N]

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: A list of which lymph nodes are defined as regional lymph nodes for each cancer site may be found in the current edition of the TNM Classification of Tumours, UICC (International Union Against Cancer) and the AJCC (American Joint Committee on Cancer) Cancer Staging Manual.

The number includes all positive nodes regardless of whether they were removed and examined at a single or multiple procedures. For example, for breast cancer, record the sum of positive nodes detected in node sampling/sentinel node biopsy and those removed at axillary clearance.

Collection methods: The information should be obtained from the patient's medical record.

For cancer registries, collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.

Source and reference attributes

Origin:

Australian Cancer Network

Commission on Cancer American College of Surgeons

Reference documents:

American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II, Commission on Cancer

American Joint Committee on Cancer 2010. AJCC Staging Manual, 7th edition. New York: Springer

Australian Cancer Network 2001. The pathology reporting of breast cancer: A guide for pathologists, surgeons and radiologists, 2nd Edition. Sydney: Australian Cancer Network

Johnson CH & Adamo M (Editors) 2007. SEER Program Coding and Staging Manual 2007, MD 2008 revision. Bethesda: National Cancer Institute, NIH Publication number 07-5581

Sobin LH, Gospodarowicz MK, Wittekind C (Editors) 2009. International Union Against Cancer (UICC): TNM Classification of Malignant Tumours, 7th edition. Wiley-Blackwell

Relational attributes

Related metadata references:

See also Number of regional lymph nodes examined Health, Standard 07/12/2011

Supersedes Person with cancer—number of positive regional lymph nodes, total N[N] Health, Superseded 07/12/2011

See also Person with cancer—number of regional lymph nodes examined, total N[N] Health, Standard 07/12/2011

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:

Conditional on the regional lymph nodes being excised and examined by a pathologist and demonstrated to be positive for malignancy.

Regular client indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—regular client indicator, yes/no code N

METeOR identifier: 436639

Registration status: Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Definition: An indicator of whether a person is a regular client of an organisation or agency, as represented by a code.

Data Element Concept: Person—regular client indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes

A person is a regular client of the organisation or agency.

CODE 2 No

A person is not a regular client of the organisation or agency.

Collection methods: The definition of a regular client can vary depending on the context and/or collection in which the term is being applied, but generally involves a minimum number of visits to an organisation or agency or uses of a facility, occurring over a specific period of time. For example, in the primary health care context a regular client may be someone who has visited a particular primary health care provider 3 or more times in the last 2 years.

In some cases, a visit may be further defined as an attendance at the organisation or agency that leads to either the creation of a new client record or the updating of an existing client record in the client management system of the organisation or agency.

The applicable number of visits to the organisation or agency and the period of time over which those visits need to take place in order for a person to be identified as a regular client should be specified in an appropriate data set specific instruction.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Removal date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Elective surgery waiting list episode—waiting list removal date, DDMMYYYY

METeOR identifier: 270082

Registration status: Health, Standard 01/03/2005

Definition: Date on which a patient is removed from an elective surgery waiting list.

Data Element Concept: Elective surgery waiting list episode—waiting list removal date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: This date is recorded when a patient is removed from an elective surgery waiting list.

Removal date will be the same as admission date for patients in Reason for removal from elective surgery waiting list categories 1 and 2.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Superseded 13/12/2011

Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 13/12/2011

Supersedes Removal date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Implementation in Data Set Elective surgery waiting times (removals data) NMDS

Specifications:	2012-2013 Health, Standard 13/12/2011
	Implementation start date: 01/07/2012

Renal disease therapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—renal disease therapy, code N
METeOR identifier:	270264
Registration status:	Health, Standard 01/03/2005
Definition:	The therapy the person is receiving for renal disease, as represented by a code.
Data Element Concept:	Person—renal disease therapy

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Drugs for modification of renal disease
2	Drugs for treatment of complications of renal disease
3	Peritoneal dialysis
4	Haemodialysis
5	Functioning renal transplant

Collection and usage attributes

Guide for use:

CODE 1 Drugs for modification of renal disease

This code is used to indicate drugs for modification of renal disease, includes drugs intended to slow progression of renal failure. Examples include antiproteinurics such as angiotensin converting enzyme inhibitors (ACEI), angiotensin II receptor antagonists (ATRA) and immunosuppressants.

CODE 2 Drugs for treatment of complications of renal disease

This code is used to indicate drugs for the treatment of the complications of renal disease. Examples include antihypertensive agents and drugs that are intended to correct biochemical imbalances caused by renal disease (e.g. loop diuretics, ACEI, erythropoietin, calcitriol, etc).

CODE 3 Peritoneal dialysis

This code is used to indicate peritoneal dialysis, chronic peritoneal dialysis, delivered at home, at a dialysis satellite centre or in hospital.

CODE 4 Haemodialysis

This code is used to indicate haemodialysis, chronic haemodialysis delivered at home, at a dialysis satellite centre or in hospital.

CODE 5 Functioning renal transplant

This code is used to indicate functioning renal transplant, the presence of a functioning renal transplant.

Data element attributes

Collection and usage attributes

Guide for use: More than one code can be recorded.

Collection methods: To be collected on commencement of treatment and regularly reviewed.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: Caring for Australians with Renal Impairment Guidelines. Australian Kidney Foundation

Relational attributes

Related metadata references: Supersedes Renal disease therapy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.5 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Renal disease—end-stage (diabetes complication)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—end-stage renal disease status (diabetes complication), code N

METeOR identifier: 270373

Registration status: Health, Standard 01/03/2005

Definition: Whether an individual has end-stage renal disease as a complication of diabetes, and has required dialysis or has undergone a kidney transplant, as represented by a code.

Data Element Concept: Person—end-stage renal disease status

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	End-stage renal disease - developed in the last 12 months
	2	End-stage renal disease - developed prior to the last 12 months
	3	No end-stage of renal disease
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods: Ask the individual if he/she has required dialysis or has undergone a kidney (renal) transplant (due to diabetic nephropathy). Alternatively obtain the relevant information from appropriate documentation.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Renal disease - end stage, diabetes complication, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Reserve placement date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim management episode—reserve placement date, DDMMYYYY
METeOR identifier:	329690
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which the **reserve** was first placed against a medical indemnity claim, expressed as DDMMYYYY.
Data Element Concept:	Medical indemnity claim management episode—reserve placement date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

The reserve placement date must be the same as or after the date the health-care incident occurred.

The reserve may be adjusted during the lifetime of a claim. However, the date(s) when the reserve was adjusted should not be reported.

This data element should be used in conjunction with the data element: *Date—accuracy indicator, code AAA* to flag whether each component in the date is accurate, estimated or unknown.

Comments:

This date is of particular significance in the context of the Medical Indemnity National Collection (MINC) as the placing of a reserve against a matter indicates when it was considered likely to materialise in a medical indemnity claim and so is required to have occurred for a claim to be reported to the MINC.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Date—accuracy indicator, code AAA Community Services, Standard 30/09/2005, Housing assistance, Standard 23/08/2010, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Residential service unit identifier

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service—residential service unit identifier, XXXXXX

METeOR identifier: 404837

Registration status: Health, Standard 07/12/2011

Definition: A unique identifier for a specialised mental health residential service unit, as represented by a combination of numeric and/or alphabetic characters.

Data Element Concept: Specialised mental health service—residential service unit identifier

Value domain attributes

Representational attributes

Representation class: Identifier

Data type: String

Format: XXXXXX

Maximum character length: 6

Data element attributes

Collection and usage attributes

Guide for use: For the residential service setting, as a minimum, 24-hour staffed residential services that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing (but the trained staff on-site for a minimum of 6 hours a day and at least 50 hours per week) should be defined as separate service units. This applies to both government-operated residential services and government-funded residential services operated by non-government organisations. In addition, residential service units should be differentiated by target population. Residential services would be separately identifiable as service units using the *Specialised mental health service—target population group, code N* data element. For additional information, please refer to the glossary item **Residential mental health care service**.

The complete identifier string, including State/Territory identifier, Region identifier, Organisation identifier, Service unit cluster identifier and Residential service unit identifier, should be a unique code for the service unit in that state/territory. Service unit reporting structures should be identical between all mental health collections (e.g., Mental Health National Minimum Data Sets and the Mental Health National Outcomes and Casemix Collection (NOCC)).

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residential service unit name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residential service unit name, text XXX[X(97)]
METeOR identifier:	407496
Registration status:	Health, Standard 07/12/2011
Definition:	The appellation by which a specialised mental health residential service unit is known or called, as represented by text.
Data Element Concept:	Specialised mental health service—residential service unit name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	XXX[X(97)]
Maximum character length:	100

Data element attributes

Collection and usage attributes

Guide for use:

For the residential service setting, as a minimum, 24-hour staffed residential services that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing (but the trained staff on-site for a minimum of 6 hours a day and at least 50 hours per week) should be defined as separate service units. This applies to both government-operated residential services and government-funded residential services operated by non-government organisations. In addition, residential service units should be differentiated by target population. Residential services would be separately identifiable as service units using the *Specialised mental health service—target population group*, *code N* data element. For additional information, please refer to the glossary item **Residential mental health care service**.

The Residential service unit name should be unique for the service unit in that state/territory. Service unit reporting structures should be identical between all mental health collections (e.g., Mental Health National Minimum Data

Sets and the Mental Health National Outcomes and Casemix Collection (NOCC)).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Specialised mental health service—target population group, code N Health, Standard 07/12/2011

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residential stay start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Residential stay—episode start date, DDMMYYYY
METeOR identifier:	269953
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which a **resident** formally started a residential stay.
Data Element Concept:	Residential stay—episode start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Relational attributes

Related metadata references:	Supersedes Residential stay start date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.6 KB)
Implementation in Data Set Specifications:	Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Residual expenditure (mental health service)—academic positions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (academic positions), total Australian currency N[N(8)]
METeOR identifier:	290151
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Academic positions refer to grants from the organisation, region or state/territory administration to academic institutions for the establishment and maintenance of academic positions in psychiatry or related disciplines. This item also includes the costs of the other academic positions associated with the professional position where these are financed from within the organisation, region or central administration's recurrent budget.
Data Element Concept:	Specialised mental health service—residual expenditure (academic positions)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite

services, self-help support group services and other unspecified services grants.

This item also includes the costs of the other academic positions associated with the professional position where these are financed from within the organisation, region or central administration's recurrent budget.

Collection methods:

Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable:

- Report academic expenditure in this section only where the academic unit operates independently. Where the academic unit or position operates as an integral part of the service (e.g. an acute inpatient unit), the expenditure should be reported for the relevant organisation.
- Where academic grants are paid directly by organisation, region or state/territory administration, these should be reported at that level.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residual expenditure (mental health service)—education and training

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service—residual expenditure (education and training), total Australian currency N[N(8)]

METeOR identifier: 290149

Registration status: Health, Standard 08/12/2004

Definition: Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Education and training refers to the cost of professional training and staff development activity within the mental health services managed by the organisation, region or state/territory administration that have not been included in expenditure reported elsewhere.

Data Element Concept: Specialised mental health service—residual expenditure (education and training)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.

Grants made to external agencies for the development of training-related resources materials or programs may also be reported under this category.

Collection methods: Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable.

Where they do exist, expenditure on schools of nursing should be reported at the organisation level.

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residual expenditure (mental health service)—insurance

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service—residual expenditure (insurance), total Australian currency N[N(8)]

METeOR identifier: 290164

Registration status: Health, Standard 08/12/2004

Definition: Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Insurance refers to public risk and other insurance amounts paid by the organisation, region or central administration in respect to its mental health services and not reported elsewhere.

Data Element Concept: Specialised mental health service—residual expenditure (insurance)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.

Collection methods: Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable.

Note: insurance expenditure already included in an establishment's expenditure should not be included in this data element.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residual expenditure (mental health service)—Mental Health Act Regulation or related legislation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (Mental Health Act Regulation or related legislation), total Australian currency N[N(8)]
METeOR identifier:	376828
Registration status:	Health, Standard 02/12/2009
Definition:	Total residual expenditure measured in Australian dollars incurred in the establishment and operation of Mental Health Act review bodies.
Data Element Concept:	Specialised mental health service—residual expenditure (Mental Health Act Regulation or related legislation)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.

Collection methods:

Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Report Mental Health Act Regulation or related legislation expenditure only where the activity occurred independently to service units and where that expenditure is not reported elsewhere. Where the Mental Health Act Regulation or related legislation activity occurs as an integral component of service delivery (e.g. in cases where the service is already reporting activity data), the expenditure should be reported under the relevant service unit.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residual expenditure (mental health service)—mental health promotion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (mental health promotion), total Australian currency N[N(8)]
METeOR identifier:	290156
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to the organisation, region or state/territory administration expenditure dedicated specifically to mental health promotion objectives. Mental health promotion is defined as activities designed to lead to improvement of the mental health functioning of persons through prevention, education and intervention activities and services.
Data Element Concept:	Specialised mental health service—residual expenditure (mental health promotion)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.

Reporting expenditure against this item is not intended to be based on costing of activities that retrospectively, entailed a significant mental health promotion component. Instead it should be confined to financial allocations that were clearly targeted towards mental health promotion objectives.

Collection methods: Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Do not count these costs if they have been included in the expenditure reported by service delivery organisations within the region.

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residual expenditure (mental health service)—mental health research

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service—residual expenditure (mental health research), total Australian currency N[N(8)]

METeOR identifier: 290153

Registration status: Health, Standard 08/12/2004

Definition: Expenditures by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to expenditure on basic or applied research in the mental health field funded by the organisation, region or state/territory administration.

Data Element Concept: Specialised mental health service—residual expenditure (mental health research)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.

Collection methods: Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable:

Report research expenditure for this category only where the research operated independently and where that expenditure is not reported elsewhere. Where the research activity occurs as an integral component of service delivery (e.g. in cases where research staff are also clinical staff within a hospital unit), the expenditure should be reported under the relevant service unit (at the organisation-level).

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residual expenditure (mental health service)—other indirect expenditure

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service—residual expenditure (other indirect expenditure), total Australian currency N[N(8)]

METeOR identifier: 290187

Registration status: Health, Standard 08/12/2004

Definition: Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Includes any other indirect expenditure (excluding grants to non-government organisations to provide mental health services other than residential services) that is incurred in the delivery of mental health services and is not reported elsewhere.

Data Element Concept: Specialised mental health service—residual expenditure (other indirect expenditure)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.

Collection methods: Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residual expenditure (mental health service)—patient transport services

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service—residual expenditure (patient transport services), total Australian currency N[N(8)]

METeOR identifier: 290183

Registration status: Health, Standard 08/12/2004

Definition: Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to direct cost of transporting patients of mental health services.

Data Element Concept: Specialised mental health service—residual expenditure (patient transport services)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.

Collection methods: Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Residual expenditure (mental health service)—program administration

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service—residual expenditure (program administration), total Australian currency N[N(8)]

METeOR identifier: 290145

Registration status: Health, Standard 08/12/2004

Definition: Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to costs of administration and other support services (such as program management, admissions reception office, medical records etc.) at the mental health program-level (i.e. at state or territory, region or organisation level). Generally, these are resources that are specifically dedicated to the mental health program, are under the direct management control of the program and are funded by the program.

Data Element Concept: Specialised mental health service—residual expenditure (program administration)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Generally, these are resources that are specifically dedicated to the mental health program, are under the direct management control of the program and are funded by the program.

Excludes grants to non-government organisations for services that are to be reported separately. These include grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.

Collection methods: Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable:

Do not count these costs if they have been included in the expenditure reported by service delivery organisations within the region.

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residual expenditure (mental health service)—property leasing costs

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service—residual expenditure (property leasing costs), total Australian currency N[N(8)]

METeOR identifier: 290185

Registration status: Health, Standard 08/12/2004

Definition: Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to the costs of leasing premises used for the provision of mental health services (e.g. community clinics).

Data Element Concept: Specialised mental health service—residual expenditure (property leasing costs)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.

Collection methods: Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residual expenditure (mental health service)—service development

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service—residual expenditure (service development), total Australian currency N[N(8)]

METeOR identifier: 373040

Registration status: Health, Standard 02/12/2009

Definition: Residual expenditure measured in Australian dollars relating to the development of new mental health services funded by the organisation, region or state/territory administration that are not yet operational and providing activity data.

Data Element Concept: Specialised mental health service—residual expenditure (service development)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.

Residual expenditures by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit).

Collection methods: Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable.

Report service development expenditure only where the service development operates independently and where that expenditure is not reported elsewhere. Where the service development activity occurs as an integral component of service delivery (e.g. in cases where the service is already reporting activity data), the expenditure should be reported under the relevant service unit.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residual expenditure (mental health service)—superannuation

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service—residual expenditure (superannuation), total Australian currency N[N(8)]

METeOR identifier: 290158

Registration status: Health, Standard 08/12/2004

Definition: Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It includes superannuation employer contributions paid, or for an emerging cost scheme, that should be paid on behalf of the employee and that are not reported elsewhere. Emerging cost schemes are those in which the cost of benefits is met at the time a benefit becomes payable, that is, there is no ongoing invested fund from which benefits are paid.

Data Element Concept: Specialised mental health service—residual expenditure (superannuation)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.

Collection methods: Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable.

Note: Superannuation expenditure already included in establishments expenditure should not be included in this data element.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residual expenditure (mental health service)—support services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (support services), total Australian currency N[N(8)]
METeOR identifier:	290147
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to the cost of administration and other support services provided at the region-level. Such services include regional administration, information systems, personnel, finance and accounting functions. These services are usually provided from a central pool of resources managed at a regional level.
Data Element Concept:	Specialised mental health service—residual expenditure (support services)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region

or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable:

These services are usually provided from a central pool of resources managed at a regional level. Do not count these costs if they have been included in the expenditure reported by service delivery organisations within the region.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residual expenditure (mental health service)—workers compensation

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service—residual expenditure (workers compensation), total Australian currency N[N(8)]

METeOR identifier: 290160

Registration status: Health, Standard 08/12/2004

Definition: Expenditures in Australian dollars specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to workers compensation premiums and payments made by the organisation, region or central administration on behalf of its employees and not reported elsewhere.

Data Element Concept: Specialised mental health service—residual expenditure (workers compensation)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.

Collection methods: Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Note: Workers compensation expenditure already included in establishments expenditure should not be included in this data element.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Resuscitation of baby—method

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—baby resuscitation method, code N
METeOR identifier:	270116
Registration status:	Health, Standard 01/03/2005
Definition:	Active measures taken immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effect and to correct metabolic disturbances, as represented by a code.
Data Element Concept:	Birth event—baby resuscitation method

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	None
	2	Suction only
	3	Oxygen therapy only
	4	Intermittent positive pressure respiration (IPPR) through bag and mask
	5	Endotracheal intubation and IPPR
	6	External cardiac massage and ventilation
Supplementary values:	9	Not stated

Collection and usage attributes

Guide for use:

CODE 3 Oxygen therapy only

If oxygen is given by bag and mask without IPPR, code as 'oxygen therapy'.

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item does not include drug therapy.

Code the most severe measure used.

Comments:

Required to analyse need for resuscitation after complications of labour and delivery and to evaluate level of services needed for different birth settings.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Resuscitation of baby, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Retirement status in registered profession

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—retirement status in registered profession, code N
METeOR identifier:	383426
Registration status:	Health, Standard 10/12/2009
Definition:	Whether a registered health professional is retired from their registered profession, as represented by a code.
Data Element Concept:	Registered health professional—retirement status in registered profession

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Retired
	2	Not retired
Supplementary values:	9	Unknown/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	Retirement and Retirement Intentions, Australia, Jul 2006 to Jun 2007 (ABS Cat. no. 6238.0)

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 RETIRED

This category includes persons who have retired from working or looking for work in the registered profession, and who do not intend to look for or take up work in the registered profession in the future. This definition is based on the ABS definition of 'retired from the labour force', as used in the ABS Retirement and Retirement Intentions survey.

CODE 2 NOT RETIRED

All persons who are not 'retired' as defined above.

Data is self-reported based on the retirement status in the registered profession in the week before registration.

The data element is only applicable to health professionals who are not employed in the registered profession in Australia.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Labour force status cluster Health, Standard 10/12/2009

Revenue—other

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—revenue (other revenue) (financial year), total Australian currency N[N(8)]

METeOR identifier: 364799

Registration status: Health, Standard 05/12/2007

Definition: All other revenue measured in Australian dollars received by the establishment for a financial year, that is not included under patient revenue or recoveries (but not including revenue payments received from State or Territory governments).

Data Element Concept: Establishment—revenue (other revenue)

Value domain attributes

Representational attributes

Representation class: Total

Data type: Currency

Format: N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Record as currency up to hundreds of millions of dollars. Rounded to the nearest whole dollar.

Relational attributes

Related metadata references: Supersedes Establishment—revenue (other revenue) (financial year), total Australian currency N[N(8)] Health, Superseded 05/12/2007

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Revenue—patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—revenue (patient) (financial year), total Australian currency N[N(8)]
METeOR identifier:	364797
Registration status:	Health, Standard 05/12/2007
Definition:	All revenue measured in Australian dollars for a financial year, received by, and due to, an establishment in respect of individual patient liability for accommodation and other establishment charges.
Data Element Concept:	Establishment—revenue (patient)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Establishment—revenue (patient) (financial year), total Australian currency N[N(8)] Health, Superseded 05/12/2007

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Revenue—recoveries

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—revenue (recoveries) (financial year), total Australian currency N[N(8)]
METeOR identifier:	364805
Registration status:	Health, Standard 05/12/2007
Definition:	All revenue received in Australian dollars for a financial year, that is in the nature of a recovery of expenditure incurred.
Data Element Concept:	Establishment—revenue (recoveries)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.

This metadata item relates to all revenue received by establishments except for general revenue payments received from state or territory governments.

Comments:

The Resources Working Party had considered splitting recoveries into staff meals and accommodation, and use of hospital facilities (private practice) and other recoveries.

Some states had felt that use of facilities was too sensitive as a separate identifiable item in a national minimum data set. Additionally, it was considered that total recoveries was an adequate category for health financing analysis purposes at the national level.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Establishment—revenue (recoveries) (financial year), total Australian currency N[N(8)] Health, Superseded 05/12/2007

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Road name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Address—road name, text X[45]
Synonymous names:	Street name
METeOR identifier:	429747
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	The name of the road or thoroughfare applicable to the address site or complex, as represented by text.
Data Element Concept:	Address—road name

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	X[45]
Maximum character length:	45

Data element attributes

Collection and usage attributes

Guide for use:

Within a road name it is possible to find what appears to be a Road type (e.g. The Boulevard). It is also possible to have a null Road type. This data element relates to the road name only.

Usage Examples:

BROWNS ROAD WEST
In this case the Road name is BROWNS, the Road type is RD and the Road suffix is W

THE AVENUE WEST
In this case the Road name is THE AVENUE, the Road type is null and the Road suffix is W

COTSWOLD BRETT
In this case the Road Name is COTSWOLD BRETT and the Road type is null

HIGH STREET ROAD
In this case the Road Name is HIGH STREET and the Road type is RD.

This data element is one of a number of items that can be used to create a primary address, as recommended by the

AS 4590-2006 *Interchange of client information* standard.
Components of the primary address are:

- Address site (or Primary complex) name
- Address number or number range
- Road name (name/type/suffix)
- Locality
- State/Territory
- Postcode (optional)
- Country (if applicable).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references: See also Address—road type, code AA[AA] Community Services, Standard 06/02/2012, Health, Standard 07/12/2011

Supersedes Person (address)—street name, text [A(30)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Supersedes Service provider organisation (address)—street name, text [A(30)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Public hospital establishment address details DSS Health, Standard 07/12/2011

Road number 1

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Address—road number 1, road number X[6]
Synonymous names:	House number 1; Street number 1
METeOR identifier:	429586
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	An alphanumeric identifier for an address or start number in a ranged address in a road or thoroughfare.
Data Element Concept:	Address—road number 1

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	X[6]
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:

A road number may include an alphabetic prefix or an alphabetic suffix.

This data element is one of a number of items that can be used to create a primary address, as recommended by the AS 4590-2006 *Interchange of client information* standard. Components of the primary address are:

- Address site (or Primary complex) name
- Address number or number range
- Road name (name/type/suffix)
- Locality
- State/Territory
- Postcode (optional)
- Country (if applicable).

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Standards Australia 2006. AS 4590—2006 Interchange of

client information. Sydney: Standards Australia.

Relational attributes

Related metadata references:

See also Address—road number 2, road number X[6] Community Services, Standard 06/02/2012, Health, Standard 07/12/2011

Supersedes Person (address)—house/property identifier, text [X(12)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Supersedes Service provider organisation (address)—house/property identifier, text [X(12)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Implementation in Data Set Specifications:

Public hospital establishment address details DSS Health, Standard 07/12/2011

Road number 2

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Address—road number 2, road number X[6]

Synonymous names: House number 2; Street number 2

METeOR identifier: 429594

Registration status: Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Definition: An alphanumeric identifier for the last number for a ranged address in the road or thoroughfare.

Data Element Concept: Address—road number 2

Value domain attributes

Representational attributes

Representation class: Identifier

Data type: String

Format: X[6]

Maximum character length: 6

Data element attributes

Collection and usage attributes

Guide for use: A road number may include an alphabetic prefix or an alphabetic suffix.

This data element is used for ranged street numbers only.

This data element is one of a number of items that can be used to create a primary address, as recommended by the AS 4590-2006 *Interchange of client information* standard. Components of the primary address are:

- Address site (or Primary complex) name
- Address number or number range
- Road name (name/type/suffix)
- Locality
- State/Territory
- Postcode (optional)
- Country (if applicable).

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references:	See also Address—road number 1, road number X[6] Community Services, Standard 06/02/2012, Health, Standard 07/12/2011 Supersedes Person (address)—house/property identifier, text [X(12)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011 Supersedes Service provider organisation (address)—house/property identifier, text [X(12)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011
Implementation in Data Set Specifications:	Public hospital establishment address details DSS Health, Standard 07/12/2011 *Conditional obligation:* Conditional on this component being part of the address of the Public hospital establishment.

Road type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Address—road type, code AA[AA]
Synonymous names:	Street type code; road type code
METeOR identifier:	429840
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	An abbreviation used to distinguish the type of road or thoroughfare applicable to the address site/complex.
Data Element Concept:	Address—road type

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	AA[AA]
Maximum character length:	4

Permissible values:

Value	Meaning
ACCS	Access
ALLY	Alley
ALWY	Alleyway
AMBL	Amble
APP	Approach
ARC	Arcade
ARTL	Arterial
ARTY	Artery
AV	Avenue
BA	Banan
BEND	Bend
BWLK	Boardwalk
BVD	Boulevard
BR	Brace
BRAE	Brae
BRK	Break
BROW	Brow
BYPA	Bypass

BYWY	Byway
CSWY	Causeway
CTR	Centre
CH	Chase
CIR	Circle
CCT	Circuit
CRCS	Circus
CL	Close
CON	Concourse
CPS	Copse
CNR	Corner
CT	Court
CTYD	Courtyard
COVE	Cove
CR	Crescent
CRST	Crest
CRSS	Cross
CSAC	Cul-de-sac
CUTT	Cutting
DALE	Dale
DIP	Dip
DR	Drive
DVWY	Driveway
EDGE	Edge
ELB	Elbow
END	End
ENT	Entrance
ESP	Esplanade
EXP	Expressway
FAWY	Fairway
FOLW	Follow
FTWY	Footway
FORM	Formation
FWY	Freeway
FRTG	Frontage
GAP	Gap
GDNS	Gardens
GTE	Gate

GLDE	Glade
GLEN	Glen
GRA	Grange
GRN	Green
GR	Grove
HTS	Heights
HIRD	Highroad
HWY	Highway
HILL	Hill
INTG	Interchange
JNC	Junction
KEY	Key
LANE	Lane
LNWY	Laneway
LINE	Line
LINK	Link
LKT	Lookout
LOOP	Loop
MALL	Mall
MNDR	Meander
MEWS	Mews
MTWY	Motorway
NOOK	Nook
OTLK	Outlook
PDE	Parade
PWY	Parkway
PASS	Pass
PSGE	Passage
PATH	Path
PWAY	Pathway
PIAZ	Piazza
PLZA	Plaza
PKT	Pocket
PNT	Point
PORT	Port
PROM	Promenade
QDRT	Quadrant
QYS	Quays

RMBL	Ramble
REST	Rest
RTT	Retreat
RDGE	Ridge
RISE	Rise
RD	Road
RTY	Rotary
RTE	Route
ROW	Row
RUE	Rue
SVWY	Serviceway
SHUN	Shunt
SPUR	Spur
SQ	Square
ST	Street
SBWY	Subway
TARN	Tarn
TCE	Terrace
THFR	Thoroughfare
TLWY	Tollway
TOP	Top
TOR	Tor
TRK	Track
TRL	Trail
TURN	Turn
UPAS	Underpass
VALE	Vale
VIAD	Viaduct
VIEW	View
VSTA	Vista
WALK	Walk
WKWY	Walkway
WHRF	Wharf
WYND	Wynd

Collection and usage attributes

Guide for use: The recommended code description is the list of standard street type abbreviations in AS/NZS 4819.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Data element attributes

Collection and usage attributes

Guide for use: Within a road name it is possible to find what appears to be a Road type. It is also possible to have a null Road type.

For postal purposes the Road type should be abbreviated.

Usage Example:
MAIN ROAD

In this case the street name is MAIN and the Road type is RD.

This data element is one of a number of items that can be used to create a primary address, as recommended by the AS 4590-2006 *Interchange of client information* standard. Components of the primary address are:

- Address site (or Primary complex) name
- Address number or number range
- Road name (name/type/suffix)
- Locality
- State/Territory
- Postcode (optional)
- Country (if applicable).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references: See also Address—road name, text X[45] Community Services, Standard 06/02/2012, Health, Standard 07/12/2011

Supersedes Person (address)—street type, code A[AAA] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Supersedes Service provider organisation (address)—street type, code A[AAA] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Implementation in Data Set Public hospital establishment address details DSS Health,

Specifications: Standard 07/12/2011

Satisfaction with participation

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—level of satisfaction with participation in a life area, code N

METeOR identifier: 320216

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Definition: The degree to which a person is satisfied with their involvement in a specified life area, as represented by a code.

Context: Human functioning and disability

Data Element Concept: Person—level of satisfaction with participation in a life area

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	0	High satisfaction with participation
	1	Moderate satisfaction with participation
	2	Neither satisfied nor dissatisfied with participation
	3	Moderate dissatisfaction with participation
	4	Extreme dissatisfaction with participation
	5	Complete restriction and dissatisfaction
Supplementary values:	8	Not specified
	9	Not applicable

Collection and usage attributes

Guide for use: This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

In the context of health, participation is involvement in a life situation. Participation restrictions are problems an individual may experience in involvement in life situations.

This metadata item gives a rating of the person's degree of satisfaction with participation in a domain of life, in relation to their current life goals. Satisfaction with participation corresponds to the person's own perspective on their participation, and reflects their attitude to their participation in the various life areas. It is essentially a summary measure in which are embedded the concepts of choice, opportunity and importance.

CODE 0 High satisfaction with participation

Used if a person is involved in the specified life situation as he or she wishes to fulfil his or her current life goals in terms of duration, frequency, manner and outcome.

CODE 1 Moderate satisfaction with participation

Used if the person is reasonably satisfied with their participation in this life situation, in terms of duration, frequency, manner and outcome. This could occur if one of the criteria (duration, frequency, manner or outcome) is not fulfilled and that criterion is not critical to the person's goals. For example, the person does not participate in the specified life situation as frequently as wished, but the other criteria are met and the frequency is not so affected that it is critical to the person's satisfaction.

CODE 2 Neither satisfied nor dissatisfied with participation

Used if the person is neither satisfied nor dissatisfied with their participation in this life situation, in terms of duration, frequency, manner and outcome.

CODE 3 Moderate dissatisfaction with participation

Used if two or three criteria (duration, frequency, manner or outcome) are not fulfilled, but are not so badly affected, in relation to the person's goals in that life area, that the person is extremely dissatisfied. For example, a person is able to participate in work, but is placed in supported employment rather than employment in the open labour market. This is not in line with the person's goals, so that the manner and outcome of the participation are not fulfilled.

CODE 4 Extreme dissatisfaction with participation

Used when all criteria (duration, frequency, manner and outcome) are not fulfilled for the specified life situation, or where any of the criteria are so badly affected in relation to the person's goals that they consider themselves to be extremely dissatisfied with this life area. An example of the latter would arise when a person is extremely dissatisfied with participation in interpersonal activities because his/her goal in terms of duration of social visits is never fulfilled, although other criteria (frequency and manner) may be fulfilled.

CODE 5 Complete restriction and dissatisfaction

Used when the person does not participate in this life situation in line with his or her own goals, i.e. in an area where they wish to participate and is completely dissatisfied with not participating in this life situation.

CODE 9 Not applicable

Used when participation in a life situation is not relevant, such as employment of an infant or where there is no participation and the person has no desire to participate in this area. For example, a personal preference not to participate in specific areas of community, social and civic life such as sport or hobbies. The area may not be applicable to the person's current life goals.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: Satisfaction with participation should be coded from the perspective of the person. This data element should be coded in conjunction with the Person—activities and participation life area, code (ICF 2001) AN[NNN] data element. For example, a person's 'moderate satisfaction with participation in exchange of information'.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:	See also Person—activity and participation life area, code (ICF 2001) AN[NNN] Community Services, Standard 16/10/2006, Health, Standard 29/11/2006
Implementation in Data Set Specifications:	Activities and Participation cluster Community Services, Standard 16/10/2006 Health, Standard 29/11/2006

Scheduled admission date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Admitted patient care waiting list episode—scheduled admission date, DDMMYYYY

METeOR identifier: 269978

Registration status: Health, Standard 01/03/2005

Definition: The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care.

Data Element Concept: Admitted patient care waiting list episode—scheduled admission date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Comments: If this metadata item were to be used to compare different hospitals or geographical locations, it would be necessary to specify when the scheduled date is to be allocated (for example, on addition to the waiting list).

This metadata item is required for the purposes of hospital management - allocation of beds, operating theatre time and other resources.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Scheduled admission date, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB)

Secondary complex name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Address—secondary complex name, text X[50]
Synonymous names:	Utility name
METeOR identifier:	429404
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	The name associated with a building or area within a complex site, which forms part of the address, as represented by text.
Data Element Concept:	Address—secondary complex name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[50]
Maximum character length:	50

Data element attributes

Collection and usage attributes

Guide for use:

This data element may represent the name given to an entire building within an address site that has its own separate address.

Usage Examples:

Biology Building B (Secondary Complex name)
20-24 Genetics Lane North
Blamey Research Institute (Address site name)
1-131 Sunshine Rd
CAIRNS QLD 4870

Rose Cottage (Secondary Complex name)
9 Garden Walk
Happy Valley Retirement Village (Address site name)
75 Davis Street
NORWOOD SA 5067

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Implementation in Data Set Specifications: Public hospital establishment address details DSS Health, Standard 07/12/2011

Conditional obligation:

Conditional on this component being part of the address of the Public hospital establishment.

Self-harm ideation in the last 12 months

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—self-harm ideation in the last 12 months, yes/no/not stated/inadequately described code N
METeOR identifier:	358880
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	An indicator of whether a person has had thoughts, in the last 12 months, of inflicting harm upon themself, as represented by a code.
Data Element Concept:	Person—self-harm ideation in the last 12 months

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: All thoughts of self-harm should be included, regardless of whether or not they were related to instances of actual self-harming behaviour.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Prison entrants DSS Health, Standard 25/08/2011

Specifications:

Self-harm indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—self-harm indicator, yes/no code N
METeOR identifier:	358878
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	An indicator of whether a person has ever deliberately inflicted physical harm upon themself, as represented by a code.
Data Element Concept:	Person—self-harm indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents:

Berry J & Harrison J 2007. Hospital separations due to injury and poisoning. Australia 2003-04. Injury research and statistics series no. 30. AIHW. cat. no. INJCAT 88. Adelaide: AIHW

Kraemer S, Gately N & Kessell J 2009. HoPE (Health of prisoner evaluation) pilot study of prisoner physical health and psychological wellbeing. Perth: Edith Cowan University, School of Law and Justice.

Relational attributes

Implementation in Data Set Specifications: Prison entrants DSS Health, Standard 25/08/2011

Separation date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of admitted patient care—separation date, DDMMYYYY

METeOR identifier: 270025

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: Date on which an admitted patient completes an episode of care.

Data Element Concept: Episode of admitted patient care—separation date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Comments: There may be variations amongst jurisdictions with respect to the recording of separation date. This most often occurs for patients who are statistically separated after a period of leave (and who do not return for further hospital care). In this case, some jurisdictions may record the separation date as the date of statistical **separation** (and record intervening days as leave days) while other jurisdictions may retrospectively separate patients on the first day of leave. Despite the variations in recording of separation date for this group of patients, the current practices provide for the accurate recording of length of stay.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Episode of admitted patient care (postnatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Is used in the formation of Episode of admitted patient

care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—length of stay (including leave days) (postnatal), total N[NN] Health, Standard 04/07/2007

Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Standard 04/07/2007

Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005

Is used in the formation of Establishment—number of separations (financial year), total N[NNNNN] Health, Standard 01/03/2005

Supersedes Separation date, version 5, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.2 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health,

Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Separation time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—separation time, hhmm
METeOR identifier:	270026
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	Time at which an admitted patient completes an episode of care.
Data Element Concept:	Episode of admitted patient care—separation time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Comments:	Required to identify the time of completion of the episode or hospital stay, for calculation of length of stay.

Relational attributes

Related metadata references:	Supersedes Separation time, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (13.3 KB)

Separations

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of separations (financial year), total N[NNNNN]
Synonymous names:	Discharge
METeOR identifier:	270407
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of **separations** occurring during the reference period. This includes both formal and statistical separations.
Data Element Concept:	Establishment—number of separations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Separation

Data element attributes

Collection and usage attributes

Guide for use:

May be calculated at:

- individual establishment level; or
- system (i.e. state/territory) level i.e. the sum of the number of establishments.

The sum of the number of separations where the separation date has a value:

- >= the beginning of the reference period (typically a financial year); and
- <= the end of the reference period.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard

01/03/2005, Tasmanian Health, Proposed 28/09/2011

Supersedes Separations, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)

Implementation in Data Set Specifications:	Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Service contact date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service contact—service contact date, DDMMYYYY
METeOR identifier:	270122
Registration status:	Health, Standard 01/03/2005
Definition:	The date of service contact between a health service provider and patient/client.
Data Element Concept:	Service contact—service contact date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

Requires services to record the date of each service contact, including the same date where multiple visits are made on one day (except where the visits may be regarded as a continuation of the one service contact). Where an individual patient/client participates in a group activity, a service contact date is recorded if the person's participation in the group activity results in a dated entry being made in the patient's/client's record.

Collection methods:

For collection from community based (ambulatory and non-residential) agencies.

Relational attributes

Related metadata references:

Is used in the formation of Person—number of service contact dates, total N[NN] Health, Standard 01/03/2005

Supersedes Service contact date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Diabetes (clinical) DSS Health, Standard 21/09/2005

Service delivery mode

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—service delivery mode, code N
Synonymous names:	Service mode
METeOR identifier:	410953
Registration status:	Health, Standard 06/10/2010
Definition:	The method of communication between a non-admitted patient and a healthcare provider during a service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—service delivery mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	In person
2	Telephone
3	Videoconference
4	Electronic mail
5	Postal/courier service
8	Other

Collection and usage attributes

Guide for use:

CODE 1 In person

The healthcare provider delivers the service in the physical presence of the patient (i.e., in the same room). Codes 1 and 3 provide a measure of 'face-to-face' service delivery.

CODE 2 Telephone

The healthcare provider delivers the service using a telephone. This includes teleconference.

CODE 3 Videoconference

The healthcare provider delivers the service using videoconference equipment. Codes 1 and 3 provide a measure of 'face-to-face' service delivery.

CODE 4 Electronic mail

The healthcare provider delivers the service via electronic mail.

CODE 5 Postal/courier service

The healthcare provider delivers the service via postal (including courier) services.

Comments: Guide for use sourced from Queensland Health (data element QHLTH 040780).

Data element attributes

Collection and usage attributes

Collection methods: The mode is from the point of view of the patient in relation to the healthcare provider who records the service event in the patient's medical record.

Source and reference attributes

Submitting organisation: NAP NMDS (Phase 1) Working Group

Relational attributes

Related metadata references: See also Non-admitted patient service event—service delivery setting, code N Health, Standard 06/10/2010

Supersedes Non-admitted patient service event—service mode, hospital code N{.N} Health, Superseded 06/10/2010

Implementation in Data Set Specifications: Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Service delivery setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—service delivery setting, code N
METeOR identifier:	403593
Registration status:	Health, Standard 06/10/2010
Definition:	The setting in which a service is provided to a non-admitted patient during a service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—service delivery setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	On the hospital campus of the healthcare provider
2	Off the hospital campus of the healthcare provider

Collection and usage attributes

Guide for use:

CODE 2 Off the hospital campus of the healthcare provider

This code includes:

- Community health or day centre or other community facility
- General practice surgery or clinic
- Residential aged care facility
- Private residence
- Other hospital

Source and reference attributes

Submitting organisation: NAP NMDS (Phase 1) Working Group

Data element attributes

Collection and usage attributes

Collection methods:	The setting is from the point of view of the patient in relation to the healthcare provider who records the service event in the patient's medical record.

Source and reference attributes

Submitting organisation:	NAP NMDS (Phase 1) Working Group

Relational attributes

Related metadata references:	See also Non-admitted patient service event—service delivery mode, code N Health, Standard 06/10/2010
Implementation in Data Set Specifications:	Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Service event date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Non-admitted patient service event—service date, DDMMYYYY

METeOR identifier: 400673

Registration status: Health, Standard 06/10/2010
Tasmanian Health, Proposed 28/09/2011

Definition: The date on which the non-admitted patient service event occurred.

Data Element Concept: Non-admitted patient service event—service date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: If the service event continues past midnight, then the date the service commenced should be recorded.

Relational attributes

Implementation in Data Set Specifications: Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Service provider consulted indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Prison entrant—individual service provider consulted indicator, yes/no code N
METeOR identifier:	402429
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether a prison entrant consulted an individual service provider, as represented by a code.
Data Element Concept:	Prison entrant—individual service provider consulted indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data elements: *Prison entrant – type of service provider consulted, occupation code (ANZSCO 1st edition) N[NNN]{NN}* and *Health service event – prisoner location, code N* to determine the health seeking behaviours of prison entrants.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Health service event—prisoner location, code N Health, Standard 25/08/2011

See also Prison entrant—type of service provider consulted, occupation code (ANZSCO 1st edition) N[NNN]{NN}

	Health, Standard 25/08/2011
Implementation in Data Set Specifications:	Health service utilisation cluster Health, Standard 25/08/2011

Service provider needed but not utilised indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Prison entrant—service provider needed but not utilised indicator, yes/no code N
METeOR identifier:	414715
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether a prison entrant needed to consult an individual service provider, but did not, as represented by a code.
Data Element Concept:	Prison entrant—service provider needed but not utilised indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Health service event—prisoner location when service provider was needed, but not utilised, prisoner location code N Health, Standard 25/08/2011

See also Prison entrant—reason for non-utilisation of health service, code NN Health, Standard 25/08/2011

Implementation in Data Set Specifications: Health service non-utilisation cluster Health, Standard 25/08/2011

Service request received date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service request—service request received date, DDMMYYYY
METeOR identifier:	400713
Registration status:	Health, Standard 06/10/2010
Definition:	The date on which a service request for a non-admitted patient was received by a healthcare provider.
Data Element Concept:	Non-admitted patient service request—service request received date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

In the case of a self-referral this would be the date of the first contact with the service.

The service request receipt date can be the same as the date of the service event; for example, at a drop-in clinic.

Source and reference attributes

Submitting organisation:	NAP NMDS (Phase 1) working group

Relational attributes

Implementation in Data Set Specifications:

Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Service request source

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Non-admitted patient service request—service request source, code N.N

METeOR identifier: 400747

Registration status: Health, Standard 06/10/2010

Definition: The person or organisation that requests a service for a non-admitted patient from a healthcare provider, as represented by a code.

Data Element Concept: Non-admitted patient service request—service request source

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: N.N

Maximum character length: 3

Permissible values:

Value	Meaning
	THIS HOSPITAL
1.1	Other outpatient clinic
1.2	Emergency department
1.3	Elsewhere in this hospital
2.0	Other hospital
	NON-HOSPITAL
3.1	General practice
3.2	Specialist practice
3.3	Other non-hospital
4.0	Self

Collection and usage attributes

Guide for use: Service requests include both referral (e.g. a written referral from a general practitioner), and other informal requests for service (e.g. self-referral for an unplanned 'walk-in' service).

The service request should not be from another provider within the same outpatient clinic but from an organisation external to the outpatient clinic.

A client/patient may be referred (by Unit A) for services to an organisation that has multiple registered health service units. That client/patient may then be referred from one health service unit (Unit B) within the organisation to another (Unit C). In these circumstances the 'source of referral' for Unit C is Unit B (not Unit A). For example if a patient is referred by his/her GP to a general medical clinic, such as an aged care clinic, then after assessment at this clinic the physician refers the patient to an allied health clinic, the service request source for the allied health outpatient clinic is 'Other outpatient clinic', whereas the service request source for the general medical clinic is 'General Practice'.

THIS HOSPITAL

The service request has come from some other part of the hospital with the same establishment ID.

CODE 2.0 Other hospital

The service request has come from a hospital with a different establishment ID.

Source and reference attributes

Submitting organisation: NAP NMDS (Phase 1) working group

Data element attributes

Source and reference attributes

Submitting organisation: NAP NMDS (Phase 1) working group

Relational attributes

Implementation in Data Set Specifications: Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Service type (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—service event type (clinical), code N[N]
METeOR identifier:	270090
Registration status:	Health, Standard 01/03/2005
Definition:	The type of clinical service provided to a non-admitted patient in a non-admitted patient service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—service event type (clinical)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Allied health and/or clinical nurse specialist
2	Dental
3	Imaging
4	Medical
5	Obstetrics and gynaecology
6	Paediatrics
7	Pathology
8	Pharmacy
9	Psychiatric
10	Surgical
11	Emergency department

Collection and usage attributes

Guide for use:

The following provides a guide to types of clinical services that are included in each of the categories in the data domain. Clinical services that are not specifically identified in this Guide for use should be classified as one of the groups in the data domain on the basis of the type of clinical professional staff involved in providing the service event.

In paediatric hospitals, the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgical should be reported as surgical.

Clinical service type	**Clinical service examples**
Allied health and/or clinical nurse specialist	Audiology Clinical pharmacy Diabetes education Neuropsychology Nutrition/dietetics Occupational therapy Optometry Orthoptics Orthotics Physiotherapy Podiatry Prosthetics Psychology Social work Speech pathology Stomal therapy Wound management
Dental	Dental
Imaging	Medical imaging
Medical	Aged care Alcohol and other drug Allergy Anti-coagulant Asthma Cardiology Clinical measurement Dermatology Dementia Developmental disabilities Diabetes Endocrine Epilepsy Falls Gastroenterology General internal medicine Genetic Haematology

	Hepatobiliary Hypertension Hyperbaric medicine Immunology Infectious diseases Medical oncology Metabolic bone Nephrology Neurology Occupational medicine Palliative care Pain management Pulmonary Radiation oncology Rehabilitation Respiratory Rheumatology Spinal Transplants
Obstetrics and gynaecology	Family planning Gynaecology Gynaecology oncology Obstetrics
Pathology	Pathology
Paediatrics	Adolescent health Neonatal Paediatric medicine Paediatric surgery
Pharmacy	Dispensing pharmacy
Psychiatric	Psychiatry
Surgical	Breast Burns Cardiac surgery Colorectal Craniofacial Ear, nose and throat Fracture General surgery Neurosurgery Ophthalmology Orthopaedics Plastic surgery Pre-admission Pre-anaesthesia Thoracic surgery Urology Vascular surgery

Emergency department	Emergency department

An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical condition/s and/or injury.

Data element attributes

Relational attributes

Related metadata references:

Supersedes Non-admitted patient service type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.1 KB)

Service unit cluster identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—service unit cluster identifier, XXXXX
METeOR identifier:	404858
Registration status:	Health, Standard 07/12/2011
Definition:	A unique identifier for a service unit cluster, which groups specialised mental health ambulatory and residential service units, as represented by a combination of numeric and/or alphabetic characters.
Data Element Concept:	Establishment—service unit cluster identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	XXXXX
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:

A *Specialised mental health service organisation* may consist of one or more clusters of service units providing services in admitted patient, residential and ambulatory settings. For example, a *Specialised mental health service organisation* may consist of several hospitals (clusters of admitted patient service units) and/or ambulatory or residential service unit clusters (for example, a cluster of child and adolescent ambulatory service units, and a cluster of aged residential service units).

To allow service units to be individually identified, but still also to be identified as part of a hospital (for the admitted patient service setting), or as part of another type of cluster (e.g. other cluster types for ambulatory or residential service setting), a separate reporting level called *Hospital* for admitted patient service units and *Service unit cluster* for ambulatory service units and residential service units is necessary.

The concept of *Service unit cluster* only applies to ambulatory and residential service units. The equivalent entity for the grouping of admitted patient service units is the *Hospital*.

However, for some ambulatory service units, the service unit may 'belong' to a hospital that contains both admitted patient and ambulatory service units. In this instance, the service unit cluster identifier for the ambulatory service unit would be the 'hospital identifier'. Other groups of ambulatory and residential service units could also be usefully identified as clusters. For example, clusters may exist of groups of residential services for aged persons, or groups of ambulatory service units in particular geographical areas.

The complete identifier string, including State/Territory identifier, Region identifier, Organisation identifier and Service unit cluster identifier, should be a unique code for the cluster in that state/territory. Service unit reporting structures should be identical between all mental health collections (e.g., Mental Health National Minimum Data Sets and the Mental Health National Outcomes and Casemix Collection (NOCC)). If no cluster applies, set to 00000.

Relational attributes

Implementation in Data Set Specifications:

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Service unit cluster name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—service unit cluster name, text XXX[X(97)]
METeOR identifier:	409209
Registration status:	Health, Standard 07/12/2011
Definition:	The appellation by which a service unit cluster, which groups specialised mental health ambulatory and residential service units, is known or called, as represented by text.
Data Element Concept:	Establishment—service unit cluster name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	XXX[X(97)]
Maximum character length:	100

Data element attributes

Collection and usage attributes

Guide for use:

A *Specialised mental health service organisation* may consist of one or more clusters of service units providing services in admitted patient, residential and ambulatory settings. For example, a *Specialised mental health service organisation* may consist of several hospitals (clusters of admitted patient service units) and/or ambulatory or residential service unit clusters (for example, a cluster of child and adolescent ambulatory service units, and a cluster of aged residential service units).

To allow service units to be individually identified, but still also to be identified as part of a hospital (for the admitted patient service setting), or as part of another type of cluster (e.g. other cluster types for ambulatory or residential service setting), a separate reporting level called *Hospital* for admitted patient service units and *Service unit cluster* for ambulatory service units and residential service units is necessary.

The concept of *Service unit cluster* only applies to ambulatory and residential service units. The equivalent entity for the grouping of admitted patient service units is the *Hospital*.

However, for some ambulatory service units, the service unit may 'belong' to a hospital that contains both admitted patient and ambulatory service units. In this instance, the service unit cluster identifier for the ambulatory service unit would be the *Hospital identifier*. Other groups of ambulatory and residential service units could also be usefully identified as clusters. For example, clusters may exist of groups of residential services for aged persons, or groups of ambulatory service units in particular geographical areas.

Where there is no Service unit cluster, then the Service unit cluster name would be the relevant organisation name.

The Service unit cluster name should be unique for the cluster in that state/territory. Service unit reporting structures should be identical between all mental health collections (e.g., Mental Health National Minimum Data Sets and the Mental Health National Outcomes and Casemix Collection (NOCC)).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Sex

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—sex, code N
METeOR identifier:	287316
Registration status:	Community Services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006 Health, Standard 04/05/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010
Definition:	The biological distinction between male and female, as represented by a code.
Data Element Concept:	Person—sex

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:	Value	Meaning
	1	Male
	2	Female
	3	Intersex or indeterminate
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Diagnosis and procedure codes should be checked against the national ICD-10-AM sex edits, unless the person is undergoing, or has undergone a sex change or has a genetic condition resulting in a conflict between sex and ICD-10-AM code.

CODE 3 Intersex or indeterminate

Intersex or indeterminate, refers to a person, who because of a genetic condition, was born with reproductive organs or sex chromosomes that are not exclusively male or female or whose sex has not yet been determined for whatever reason.

Intersex or indeterminate, should be confirmed if reported for people aged 90 days or greater.

Comments: The definition for Intersex in Guide for use is sourced from the ACT Legislation (Gay, Lesbian and Transgender) Amendment Act 2003.

Source and reference attributes

Origin: Australian Capital Territory 2003. Legislation (Gay, Lesbian and Transgender) Amendment Act 2003

Reference documents: Legislation (Gay, Lesbian and Transgender) Amendment Act 2003. See http://www.legislation.act.gov.au/a/2003-14/20030328-4969/pdf/2003-14.pdf.

Data element attributes

Collection and usage attributes

Collection methods: Operationally, sex is the distinction between male and female, as reported by a person or as determined by an interviewer.

When collecting data on sex by personal interview, asking the sex of the respondent is usually unnecessary and may be inappropriate, or even offensive. It is usually a simple matter to infer the sex of the respondent through observation, or from other cues such as the relationship of the person(s) accompanying the respondent, or first name. The interviewer may ask whether persons not present at the interview are male or female.

A person's sex may change during their lifetime as a result of procedures known alternatively as sex change, gender reassignment, transsexual surgery, transgender reassignment or sexual reassignment. Throughout this process, which may be over a considerable period of time, the person's sex could be recorded as either Male or Female.

In data collections that use the ICD-10-AM classification, where sex change is the reason for admission, diagnoses should include the appropriate ICD-10-AM code(s) that clearly identify that the person is undergoing such a process. This code(s) would also be applicable after the person has completed such a process, if they have a procedure involving an organ(s) specific to their previous sex (e.g. where the patient has prostate or ovarian cancer).

CODE 3 Intersex or indeterminate

Is normally used for babies for whom sex has not been determined for whatever reason.

Should not generally be used on data collection forms completed by the respondent.

Should only be used if the person or respondent volunteers that the person is intersex or where it otherwise becomes clear during the collection process that the individual is neither male nor female.

CODE 9 Not stated/inadequately described

Is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Source and reference attributes

Origin:

Australian Institute of Health and Welfare (AIHW) National Mortality Database 1997/98 AIHW 2001 National Diabetes Register, Statistical Profile, December 2000 (Diabetes Series No. 2.)

Reference documents:

Australian Bureau of Statistics

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

In AS4846 and AS5017 alternative codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references:

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Supersedes Person—sex, code N Community Services, Superseded 31/08/2005, Health, Superseded 04/05/2005

Is used in the formation of Record—linkage key, code 581 XXXXXDDMMYYYYN Community Services, Standard 21/05/2010, Housing assistance, Standard 23/08/2010, Health, Standard 07/12/2011, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient palliative care NMDS 2012-13 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Cancer (clinical) DSS Health, Standard 07/12/2011

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Diabetes (clinical) DSS Health, Standard 21/09/2005

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Indigenous primary health care DSS Health, Standard 07/12/2011

Medical indemnity DSS Health, Standard 07/12/2011

Non-admitted patient DSS 2012-13 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Prison clinic contact DSS Health, Standard 25/08/2011

Prison entrants DSS Health, Standard 25/08/2011

Prisoners in custody repeat medications DSS Health, Standard 25/08/2011

Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Sex of prison entrants cluster Health, Standard 25/08/2011

Statistical linkage key 581 cluster Community Services, Standard 21/05/2010
Housing assistance, Standard 23/08/2010
Health, Standard 07/12/2011
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Smoking status recorded indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—smoking status recorded indicator, yes/no code N
METeOR identifier:	441380
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a person's smoking status has been recorded, as represented by a code.
Data Element Concept:	Person—smoking status recorded indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A person has had their smoking status recorded.

CODE 2 No

A person has not had their smoking status recorded.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications:

Indigenous primary health care DSS Health, Standard 07/12/2011

Conditional obligation:

This item is only collected for persons aged 15 years and older.

Source of public and private revenue

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health industry relevant organisation—source of revenue, public and private code NNN
METeOR identifier:	352427
Registration status:	Health, Standard 05/12/2007
Definition:	The source of revenue received by a health industry relevant organisation, as represented by a code.
Data Element Concept:	Health industry relevant organisation—source of revenue

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NNN
Maximum character length:	3

Permissible values:

Value	Meaning
	Public sector
101	Australian Health Care Agreements
102	Other Special Purpose Payments
103	Medicare
104	Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme
105	National Health and Medical Research Council
106	Department of Veterans' Affairs
107	Other Australian government departments
108	State/Territory non-health departments
188	Other public sector revenue
	Private sector
201	Private health insurance
202	Workers compensation insurance
203	Motor vehicle third party insurance
204	Other compensation (e.g. Public liability, common law, medical negligence)
205	Private households (self-funded and out-of-pocket expenditure)

206	Non-profit institutions serving households
207	Corporations (other than health insurance)
288	Other private sector revenue
301	Overseas
999	Not further defined

Collection and usage attributes

Guide for use: Public sector

CODE 101 Australian Health Care Agreements

This item is not currently required to be reported by state or territory health authorities.

Revenue received from the Australian Government Department of Health and Ageing under the Australian Health Care Agreements to assist in the cost of providing public patients with free access to public hospital services within a clinically appropriate time irrespective of where patients live.

CODE 102 Other Special Purpose Payments

This item is not currently required to be reported by state or territory health authorities.

Includes Specific Purpose Payments provided by the Australian Government to the states and territories such as:

- Public Health Outcomes Funding Agreement grants
- Highly Specialised Drugs grants
- National Radiotherapy grants
- National Mental Health Information Development grant
- Magnetic Resonance Imaging grants
- Postgraduate Medical Training grants
- Hepatitis C Education and Prevention grant
- Royal Flying Doctor Service grants

Excludes AHCA grants, Medicare or PBS/RPBS payments.

CODE 103 Medicare

This item is not currently required to be reported by state or territory health authorities.

Includes revenue received for services listed in the Medical Benefits Schedule that are provided by registered medical practitioners. Many medical services in Australia are provided on a fee-for-service basis and attract benefits or revenue from the Australian Government under Medicare.

Includes revenue received for medical services provided to private admitted patients in hospitals as well as some revenue that is not based on fee-for-service (i.e. alternative funding arrangements).

CODE 104 Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceuticals Benefits Scheme (RPBS)

Includes pharmaceuticals in the PBS and RPBS for which the

Australian Government paid a benefit.

Excludes:

- revenue received for pharmaceuticals for which no PBS or RPBS benefit was paid;
- revenue received for other non-pharmaceutical medications;
- pharmaceuticals listed in the PBS or RPBS, the total costs of which are equal to, or less than, the statutory patient contribution for the class of patient concerned;
- medicines dispensed through private prescriptions that do not fulfil the criteria for payment under the PBS or RPBS; and
- over-the-counter medicines such as pharmacy-only medicines, aspirin, cough and cold medicines, vitamins and minerals, herbal and other complementary medicines, and a range of medical non-durables, such as bandages, band aids and condoms.

CODE 105 National Health and Medical Research Council

Includes health research funded by the National Health and Medical Research Council that is not reported elsewhere.

CODE 106 Department of Veterans' Affairs

Includes revenues received for health services provided to veterans, war widows and widowers with gold or white DVA cards. Types of services include public and private hospitals, local medical officers and specialists, residential aged care subsidy, allied health, rehabilitation appliances, dental services, community nursing, Veterans' Home Care and travel for treatment.

Excludes revenues received for pharmaceuticals provided to veterans, war widows and widowers with gold, white or orange DVA cards which are reported under code 104.

CODE 107 Other Australian Government Departments

Includes other revenues received for health services from, for example, the Department of Immigration and Citizenship and Department of Defence. Excludes Medicare payments from Medicare Australia (part of Department of Human Services) reported under code 103.

CODE 108 State/Territory non-health Departments

Includes correctional facilities, and departments that have contributed funding for the provision of a health service e.g. public health, emergency services, NSW Food Authority, NSW Health Care Complaints Commission, South Australia Ambulance Service, National Blood Authority, Red Cross, and prison health services such as WA Health services directorate and St Vincent's Correctional Health Service Victoria.

CODE 188 Other public sector revenue

Includes all public sector revenue other than those reported under codes 101 to 108. May include revenue from Local governments.

Private sector

CODE 201 Private health insurance

Includes revenue from businesses mainly engaged in providing insurance cover for hospital, medical, dental or pharmaceutical expenses or costs.

Excludes:

3. accident and sickness insurance
4. liability insurance
5. life insurance
6. general insurance
7. other insurance business excluded by the Private Health Insurance (Health Insurance Business) Rules
8. overseas visitors for whom travel insurance is the major funding source.

State and territory health authorities may report revenues for admitted patients, from private health insurance funds and private households, as a combined total if these revenues are not able to be reported separately.

CODE 202 Workers compensation insurance

Includes benefits paid under workers compensation insurance to the health industry relevant organisation for health care provided to workers, including trainees and apprentices, who have experienced a work-related injury. Type of benefits includes fees for medical or related treatment.

Excludes benefits paid under public liability, common law or medical negligence.

CODE 203 Motor vehicle third party insurance

Includes personal injury claims arising from motor accidents and compensation for accident victims and their families for injuries or death. Excludes benefits paid under workers compensation insurance, public liability, common law or medical negligence.

CODE 204 Other compensation (e.g. Public liability, common law, medical negligence).

This item is not currently required to be reported by state or territory health authorities.

Includes revenues received from:

- public liability insurance for injury arising from an incident related to the organisation's normal activities;
- a court-ordered settlement for damages because of negligence under specific conditions a duty of care exists and was breached and material damage resulted as a consequence;
- health professionals employed by health authorities or otherwise covered by health authority professional indemnity arrangements; and
- a common law settlement cancels all other entitlements to workers compensation benefits. If a common law claim is not successful, the worker will continue to receive workers

compensation under the statutory scheme.

Excludes benefits paid under motor vehicle third party insurance.

CODE 205 Private households (self-funded and out-of-pocket expenditure)

Includes payments received from the patient, the patient's family or friends, or other benefactors (i.e. patient revenue).

Includes cost-sharing and informal payments to health care providers. Cost-sharing is a provision of health insurance or third-party payment that requires the individual who is covered to pay part of the cost of health care received. This is distinct from the payment of a health insurance premium, contribution or tax which is paid whether health care is received or not.

Cost-sharing can be in the form of co-payments, co-insurance or deductibles:

- co-payment: cost-sharing in the form of a fixed amount to be paid for a service;
- co-insurance: cost-sharing in the form of a set proportion of the cost of a service; and
- deductibles: cost-sharing in the form of a fixed amount which must be paid for a service before any payment of benefits can take place.

CODE 206 Non-profit institutions serving households

Non-profit institutions serving households (NPISHs) (i.e. non-profit NGOs) consist of non-profit institutions which provide goods or services to households free or at prices that are not economically significant. Such NPISHs may provide health care goods or services on a non-market basis to households in need, including households affected by natural disasters or war.

The revenues received from such NPISHs are provided mainly by donations in cash or in kind from the general public, corporations or governments. These include organisations such as the National Heart Foundation, Diabetes Australia or the Cancer Council etc. Excludes non-profit institutions that are market producers of goods and services.

NOTE: This item is to be used for the reporting of revenues received from trusts or charities.

CODE 207 Corporations (other than health insurance)

This item is not currently required to be reported by state or territory health authorities.

Include revenues received from all corporations or quasi-corporations, whose principal activity is the production of market goods or services (other than health insurance). Included are all resident non-profit institutions that are market producers of goods or non-financial services. These include health or health-related organisations such as hospitals, pharmacies, medical and diagnostic laboratories, residential aged care facilities and providers of medical specialist services, and non-health organisations such as research organisations.

CODE 288 Other private sector revenue

Includes all private sector revenue other than those reported under codes 201 to 207.

CODE 301 Overseas

This item is not currently required to be reported by state or territory health authorities.

Includes funds provided from overseas countries for areas of health care such as research. Funds may be channelled through government or non-government organisations or private institutions. Also includes overseas visitors receiving health care for whom travel insurance is the major funding source.

CODE 999 Not further defined

Includes all revenue that could be a combination of categories 101 to 108, 188, 201 to 207 and 288 but which could not be further disaggregated.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents: Australian Institute of Health and Welfare 2007. Episode of care—principal source of funding, hospital code NN. Viewed 26 July 2007. <http://meteor.aihw.gov.au/content/index.phtml/itemId/339080>

Organisation for Economic Co-operation and Development A system of health accounts, Version 1. OECD 2000.

Australian Bureau of Statistics 2006, Australian and New Zealand Standard Industrial Classification (ANZSIC), 2006, cat. no. 1292.0, ABS, Canberra

Standard Economic Sector Classifications of Australia (SESCA), 2002, cat. no. 1218.0, ABS, Canberra

Private Health Insurance Act 2007 No. 31, 2007 Chapter 4, Part 4–3 at http://www.comlaw.gov.au/

Data element attributes

Collection and usage attributes

Guide for use: If there is an expected source of revenue followed by a finalised actual source of revenue (for example, in relation to compensation claims), then the actual revenue source known at the end of the reporting period should be recorded.

The expected revenue source should be reported if the fee has not been paid but is not to be waived.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Relational attributes

Implementation in Data Set Specifications:	Government health expenditure function revenue data element cluster Health, Standard 03/12/2008 Government health expenditure organisation revenue data element cluster Health, Standard 01/04/2009

Source of referral to alcohol and other drug treatment service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—referral source, code NN
METeOR identifier:	269946
Registration status:	Health, Standard 01/03/2005
Definition:	The source from which the person was transferred or referred to the alcohol and other drug treatment service, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—referral source

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Permissible values:	Value	Meaning
	01	Self
	02	Family member/friend
	03	Medical practitioner
	04	Hospital
	05	Mental health care service
	06	Alcohol and other drug treatment service
	07	Other community/health care service
	08	Correctional service
	09	Police diversion
	10	Court diversion
	98	Other
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 03 Medical practitioner

Includes medical specialists, vocationally registered general practitioners, vocationally registered general practitioner trainees and other primary-care medical practitioners in private practice.

CODE 04 Hospital

Includes public and private hospitals, hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical care, satellite units managed and staffed by a hospital, emergency departments of hospitals, and mothercraft hospitals. Excludes psychiatric hospitals, psychiatric units and drug and alcohol units located within or operating from hospitals, and outpatient clinics (see codes 05-07).

CODE 05 Mental health care service

Includes both residential and non-residential services. Includes psychiatric hospitals and psychiatric units within and outside of hospitals.

CODE 06 Alcohol and other drug treatment service

Includes both residential and non-residential services. Includes drug and alcohol units within and outside of hospitals.

CODE 07 Other community/health care service

Includes outpatient clinics and aged care facilities.

CODE 09 Police diversion

This code should be used when a person detained for a minor drug offence is formally referred to treatment by the police in order to divert the offender from the criminal justice pathway.

CODE 10 Court diversion

This code refers to the diversion of an offender into drug education, assessment and treatment at the discretion of a magistrate. This may occur at the point of bail or prior to sentencing.

CODE 98 Other

Includes persons referred under a legislative act (other than Drug *Diversion Act*) e.g. *Mental Health Act*.

Data element attributes

Collection and usage attributes

Comments: Source of referral is important in assisting in the analyses of inter-sectoral patient/client flow and for health care planning.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:	Supersedes Source of referral to alcohol and other drug treatment service, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013

Source of referral to public psychiatric hospital

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of admitted patient care—referral source, public psychiatric hospital code NN

METeOR identifier: 269947

Registration status: Health, Standard 01/03/2005

Definition: Source from which the person was transferred/referred to the public psychiatric hospital, as represented by a code.

Context: To assist in analyses of intersectoral patient flow and health care planning.

Data Element Concept: Episode of admitted patient care—referral source

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: NN

Maximum character length: 2

Permissible values:	Value	Meaning
	01	Private psychiatric practice
	02	Other private medical practice
	03	Other public psychiatric hospital
	04	Other health care establishment
	05	Other private hospital
	06	Law enforcement agency
	07	Other agency
	08	Outpatient department
	09	Other
Supplementary values:	10	Unknown

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Source of referral to public psychiatric hospital, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised mental health service program type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—admitted patient care program type, code N
METeOR identifier:	288889
Registration status:	Health, Standard 08/12/2004
Definition:	Type of admitted patient care program provided by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service—admitted patient care program type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Acute care
2	Other

Collection and usage attributes

Guide for use:

The categorisation of the admitted patient program is based on the principal purpose(s) of the program rather than the classification of the individual patients.

CODE 1 Acute care

Programs primarily providing specialist psychiatric care for people with acute episodes of mental disorder. These episodes are characterised by recent onset of severe clinical symptoms of mental disorder that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that this treatment effort is focused on short-term treatment. Acute services may be focused on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing mental disorder for whom there has been an acute exacerbation of symptoms. This category applies only to services with a mental health service setting of overnight admitted patient care or residential care.

CODE 2 Other

Refers to all other programs primarily providing admitted patient care.

Includes programs providing rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery.

They are characterised by an expectation of substantial improvement over the short to mid-term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms.

Also includes programs providing extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental disorder. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.

Data element attributes

Collection and usage attributes

Guide for use: This data element is used to disaggregate data on beds, activity, expenditure and staffing for admitted patient settings in mental health service units (see Specialised mental health service—service setting, code N data element).

Relational attributes

Related metadata references: See also Specialised mental health service—admitted patient service unit identifier, XXXXXX Health, Standard 07/12/2011

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised mental health service setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—service setting, code N
METeOR identifier:	288899
Registration status:	Health, Standard 08/12/2004
Definition:	The setting for care provided by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service—service setting

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Admitted patient care setting
	2	Residential care setting
	3	Ambulatory care setting
Supplementary values:	9	Unknown/not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Admitted patient care setting

The component of specialised mental health services that provides admitted patient care. These are specialised psychiatric hospitals and specialist psychiatric units located within hospitals that are not specialised psychiatric hospitals. Excludes hospital outpatient clinics.

CODE 2 Residential care setting

The component of specialised mental health services that provides residential care within **residential mental health services**. Excludes components that provide ambulatory care to patients or clients who are not residents.

CODE 3 Ambulatory care setting

The component of specialised mental health services that provides ambulatory care (service contacts). They include hospital outpatient clinics and non-hospital community mental health services, such as crisis or mobile assessment and treatment services, day programs, outreach services and consultation/liaison services.

Data element attributes

Collection and usage attributes

Guide for use: A single mental health service unit may provide care in more than one setting. This data element is intended to allow staffing, resource and expenditure data related to these settings to be identified and reported separately.

Relational attributes

Related metadata references: Supersedes Specialised mental health service—service delivery setting, code N Health, Superseded 08/12/2004

See also Specialised mental health service—target population group, code N Health, Superseded 07/12/2011

See also Specialised mental health service—target population group, code N Health, Standard 07/12/2011

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised mental health service target population

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—target population group, code N
METeOR identifier:	445778
Registration status:	Health, Standard 07/12/2011
Definition:	The population group primarily targeted by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service—specialised mental health service target population group

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Child and adolescent
2	Older person
3	Forensic
4	General
5	Youth

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used to disaggregate data on beds, activity, expenditure and staffing for patients in mental health service units (see the *Specialised mental health service – service setting, code N* data element).

CODE 1 Child and adolescent

These services principally target children and young people under the age of 18 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

CODE 2 Older person

These services principally target people in the age group of 65 years and over. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

CODE 3 Forensic

Health services that provide services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment. This includes prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.

CODE 4 General

These services principally target the general adult population (aged 18–64 years) but may also provide services to children, adolescents or older people. These services are those services that cannot be described as specialist child and adolescent services, youth services or services for older people. It excludes forensic services.

CODE 5 Youth

These services principally target children and young people generally aged 16-24 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

The order of priority for coding is:

- where the forensic services are for children/adolescents, youth or older persons these services should be coded to the category for that age group; and
- where the forensic services are for adults these services should be coded to forensic.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Specialised mental health service—admitted patient service unit identifier, XXXXXX Health, Standard 07/12/2011

See also Specialised mental health service—admitted patient service unit name, text XXX[X(97)] Health, Standard 07/12/2011

See also Specialised mental health service—ambulatory service unit identifier, XXXXXX Health, Standard 07/12/2011

See also Specialised mental health service—ambulatory service unit name, text XXX[X(97)] Health, Standard 07/12/2011

See also Specialised mental health service—residential service unit name, text XXX[X(97)] Health, Standard 07/12/2011

See also Specialised mental health service—service setting, code N Health, Standard 08/12/2004

Supersedes Specialised mental health service—target population group, code N Health, Superseded 07/12/2011

Implementation in Data Set Specifications:

Community mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised mental health service—hours staffed

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—number of hours staffed, average hours NN
METeOR identifier:	288877
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of hours per day during which a residential mental health service has appropriately trained staff employed on-site. Training may include formal qualifications and/or on the job training.
Data Element Concept:	Specialised mental health service—number of hours staffed

Value domain attributes

Representational attributes

Representation class:	Average	
Data type:	Number	
Format:	NN	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Unknown/not stated/inadequately described
Unit of measure:	Hour (h)	

Data element attributes

Collection and usage attributes

Guide for use:

Whole numbers of hours staffed (no decimals or fractions).

Valid numbers are 1 to 24.

The hours staffed provides a measure of service intensity for the reporting and analysis of staff, financial and activity data.

For residential mental health services, this refers to the number of hours per day during which appropriately trained staff (either with formal qualifications and/or on the job training) are employed on site, as their normal place of employment, within the service unit. It excludes periods where the service unit is only staffed by a resident sleepover staff member or any period where staff are present but not employed on site at the service unit.

Excludes ambulatory and admitted patient services.

Round to nearest whole hour.

Where the number of hours staffed varies by day, average the number of hours staffed over a week, including the weekend.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—acquired immune deficiency syndrome unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (acquired immune deficiency syndrome unit), yes/no code N
METeOR identifier:	270448
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the treatment of Acquired Immune Deficiency Syndrome (AIDS) patients is provided within an establishment as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—acute renal dialysis unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (acute renal dialysis unit), yes/no code N
METeOR identifier:	270435
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to dialysis of renal failure patients requiring acute care is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—acute spinal cord injury unit

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—specialised service indicator (acute spinal cord injury unit), yes/no code N

METeOR identifier: 270432

Registration status: Health, Standard 01/03/2005

Definition: Whether or not a specialised facility dedicated to the initial treatment and subsequent ongoing management and rehabilitation of patients with acute spinal cord injury, largely conforming to Australian Health Minister's Advisory Council guidelines for service provision, is provided within an establishment, as represented by a code.

Data Element Concept: Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—alcohol and drug unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (alcohol and drug unit), yes/no code N
METeOR identifier:	270431
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility/service dedicated to the treatment of alcohol and drug dependence is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—bone marrow transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (bone marrow transplantation unit), yes/no code N
METeOR identifier:	308862
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for bone marrow transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—burns unit (level III)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (burns unit (level III)), yes/no code N
METeOR identifier:	270438
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the initial treatment and subsequent rehabilitation of the severely injured burns patient (usually >10 per cent of the patient's body surface affected) is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—cardiac surgery unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (cardiac surgery unit), yes/no code N
METeOR identifier:	270434
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to operative and peri-operative care of patients with cardiac disease is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—clinical genetics unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (clinical genetics unit), yes/no code N
METeOR identifier:	270444
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to diagnostic and counselling services for clients who are affected by, at risk of, or anxious about genetic disorders, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—comprehensive epilepsy centre

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (comprehensive epilepsy centre), yes/no code N
METeOR identifier:	270442
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to seizure characterisation, evaluation of therapeutic regimes, pre-surgical evaluation and epilepsy surgery for patients with refractory epilepsy, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—coronary care unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (coronary care unit), yes/no code N
METeOR identifier:	270433
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to acute care services for patients with cardiac diseases is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—diabetes unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (diabetes unit), yes/no code N
METeOR identifier:	270449
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the treatment of diabetics is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—domiciliary care service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (domiciliary care service), yes/no code N
METeOR identifier:	270430
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility/service dedicated to the provision of nursing or other professional paramedical care or treatment and non-qualified domestic assistance to patients in their own homes or in residential institutions not part of the establishment is provided by the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—geriatric assessment unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (geriatric assessment unit), yes/no code N
METeOR identifier:	270429
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not facilities dedicated to the Commonwealth-approved assessment of the level of dependency of (usually) aged individuals either for purposes of initial **admission** to a long-stay institution or for purposes of reassessment of dependency levels of existing long-stay institution residents, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—heart, lung transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (heart, lung transplantation unit), yes/no code N
METeOR identifier:	308866
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for heart including heart lung transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—hospice care unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (hospice care unit), yes/no code N
METeOR identifier:	270427
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility dedicated to the provision of palliative care to terminally ill patients is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—in-vitro fertilisation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (in-vitro fertilisation unit), yes/no code N
METeOR identifier:	270441
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the investigation of infertility provision of in-vitro fertilisation services is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—infectious diseases unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (infectious diseases unit), yes/no code N
METeOR identifier:	270447
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the treatment of infectious diseases is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—intensive care unit (level III)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (intensive care unit (level III)), yes/no code N
METeOR identifier:	270426
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of paediatric and adult patients requiring intensive care and sophisticated technological support services is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—liver transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (liver transplantation unit), yes/no code N
METeOR identifier:	308868
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for liver transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—maintenance renal dialysis centre

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (maintenance renal dialysis centre), yes/no code N
METeOR identifier:	270437
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a specialised facility dedicated to maintenance dialysis of renal failure patients, as represented by a code. It may be a separate facility (possibly located on hospital grounds) or known as a satellite centre or a hospital-based facility but is not a facility solely providing training services.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—major plastic/reconstructive surgery unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (major plastic/reconstructive surgery unit), yes/no code N
METeOR identifier:	270439
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to general purpose plastic and specialised reconstructive surgery, including maxillofacial, microsurgery and hand surgery, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—neonatal intensive care unit (level III)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (neonatal intensive care unit (level III)), yes/no code N
METeOR identifier:	270436
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of neonates requiring care and sophisticated technological support, is provided within an establishment, as represented by a code. Patients usually require intensive cardiorespiratory monitoring, sustained assistance ventilation, long-term oxygen administration and parenteral nutrition.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—neurosurgical unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (neurosurgical unit), yes/no code N
METeOR identifier:	270446
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the surgical treatment of neurological conditions is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—nursing home care unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (nursing home care unit), yes/no code N
METeOR identifier:	270428
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility dedicated to the provision of nursing home care is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—obstetric/maternity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (obstetric/maternity), yes/no code N
METeOR identifier:	270150
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of obstetric/maternity patients is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—oncology unit, cancer treatment

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—specialised service indicator (oncology unit) (cancer treatment), yes/no code N

METeOR identifier: 270440

Registration status: Health, Standard 01/03/2005

Definition: Whether or not a specialised facility dedicated to multidisciplinary investigation, management, rehabilitation and support services for cancer patients, is provided within an establishment, as represented by a code. Treatment services include surgery, chemotherapy and radiation.

Data Element Concept: Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—pancreas transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (pancreas transplantation unit), yes/no code N
METeOR identifier:	308870
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for pancreas transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—psychiatric unit/ward

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (psychiatric unit/ward), yes/no code N
METeOR identifier:	270425
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised unit/ward dedicated to the treatment and care of admitted patients with psychiatric, mental, or behavioural disorders, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—rehabilitation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (rehabilitation unit), yes/no code N
METeOR identifier:	270450
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not dedicated units within recognised hospitals which provide post-acute rehabilitation and are designed as such by the State health authorities (see metadata item Type of episode of care) are provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—renal transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (renal transplantation unit), yes/no code N
METeOR identifier:	308864
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for renal transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—sleep centre

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—specialised service indicator (sleep centre), yes/no code N

METeOR identifier: 270445

Registration status: Health, Standard 01/03/2005

Definition: Whether or not a specialised facility linked to a sleep laboratory dedicated to the investigation and management of sleep disorders is provided within an establishment, as represented by a code.

Data Element Concept: Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—specialist paediatric

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (specialist paediatric), yes/no code N
METeOR identifier:	270424
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of children aged 14 or less is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Specialised service indicators—transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (transplantation unit), yes/no code N
METeOR identifier:	270443
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to organ retrieval, transplantation and ongoing care of the transplant recipient, is provided within an establishment. • bone marrow • renal • heart, including heart-lung • liver • pancreas.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Specialist private sector rehabilitation care indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of care—specialist private sector rehabilitation care indicator, code N

METeOR identifier: 270397

Registration status: Health, Standard 01/03/2005

Definition: Whether the rehabilitation care that a patient receives from a private hospital meets the criteria for 'Specialist private sector rehabilitation care', as represented by a code.

Data Element Concept: Episode of care—specialist private sector rehabilitation care indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: This metadata item is a qualifier of the three 'Rehabilitation' care types for admitted patients in private hospitals. When an admitted patient in a private hospital is receiving rehabilitation care (as defined in Hospital service—care type, code N[N].N), this metadata item should be recorded to denote whether or not that care meets the criteria for 'specialist rehabilitation'.

These are the criteria determined by The Commonwealth Department of Health and Ageing in respect of patients treated in the private sector, specialist rehabilitation is:

- Provided by a specialist rehabilitation unit (a separate physical space and a specialist rehabilitation team providing admitted patient and/or ambulatory care) meeting guidelines issued by the Commonwealth Department of Health and Ageing, and
- provided by a multi-disciplinary team which is under the

clinical management of a consultant in rehabilitation medicine or equivalent, and

- provided for a person with limited functioning (impairments, activity limitations and participation restrictions) and for whom there is a reasonable expectation of functional gain, and
- for whom the primary treatment goal is improvement in functioning status which is evidenced in the medical record by:

  an individualised and documented initial and periodic assessment of functional ability, or

  an individualised multi-disciplinary rehabilitation plan which includes agreed rehabilitation goals and indicative timeframes.

Comments: This metadata item has been developed by the Private Rehabilitation Working Group, and agreed by the private rehabilitation hospital sector, the private health insurance sector and the Commonwealth Department of Health and Ageing. Whilst most patients will be treated by a consultant in rehabilitation medicine (a Fellow of the Australasian Faculty of Rehabilitation Medicine) there are circumstances in which the treating doctor will not be a Fellow of the Faculty. These include, but are not limited to, care provided in geographic areas where there is a shortage of Fellows of the Australasian Faculty of Rehabilitation Medicine.

Source and reference attributes

Submitting organisation: Private Rehabilitation Working Group

Commonwealth Department of Health and Ageing

Specific chronic condition indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—specific chronic condition indicator, yes/no code N
METeOR identifier:	399225
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether a person has ever been told by a doctor or nurse that they suffer from a specific chronic condition, as represented by a code.
Data Element Concept:	Person—specific chronic condition indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:	This data element can be used in conjunction with the data elements: *Person – type of chronic condition, code N* and *Person – chronic condition indicator, yes/no code N* to obtain information on the prevalence of chronic conditions in a population group.
Comments:	The term 'ever been told' was used instead of 'diagnosed' to allow comparability with the National Health Survey and the National Aboriginal and Torres Strait Islander Health Survey.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	ABS (Australian Bureau of Statistics) 2006. National Aboriginal and Torres Strait Islander Health Survey, 2004-

05. Cat. no. 4715.0. Canberra: ABS.

ABS 2009. National health survey: users' guide-electronic publication, 2007-08. ABS cat. no. 4363.0.55.001. Canberra: ABS.

Relational attributes

Related metadata references:

See also Person—chronic condition indicator, yes/no code N Health, Standard 25/08/2011

See also Person—type of chronic condition, code N Health, Standard 25/08/2011

Implementation in Data Set Specifications:

Chronic condition cluster Health, Standard 25/08/2011

Staging basis of cancer

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Cancer staging—staging basis of cancer, code A

METeOR identifier: 422604

Registration status: Health, Standard 07/12/2011

Definition: The timing and evidence for cancer stage values, as represented by a code.

Data Element Concept: Cancer staging—staging basis of cancer

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: A

Maximum character length: 1

Permissible values:

Value	Meaning
P	Pathological
C	Clinical

Collection and usage attributes

Guide for use: CODE P Pathological

Pathological stage is based on histological evidence acquired before treatment, supplemented or modified by additional evidence acquired from surgery and from pathological examination.

CODE C Clinical

Clinical stage is based on evidence obtained prior to treatment from physical examination, imaging, endoscopy, biopsy, surgical exploration or other relevant examinations.

Refer to the latest edition of the manual containing the appropriate classification system for the cancer. For example, refer to the latest edition of the International Union Against Cancer (UICC) reference manual TNM Classification of Malignant Tumours or the American Joint Committee on Cancer (AJCC) Cancer Staging Manual for coding rules for those tumours classified using the TNM system.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Collection methods:	From information provided by the treating doctor and recorded on the patient's medical record.
Comments:	For survival analysis adjusted by stage at diagnosis and distribution of cancer case by type and stage.

Relational attributes

Related metadata references:	Supersedes Cancer staging—staging basis of cancer, code A Health, Superseded 07/12/2011 See also Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011 See also Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011 See also Person with cancer—extent of primary cancer, stage grouping other, code X[XXXXX] Health, Standard 07/12/2011 See also Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XXX] Health, Standard 07/12/2011 See also Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Standard 07/12/2011

Staging scheme source

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer staging—cancer staging scheme source, code N[N]
METeOR identifier:	393364
Registration status:	Health, Standard 07/12/2011
Definition:	The reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer, as represented by a code.
Data Element Concept:	Cancer staging—cancer staging scheme source

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	TNM Classification of Malignant Tumours (UICC)
2	Durie & Salmon for multiple myeloma staging
3	French-American-British (FAB) for leukaemia classification
4	Australian Clinico-Pathological Staging (ACPS) System for colorectal cancer
5	International Federation of Gynecologists & Obstetricians (FIGO) for gynaecological cancers
6	Dukes/Modified Dukes for colorectal cancer
7	Ann Arbor staging system for lymphomas
8	Binet Staging Classification for chronic lymphocytic leukaemia
9	Rai staging system for chronic lymphocytic leukaemia
10	Chronic Myeloid Leukaemia (CML) staging system
11	International Staging System (ISS) for

		myeloma
	12	American Joint Committee on Cancer (AJCC) Cancer Staging Manual
	96	Other reference
Supplementary values:	97	Not applicable
	98	Unknown
	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 10 Chronic Myeloid Leukaemia (CML) staging system

Criteria for diagnosing the transition from the chronic phase into the accelerated phase in patients with Chronic Myeloid Leukaemia (CML) is variable. The WHO criteria (Vardiman et al. 2002) are perhaps the most widely used and are recommended.

Source and reference attributes

Reference documents:

American Joint Committee on Cancer 2010. AJCC Cancer Staging Manual, 7th edition. Springer: New York

Astler VB & Coller FA 1954. The prognostic significance of direct extension of carcinoma of the colon and rectum. Ann Surg 139:846

Australian Cancer Network Colorectal Cancer Guidelines Revision Committee 2005. Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer. Sydney: The Cancer Council Australia and Australian Cancer Network

Benedet JL & Pecorelli S 2000. Staging classifications and clinical practice guidelines of gynaecologic cancers. FIGO Committee on Gynaecologic Oncology

Bennett JM et al. 1985. Proposed revised criteria for the classification of acute myeloid leukaemia. French-American-British (FAB) co-operative group. Ann Intern Med 103(4):620-625

Binet JL et al. 1981. A new prognostic classification of chronic lymphocytic leukemia derived from a multivariate survival analysis. Cancer 48:198-206

Binet JL et al. 1981. Proposals for a revised staging system. Br J Haematol 48:365-7

Carbone PA, Kaplan HS, Musshoff K, Smithers, DW, Tubiana M 1971. Report of the committee on Hodgkin's disease staging classification. Cancer Research 31:1860-1861

Davis NC & Newland RC 1983. The reporting of colorectal cancer: the Australian Clinico-pathological Staging (ACPS) System. Med J Aust 1(6):282

Dukes CE 1932. The classification of cancer of the rectum. J Pathol Bacteriol 35:323

Durie BG & Salmon SE 1975. A clinical staging system for multiple myeloma: correlation of measured myeloma cell mass with presenting clinical features, response to treatment, and survival. Cancer 36(3):842-54

Greipp PR et al. 2005. International Staging System for Multiple Myeloma. J Clin Oncol 23(15):3412-20

International Myeloma Working Group 2003. Criteria for the classification of monoclonal gammopathies, multiple myeloma and related disorders: a report of the International Myeloma Working Group. Br J Haematol 121:749-757

Lister TA et al. 1989. Report of a committee convened to discuss the evaluation and staging of patients with Hodgkin's disease: Cotswolds meeting. J Clin Oncol 7(11):1630-6

Rai KR, Sawitsky A, Cronkite EP, Chanana AD, Levy RN 1975. Clinical staging of chronic lymphocytic leukaemia. Blood 46(2):219-34

Rosenberg SA 1977. Validity of the Ann Arbor staging classification for the non-Hodgkin's lymphomas. Cancer Treat Rev 61:1023-27

Sobin LH, Gospodarowicz MK, Wittekind C (Editors) 2009. International Union Against Cancer (UICC): TNM Classification of Malignant Tumours, 7th edition. Wiley-Blackwell

Vardiman JW, Harris NL, Brunning RD 2002. The World Health Organization (WHO) classification of the myeloid neoplasms. Blood 100(7):2292-2302

Data element attributes

Collection and usage attributes

Guide for use: It is recommended that the TNM Classification of Malignant Tumours (International Union Against Cancer (UICC)) or the American Joint Committee on Cancer (AJCC) Cancer Staging Manual be used whenever it is applicable. The classifications published in the AJCC Cancer Staging Manual are identical to the TNM classifications of the UICC.

TNM is not applicable to all tumour sites. Staging is of limited use in some cancers, for example, haematological malignancies. In these cases use the most appropriate classification system.

The Cancer Council Australia and Australian Cancer Network *Guidelines for the prevention, early detection and*

	management of colorectal cancer (2005, pp. 159-162) support the use of the Australian Clinico-Pathological Staging (ACPS) System. They recommend that both TNM and ACPS staging data be recorded to enable national and international comparisons. A table of correspondences between ACPS and TNM classifications is available. The current edition of each staging scheme should be used.
Comments:	Collected to identify which classification system is used to determine the extent of cancer at the time of diagnosis. Cancer stage is an important determinant of treatment and prognosis, and is used to evaluate new treatments and analyse outcomes. Survival analysis is adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Source and reference attributes

Submitting organisation:	Cancer Australia
Origin:	International Union Against Cancer (UICC) FAB (French-American-British) Group NSW Health Department National Health & Medical Research Council Clinical Oncological Society of Australia Australian Cancer Network

Relational attributes

Related metadata references:	See also Cancer staging—cancer staging scheme source edition number, code N[N] Health, Standard 07/12/2011 Supersedes Cancer staging—cancer staging scheme source, code N Health, Superseded 07/12/2011 See also Person with cancer—extent of primary cancer, stage grouping other, code X[XXXXX] Health, Standard 07/12/2011
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Standard 07/12/2011

Standards assessment indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Service provider organisation—standards assessment indicator, yes/no code N

METeOR identifier: 356457

Registration status: Health, Standard 05/12/2007

Definition: Whether a service provider organisation routinely undertakes or undergoes formal assessment against defined industry standards, as represented by a code.

Data Element Concept: Service provider organisation—standards assessment indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Boolean

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: Formal assessment against the relevant standards may occur via self-assessment or external assessment methods. A 'formal' self-assessment should involve a number of aspects, including the planning and development of a clear structure for the assessment process; the use of an accepted evaluation method such as a peer review; and the use of validated tools where these are available. A 'formal' assessment also includes a formal in-depth review against the relevant standards by an independent external reviewer. This may take place in the context of an accreditation process for the service provider organisation or the organisation of which the service provider organisation is a sub-unit.

CODE 1 Yes

The service provider organisation routinely undertakes or undergoes formal assessment against the specified healthcare standards.

CODE 2 No
The service provider organisation does not routinely undertake or undergo formal assessment against the specified healthcare standards.

Collection methods: Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Palliative care performance indicators DSS Health, Standard 05/12/2007

Standards assessment level

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—standards assessment level, code N
METeOR identifier:	359019
Registration status:	Health, Standard 05/12/2007
Definition:	The level of assessment undertaken or undergone by a service provider organisation against relevant industry standards as represented by a code.
Data Element Concept:	Service provider organisation—standards assessment level

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Formally assessed
2	Accredited

Collection and usage attributes

Guide for use:

CODE 1 Formally assessed

Formal assessment may entail self-assessment and/or assessment by an independent external reviewer. This assessment may take place in the context of an accreditation process for the organisation.

A formal assessment, whether self-assessed or externally reviewed, should involve a number of aspects, including the planning and development of a clear structure for the assessment process, the use of an accepted evaluation method such as a peer review, and the use of validated tools where these are available.

CODE 2 Accredited

This code should only be recorded where accreditation has been granted to the organisation and is current.

Data element attributes

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:

Indigenous primary health care DSS Health, Standard 07/12/2011

Palliative care performance indicators DSS Health, Standard 05/12/2007

Conditional obligation:
Recorded when the data element Service provider organisation—standards assessment indicator, yes/no code N value is 'yes' (code 1).

Standards assessment method

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Service provider organisation—standards assessment method, code N

METeOR identifier: 287762

Registration status: Health, Standard 05/12/2007

Definition: The method used by a service provider organisation to undertake or undergo formal assessment against defined industry standards, as represented by a code.

Data Element Concept: Service provider organisation—standards assessment method

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Formal self-assessment
2	In-depth external review

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Formal self-assessment

The service provider organisation undertakes formal self-assessment, on a routine basis, against the agreed criteria outlined in the defined industry standards.

A formal self-assessment should involve a number of aspects, including the planning and development of a clear structure for the assessment process; the use of an accepted evaluation method such as a peer review; and the use of validated tools where these are available.

CODE 2 In-depth external review

The service provider organisation routinely undergoes an in-depth review against the defined industry standards by an independent external reviewer. This may take place in the context of an accreditation process for the service provider organisation.

Collection methods: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Conditional obligation:
Recorded when the data element *Service provider organisation—standards assessment indicator, yes/no code N* value is 'yes' (code 1).

State/Territory of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—state/territory of birth, code N
METeOR identifier:	270151
Registration status:	Health, Standard 01/03/2005
Definition:	The state/territory in which the baby was delivered, as represented by a code.
Data Element Concept:	Birth event—state/territory of birth

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	New South Wales
2	Victoria
3	Queensland
4	South Australia
5	Western Australia
6	Tasmania
7	Northern Territory
8	Australian Capital Territory
9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)

Collection and usage attributes

Guide for use: The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Source and reference attributes

Reference documents: Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0.

Canberra: ABS.

Data element attributes

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes State/Territory of birth, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.2 KB)

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Statistical area level 2 (SA2)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Address—statistical area, level 2 (SA2) code (ASGS 2011) N(9)

Synonymous names: SA2

METeOR identifier: 457289

Registration status: Community Services, Standard 06/12/2011
Health, Standard 07/12/2011

Definition: A designated region describing location and contact details that represents a medium-sized area built from a number of Statistical Area 1, as represented by a code. The aim is to represent a community that interacts together socially and economically.

Data Element Concept: Address—statistical area

Value domain attributes

Representational attributes

Classification scheme: Australian Statistical Geography Standard 2011

Representation class: Code

Data type: String

Format: N(9)

Maximum character length: 9

Collection and usage attributes

Guide for use: SA2 coding structure:

An SA2 is identifiable by a 9-digit fully hierarchical code. The SA2 identifier is a 4-digit code, assigned in alphabetical order within an SA3. An SA2 code is only unique within a state/territory if it is preceded by the state/territory identifier.

For example:

State/territory	SA4	SA3	SA2
N	NN	NN	NNNN

Comments: There are 2,196 SA2 spatial units. In aggregate, they cover the whole of Australia without gaps or overlaps. Jervis Bay Territory, the Territory of the Cocos (Keeling) Islands and the Territory of Christmas Island are each represented by an SA2.

Source and reference attributes

Origin: 1270.0.55.001 - Australian Statistical Geography Standard (ASGS): Volume 1 - Main Structure and Greater Capital City Statistical Areas, July 2011
http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1270.0.55.001July%202011?OpenDocument

Data element attributes

Relational attributes

Related metadata references: See also Address—Australian postcode, code (Postcode datafile) {NNNN} Community Services, Standard 06/02/2012, Health, Standard 07/12/2011, Early Childhood, Standard 09/03/2012

See also Address—suburb/town/locality name, text X[46] Community Services, Standard 06/02/2012, Health, Standard 07/12/2011, Early Childhood, Standard 09/03/2012

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Statistical linkage key 581

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Record—linkage key, code 581 XXXXXDDMMYYYYN
METeOR identifier:	349895
Registration status:	Community Services, Standard 21/05/2010 Housing assistance, Standard 23/08/2010 Health, Standard 07/12/2011 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010
Definition:	A key that enables two or more records belonging to the same individual to be brought together. It is represented by a code consisting of the second, third and fifth characters of a person's family name, the second and third letters of the person's given name, the day, month and year when the person was born and the sex of the person, concatenated in that order.
Data Element Concept:	Record—linkage key

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	XXXXXDDMMYYYYN
Maximum character length:	14

Data element attributes

Collection and usage attributes

Collection methods:	Information about whether or not the person's date of birth is accurate should be noted. By knowing that date of birth is accurate it is possible to reduce underestimation of total service user numbers and overestimation of service users' ages.
Comments:	The linkage key is designed to make it possible to count number of clients and services they received, without counting the same client more than once. It can also be used for linking to other related data collections. It is for statistical linkage purposes only, not for case management or the tracking of individual persons. This may be done using a range of identifiers and/or keys.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare.
Steward:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Date—accuracy indicator, code AAA Community Services, Standard 30/09/2005, Housing assistance, Standard 23/08/2010, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010 Is formed using Person—date of birth, DDMMYYYY Community Services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010, Tasmanian Health, Proposed 28/09/2011 Is formed using Person—letters of family name, text XXX Community Services, Standard 27/03/2007, Housing assistance, Standard 23/08/2010, Health, Standard 07/12/2011, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010 Is formed using Person—letters of given name, text XX Community Services, Standard 27/03/2007, Housing assistance, Standard 23/08/2010, Health, Standard 07/12/2011, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010 Is formed using Person—sex, code N Community Services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010
Implementation in Data Set Specifications:	Statistical linkage key 581 cluster Community Services, Standard 21/05/2010 Housing assistance, Standard 23/08/2010 Health, Standard 07/12/2011 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010

Status of the baby

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth—birth status, code N
METeOR identifier:	269949
Registration status:	Health, Standard 01/03/2005
Definition:	The status of the baby at birth as represented by a code.
Data Element Concept:	Birth—birth status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Live birth
	2	Stillbirth (fetal death)
Supplementary values:	9	Not stated

Collection and usage attributes

Guide for use:

Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered liveborn (WHO, 1992 definition).

Stillbirth is a fetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more **birthweight**; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. (This is the same as the WHO definition of fetal death, except that there are no limits of gestational age or birthweight for the WHO definition.)

Source and reference attributes

Reference documents: International Classification of Diseases and Related Health Problems, 10th Revision, Vol 1, WHO 1992.

Data element attributes

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Status of the baby, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Implementation in Data Set Specifications: Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Street suffix code (person)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person (address)—street suffix, code A[A]

METeOR identifier: 270022

Registration status: Community Services, Superseded 06/02/2012
Health, Standard 01/03/2005

Definition: The abbreviated suffix that identifies the type of street where a person resides, as represented by a code.

Data Element Concept: Person (address)—street suffix

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: A[A]

Maximum character length: 2

Permissible values:

Value	Meaning
CN	Central
E	East
EX	Extension
LR	Lower
N	North
NE	North East
NW	North West
S	South
SE	South East
SW	South West
UP	Upper
W	West

Data element attributes

Collection and usage attributes

Collection methods: To be used in conjunction with street name. To be used in conjunction with street type.

For example:

Browns Rd W

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references: Is used in the formation of Person (address)—address line, text [X(180)] Community Services, Standard 30/09/2005, Health, Standard 04/05/2005

Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Supersedes Street suffix code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Street suffix code (service provider organisation)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Service provider organisation (address)—street suffix, code A[A]

METeOR identifier: 290170

Registration status: Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Definition: The abbreviated suffix that identifies the type of street where an organisation is located, as represented by a code.

Data Element Concept: Service provider organisation (address)—street suffix

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: A[A]

Maximum character length: 2

Permissible values:

Value	Meaning
CN	Central
E	East
EX	Extension
LR	Lower
N	North
NE	North East
NW	North West
S	South
SE	South East
SW	South West
UP	Upper
W	West

Data element attributes

Collection and usage attributes

Collection methods: To be used in conjunction with street name. To be used in conjunction with street type.

For example:

Browns Rd W

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references: Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Community Services, Standard 30/09/2005, Housing assistance, Recorded 13/10/2011, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010

Implementation in Data Set Specifications: Health care provider identification DSS Health, Standard 03/12/2008

Sub-dwelling unit number

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Address—sub-dwelling unit number, identifier [X(7)]

METeOR identifier: 429012

Registration status: Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Definition: A numeric identifier used to distinguish an address within a building/sub-complex or marina.

Data Element Concept: Address—sub-dwelling unit number

Value domain attributes

Representational attributes

Representation class: Identifier

Data type: String

Format: [X(7)]

Maximum character length: 7

Data element attributes

Collection and usage attributes

Guide for use: This data element may include a leading alphabetic prefix or a trailing alphabetic suffix.

Example:

Mrs Joyce Citizen
Apartment 7 (Sub-dwelling unit number is 7)
Level 3
Apex Building
48 Johnson Rd
CLAYTON VIC 3168

Mr XYZ
Suite 54 (Sub-dwelling unit number is 54)
Beacon Cove Foodstore
103 Beach Road
PORT MELBOURNE VIC 3207

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references:

Supersedes Person (address)—building/complex sub-unit identifier, [X(7)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Supersedes Service provider organisation (address)—building/complex sub-unit identifier, [X(7)] Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Implementation in Data Set Specifications:

Public hospital establishment address details DSS Health, Standard 07/12/2011

Conditional obligation:

Conditional on this component being part of the address of the Public hospital establishment.

Substance used illicitly indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—substance used illicitly indicator, yes/no/not stated/inadequately described code N
METeOR identifier:	365254
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	An indicator of whether a person has used a substance in an illicit manner, as represented by a code.
Data Element Concept:	Person—substance used illicitly indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: This data element is used in conjunction with the data element: *Person – type of substance used illicitly, drug of concern (ASCDC 2000 extended) code NNNN* to provide information on the type of substance(s) used illicitly by a person.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Australian Institute of Health and Welfare 2008. 2007 National Drug Strategy Household Survey: first results.

Drug Statistics Series number 20.Cat. no. PHE 98. Canberra: AIHW

Relational attributes

Related metadata references:	See also Person—type of substance used illicitly, drug of concern (ASCDC 2000 extended) code NNNN Community Services, Standard 06/02/2012, Health, Standard 25/08/2011
Implementation in Data Set Specifications:	Substances used illicitly cluster Health, Standard 25/08/2011

Suburb/town/locality name within address

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Address—suburb/town/locality name, text X[46]

Synonymous names: Suburb name; Locality name

METeOR identifier: 429889

Registration status: Community Services, Standard 06/02/2012
Health, Standard 07/12/2011
Early Childhood, Standard 09/03/2012

Definition: The name of the locality/suburb of the address, as represented by text.

Data Element Concept: Address—suburb/town/locality name

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: X[46]

Maximum character length: 46

Data element attributes

Collection and usage attributes

Guide for use: The suburb/town/locality name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community.

This metadata item may be used to describe the location of an organisation or person. It can be a component of a street or postal address.

If used for mailing purposes, the format of this data element should be upper case. Refer to Australia Post Address Presentation Standard. Any forced abbreviations shall be done by truncation from the right.

This data element is one of a number of items that can be used to create a primary address, as recommended by the AS 4590-2006 *Interchange of client information* standard. Components of the primary address are:

- Address site (or Primary complex) name
- Address number or number range
- Road name (name/type/suffix)

- Locality
- State/Territory
- Postcode (optional)
- Country (if applicable).

Comments: Official locality names and their associated boundary extents are assigned by relevant state naming committees/protocols. Their correct usage is encouraged.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references:

See also Address—statistical area, level 2 (SA2) code (ASGS 2011) N(9) Community Services, Standard 06/12/2011, Health, Standard 07/12/2011

Supersedes Person (address)—suburb/town/locality name, text [A(50)] Community Services, Superseded 06/02/2012, Housing assistance, Standard 23/08/2010, Health, Superseded 07/12/2011, Early Childhood, Superseded 09/03/2012, Homelessness, Standard 23/08/2010, Tasmanian Health, Proposed 28/09/2011

Supersedes Service provider organisation (address)—suburb/town/locality name, text [A(50)] Community Services, Superseded 06/02/2012, Housing assistance, Recorded 13/10/2011, Health, Superseded 07/12/2011, Early Childhood, Superseded 09/03/2012, Tasmanian Health, Proposed 28/09/2011

Supersedes Workplace (address)—suburb/town/locality name, text [A(50)] Health, Superseded 07/12/2011, Tasmanian Health, Proposed 30/09/2011

Implementation in Data Set Specifications: Public hospital establishment address details DSS Health, Standard 07/12/2011

Supported mental health housing places

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Specialised mental health service—supported mental health housing places, total NNNNNN

METeOR identifier: 390929

Registration status: Health, Standard 07/12/2011

Definition: The total number of housing places supported by specialised mental health services available at 30 June, targeted to people affected by mental illness or psychiatric disability.

Data Element Concept: Specialised mental health service—supported mental health housing places

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: NNNNNN

Maximum character length: 6

Source and reference attributes

Steward: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: These are places made available by public housing authorities, health departments or non-government organisations (NGOs) under an agreement with the relevant State or Territory government authority responsible for funding mental health services. Such agreements commit the State or Territory funding authority to ensure provision of assistance to people within their homes through ongoing clinical and/or psychosocial rehabilitation support for their mental illness, including outreach services.

To be counted as a supported mental health housing place there must be a clear link between the housing place and the provision of clinical or psychosocial support by trained staff.

'Place' refers to number of supported places (beds) available for mental health consumers as at 30 June. It is not a count of consumers supported through the year nor a count of physical residences.

Excludes residential mental health services defined as specialised mental health services.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Specialised mental health service—number of supported public housing places, total N[N(5)] Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Surgery target site

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Cancer treatment—surgery target site, topography code (ICD-O-3) ANN.N

METeOR identifier: 393415

Registration status: Health, Standard 07/12/2011

Definition: The target site of cancer-directed surgery performed during the initial course of treatment for cancer, as represented by an ICD-O-3 code.

Data Element Concept: Cancer treatment—surgery target site

Value domain attributes

Representational attributes

Classification scheme: International Classification of Diseases for Oncology 3rd edition

Representation class: Code

Data type: String

Format: ANN.N

Maximum character length: 5

Collection and usage attributes

Guide for use: Record all four alphanumeric characters of the topography code. The number after the decimal point represents the subsite or subcategory.

Data element attributes

Collection and usage attributes

Guide for use: The target site is collected for all cancer-directed surgery performed during the initial course of treatment. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

Cancer-directed surgery refers to all surgery that destroys or modifies cancer tissue anywhere in the body.

Cancer-directed surgery may be palliative, (to control symptoms, alleviate pain, or make the patient more comfortable), or curative.

Target sites for biopsies that remove the entire tumour and/or leave only microscopic margins are to be recorded here.

All sites or regions targeted for cancer-directed surgery during the initial course of treatment should be recorded. There may be more than one site targeted for treatment. For example, the primary tumour site and the site of a distant metastasis may receive cancer-directed surgery as part of the initial course of treatment.

The target site for radiotherapy is collected as a separate item.

Collection methods: This information should be obtained from the patient's medical record.

Comments: This is collected to identify which anatomical structures are targeted by surgery and is useful in evaluating patterns of care and patient outcomes.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references: See also Cancer treatment—surgical procedure date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—surgical procedure for cancer, procedure code (ACHI 7th edn) NNNNN-NN Health, Standard 07/12/2011

See also Surgical procedure Health, Standard 07/12/2011

Implementation in Data Set Specifications: Surgery for cancer cluster Health, Standard 07/12/2011

Surgical procedure date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Cancer treatment—surgical procedure date, DDMMYYYY

METeOR identifier: 393424

Registration status: Health, Standard 07/12/2011

Definition: The date on which a cancer-directed surgical procedure was performed during the initial course of treatment for cancer, expressed as DDMMYYYY.

Data Element Concept: Cancer treatment—surgical procedure date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: The surgical procedure date is collected for all cancer-directed surgery delivered to the patient during initial treatment for cancer. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease recurrence or progression.

Cancer-directed surgery refers to all surgery that destroys or modifies cancer tissue anywhere in the body.

Cancer-directed surgery may be palliative (to control symptoms, alleviate pain, or make the patient more comfortable), or curative.

The date of each surgical treatment episode should be entered separately.

Procedure dates for biopsies that remove all of the tumour and/or leave only microscopic margins are to be recorded here.

Dates for radiotherapy and systemic treatments are collected as separate items.

Collection methods: This information should be obtained from the patient's medical record.

Comments: Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references:

See also Cancer treatment—surgery target site, topography code (ICD-O-3) ANN.N Health, Standard 07/12/2011

Supersedes Cancer treatment—surgical procedure date, DDMMYYYY Health, Superseded 07/12/2011

See also Cancer treatment—surgical procedure for cancer, procedure code (ACHI 7th edn) NNNNN-NN Health, Standard 07/12/2011

See also Surgical procedure Health, Standard 07/12/2011

Implementation in Data Set Specifications: Surgery for cancer cluster Health, Standard 07/12/2011

Surgical procedure for cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—surgical procedure for cancer, procedure code (ACHI 7th edn) NNNNN-NN
METeOR identifier:	393426
Registration status:	Health, Standard 07/12/2011
Definition:	The cancer-directed surgical procedure performed during the initial course of treatment for cancer, as represented by a code.
Data Element Concept:	Cancer treatment—surgical procedure for cancer

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 7th edition
Representation class:	Code
Data type:	Number
Format:	NNNNN-NN
Maximum character length:	7

Data element attributes

Collection and usage attributes

Guide for use:

The procedure code is collected for all cancer-directed surgery performed during initial treatment for cancer. The initial treatment includes all treatments performed from diagnosis and before disease progression or recurrence.

Cancer-directed surgery refers to all surgery that destroys or modifies cancer tissue anywhere in the body.

Cancer-directed surgery may be palliative (to control symptoms, alleviate pain, or make the patient more comfortable), or curative.

Biopsies that remove the entire tumour and/or leave only microscopic margins are to be recorded here.

The procedure code for each surgical treatment episode should be entered separately.

Endocrine surgery for the purpose of modifying hormone levels is recorded with data element *Cancer treatment—systemic therapy procedure, code N[N].*

Collection methods:

This information should be obtained from the patient's medical record.

Comments: The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: National Centre for Classification in Health

New South Wales Department of Health, Public Health Division

Reference documents: Public Health Division 2001. NSW Clinical Cancer Data Collection for Outcomes and Quality: Data Dictionary, Version 1. Sydney:NSW Health Department

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references: See also Cancer treatment—surgery target site, topography code (ICD-O-3) ANN.N Health, Standard 07/12/2011

See also Cancer treatment—surgical procedure date, DDMMYYYY Health, Standard 07/12/2011

Supersedes Cancer treatment—surgical procedure for cancer, procedure code (ACHI 7th edn) NNNNN-NN Health, Superseded 07/12/2011

See also Surgical procedure Health, Standard 07/12/2011

Implementation in Data Set Specifications: Surgery for cancer cluster Health, Standard 07/12/2011

Surgical specialty

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—surgical specialty (of scheduled doctor), code NN
METeOR identifier:	270146
Registration status:	Health, Standard 01/03/2005
Definition:	The area of clinical expertise held by the doctor who will perform the elective surgery, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—surgical specialty (of scheduled doctor)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Cardio-thoracic surgery
02	Ear, nose and throat surgery
03	General surgery
04	Gynaecology
05	Neurosurgery
06	Ophthalmology
07	Orthopaedic surgery
08	Plastic surgery
09	Urology
10	Vascular surgery
11	Other

Collection and usage attributes

Comments: The above classifications are consistent with the Recommended Medical Specialties and Qualifications agreed by the National Specialist Qualification Advisory Committee of Australia, September 1993. Vascular surgery is a subspecialty of general surgery. The Royal Australian College of Surgeons has a training program for vascular surgeons. The specialties listed above refer to the surgical component of these specialties - ear, nose and throat surgery refers to the surgical component of the specialty otolaryngology; gynaecology refers to the gynaecological surgical component of obstetrics and gynaecology; ophthalmology refers to the surgical component of the specialty (patients awaiting argon laser phototherapy are not included).

Data element attributes

Source and reference attributes

Submitting organisation: Hospital Access Program Waiting Lists Working Group
Waiting Times Working Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Surgical specialty, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (15.7 KB)

Implementation in Data Set Specifications: Elective surgery waiting times (census data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 30/09/2012

Elective surgery waiting times (removals data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 01/07/2012

Elective surgery waiting times cluster Health, Standard 07/12/2011

Systemic therapy agent or protocol

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—systemic therapy agent or protocol, text X[(149)]
METeOR identifier:	393623
Registration status:	Health, Standard 07/12/2011
Definition:	The systemic therapy agent or protocol administered during the initial course of treatment for cancer, as represented by text.
Data Element Concept:	Cancer treatment—systemic therapy agent or protocol

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[(149)]
Maximum character length:	150

Data element attributes

Collection and usage attributes

Guide for use:

Systemic therapy agents are drugs that travel through the bloodstream and reach and effect cells all over the body. They are administered orally or intravenously.

Each systemic therapy agent or protocol used during the initial treatment of the cancer should be recorded. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The name of each systemic therapy agent or protocol given as initial treatment is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of the treatment.

Oral systemic therapy agents normally given on an outpatient basis should also be included.

Systemic therapy agents may be administered as single-agent treatments or as a combination of drugs administered according to a prespecified regimen or protocol. A protocol is a precise and detailed plan for therapy that includes the type, quantity, method and length of time of taking the drugs required for any treatment cycle.

A combination of drugs may be known by acronyms but since details of drugs and acronyms may vary it is recommended that the name of each agent be recorded.

When recording systemic therapy protocol names, eviQ should be used wherever possible. eviQ Cancer Treatments Online is a point of care clinical information resource that provides health professionals with current evidence based, peer maintained, best practice cancer treatment protocols and information. It was developed and is maintained by the Cancer Institute NSW.

If a single agent is being used or a protocol is not included in eviQ, then the full, generic name of any agent should be recorded preferably using the Australian Medicines Terminology (AMT), or if necessary, the Australian Medicines Handbook (AMH) or MIMS. If a generic name is not available because the drug is experimental or under patent protection, record the brand name.

The eviQ protocol identifier number should be recorded separately in the data element *Cancer treatment—systemic therapy agent(s) or protocol, eviQ protocol identifier, NNNNNN*.

Systemic therapy agents are encompassed in the treatment modalities **chemotherapy**, **immunotherapy** and **hormone therapy** administered for the treatment of cancer.

A patient may receive treatment with a protocol that includes different types of systemic therapy agents, for example, a chemotherapy agent and an immunotherapy agent.

Targeted therapies (treatments that use drugs or other substances to identify and attack specific cancer cells) using a chemotherapy agent are included. Other targeted therapies, such as monoclonal antibody therapy, are recorded in the data element *Cancer treatment—other cancer treatment, text [X(150)]*.

Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment. Only record prednisone as hormone therapy when administered in combination with chemotherapy such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

Tumour involvement or cancer treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of the initial course of treatment.

Collection methods: This information should be collected from the patient's medical record.

Comments: Note the distinction between the administration of systemic agents or drugs and systemic therapy procedures that affect the hormonal or immunologic balance of the patient.

The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Stedman TL 2006. Stedman's medical dictionary. 28th edition. Maryland: Lippincott Williams & Wilkins

Standard Cancer Treatment and Management Pathways Program, Cancer Services and Education Division. eviQ Cancer Treatments Online. Cancer Institute NSW

The National Clinical Terminology and Information Service (NCTIS) 2011. Australian Medicines Terminology (AMT). Sydney: National E-Health Transition Authority (NEHTA). AMT releases are provided every month and are available from the NCTIS Secure Website

Australian Medicines Handbook (AMH). Australian Medicines Handbook Pty Ltd

MIMS Medicines Information. St Leonards, New South Wales: UBM Medica Pty Ltd

Relational attributes

Related metadata references: See also Cancer treatment—cancer treatment type, code N Health, Superseded 07/12/2011

See also Cancer treatment—chemotherapy completion date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—chemotherapy cycles administered, number of cycles N[NN] Health, Standard 07/12/2011

See also Cancer treatment—chemotherapy start date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—hormone therapy completion date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—hormone therapy start date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—immunotherapy completion date, DDMMYYYY Health, Standard 07/12/2011

See also Cancer treatment—immunotherapy start date, DDMMYYYY Health, Standard 07/12/2011

Supersedes Cancer treatment—systemic therapy agent name (primary cancer), antineoplastic drug code (Self-Instructional Manual for Tumour Registrars Book 8 3rd edn) X[X(39)] Health, Superseded 07/12/2011

See also Cancer treatment—systemic therapy agent or protocol, eviQ protocol identifier, NNNNNN Health, Standard 07/12/2011

Implementation in Data Set Specifications:

Chemotherapy for cancer cluster Health, Standard 07/12/2011

Hormone therapy for cancer cluster Health, Standard 07/12/2011

Immunotherapy for cancer cluster Health, Standard 07/12/2011

Systemic therapy agent or protocol, eviQ

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—systemic therapy agent or protocol, eviQ protocol identifier, NNNNNN
METeOR identifier:	444090
Registration status:	Health, Standard 07/12/2011
Definition:	The eviQ protocol identifier for the systemic therapy agent protocol administered during the initial course of treatment for cancer.
Data Element Concept:	Cancer treatment—systemic therapy agent or protocol

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	NNNNNN
Maximum character length:	6

Collection and usage attributes

Guide for use:	The eviQ protocol identifier must always be recorded as a six digit number, with leading zeros if applicable, for example, 000123.
Collection methods:	eviQ protocol identifiers are available from the eviQ Cancer Treatments Online website.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Standard Cancer Treatment and Management Pathways Program, Cancer Services and Education Division. eviQ Cancer Treatments Online. Cancer Institute NSW Commission on Cancer, American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision Stedman TL 2006. Stedman's Medical Dictionary. 28th edition. Maryland: Lippincott Williams & Wilkins

Data element attributes

Collection and usage attributes

Guide for use:	eviQ Cancer Treatments Online is a point of care clinical

information resource that provides health professionals with current evidence based, peer maintained, best practice cancer treatment protocols and information. It was developed and is maintained by the Cancer Institute NSW.

Record the six digit eviQ protocol identifier (where available) for each systemic therapy agent protocol administered to the patient during the initial treatment of the cancer. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

Systemic therapy agents are drugs that travel through the bloodstream and reach and effect cells all over the body. They are administered orally or intravenously.

Systemic therapy may involve a single agent or a combination regimen of two or more drugs. They are administered in treatment cycles.

A protocol is a precise and detailed plan for therapy that includes the type, quantity, method and length of time of taking the drugs required for any treatment cycle.

The systemic therapy agent eviQ protocol identifier applies to **chemotherapy**, **hormone therapy** and **immunotherapy** administered for the treatment of cancer.

Collection methods: This name of the protocol should be obtained from the patient's medical record.

Comments: The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Submitting organisation: Cancer Australia.

Origin: Cancer Institute NSW, eviQ Cancer Treatments Online.

Reference documents: Standard Cancer Treatment and Management Pathways Program, Cancer Services and Education Division. eviQ Cancer Treatments Online. Cancer Institute NSW.

Relational attributes

Related metadata references: See also Cancer treatment—systemic therapy agent or protocol, text X[(149)] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Chemotherapy for cancer cluster Health, Standard 07/12/2011

Conditional obligation:
Conditional on the administration of systemic therapy agents according to a prespecified regimen or protocol, and on the availability of the protocol number on the eviQ website.

Hormone therapy for cancer cluster Health, Standard 07/12/2011

> *Conditional obligation:*
> Conditional on the administration of systemic therapy agents according to a prespecified regimen or protocol, and on the availability of the protocol number on the eviQ website.

Immunotherapy for cancer cluster Health, Standard 07/12/2011

> *Conditional obligation:*
> Conditional on the administration of systemic therapy agents according to a prespecified regimen or protocol, and on the availability of the protocol number on the eviQ website.

Systemic therapy procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—systemic therapy procedure, code N[N]
Synonymous names:	Haematologic transplant, endocrine procedures
METeOR identifier:	394697
Registration status:	Health, Standard 07/12/2011
Definition:	The **systemic therapy procedure** administered during the initial course of treatment for cancer, as represented by a code.
Data Element Concept:	Cancer treatment—systemic therapy procedure

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:	Value	Meaning
	1	A bone marrow transplant procedure was administered but the type was not specified
	2	Bone marrow transplant—autologous only
	3	Bone marrow transplant—allogeneic only
	4	Stem cell harvest and infusion only
	5	Endocrine surgery and/or endocrine radiation therapy only
	6	Combination of endocrine surgery and/or radiation with a transplant procedure
	96	Other systemic therapy procedure
Supplementary values:	97	Not applicable-no systemic therapy procedures were administered
	98	Unknown whether systemic therapy procedures were administered
	99	Systemic therapy procedures were administered but were not stated/inadequately described

Collection and usage attributes

Guide for use: Systemic therapy procedures are medical, surgical or radiation procedures that have an effect on the hormonal or immunological balance of the patient, and refers to haematologic transplant and endocrine procedures.

Source and reference attributes

Submitting organisation: Cancer Australia.

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer, 28D-28E, 182-183.

Data element attributes

Collection and usage attributes

Guide for use: Systemic therapy procedures refers to haematologic transplant and endocrine procedures. Haematologic transplants are bone marrow or stem cell transplants performed to protect patients from myelosuppression or bone marrow ablation associated with the administration of high-dose chemotherapy or radiotherapy.

Endocrine therapy is cancer therapy that achieves its antitumour effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient (when the cancer occurs at another site) and, therefore, alter or affect the long-term control of the cancer's growth.

Haematologic transplant or endocrine procedures may be provided to prolong a patient's life by controlling symptoms, to alleviate pain, or make the patient more comfortable.

Each systemic therapy procedure delivered to the patient during the initial treatment for cancer should be recorded. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease recurrence or progression.

The procedure code for each treatment episode should be entered separately.

Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.

Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.

Endocrine procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.

Collection methods: This information should be obtained from the patient's medical record.

Comments: The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Note the distinction between the administration of systemic agents or drugs and systemic therapy procedures that affect the hormonal or immunologic balance of the patient.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Relational attributes

Related metadata references: See also Cancer treatment—systemic therapy procedure date, DDMMYYYY Health, Standard 07/12/2011

Implementation in Data Set Specifications: Systemic therapy procedure for cancer cluster Health, Standard 07/12/2011

Systemic therapy procedure date

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Cancer treatment—systemic therapy procedure date, DDMMYYYY

Synonymous names: Haematologic transplant, endocrine procedures

METeOR identifier: 394581

Registration status: Health, Standard 07/12/2011

Definition: The date on which a **systemic therapy procedure** was administered during the initial course of treatment for cancer, expressed as DDMMYYYY.

Data Element Concept: Cancer treatment—systemic therapy procedure date

Value domain attributes

Representational attributes

Representation class: Date

Data type: Date/Time

Format: DDMMYYYY

Maximum character length: 8

Data element attributes

Collection and usage attributes

Guide for use: The date is collected for all systemic therapy procedures administered to the patient during the initial treatment for cancer. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease recurrence or progression.

A systemic therapy procedure is a medical, surgical or radiation procedure that has an effect on the hormonal or immunologic balance of the patient, and refers to haematologic transplant and endocrine procedures. Haematologic transplants are bone marrow or stem cell transplants performed to protect patients from myelosuppression or bone marrow ablation associated with the administration of high-dose chemotherapy or radiotherapy.

Endocrine therapy is cancer therapy that achieves its antitumour effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient (when the cancer occurs at another site) and, therefore, alter or affect the long-term control of the cancer's growth.

Haematologic transplant or endocrine procedures may be provided to prolong a patient's life by controlling symptoms, to alleviate pain, or make the patient more comfortable.

The date of each treatment episode should be entered separately.

The date of cancer-directed surgery, radiotherapy and treatment with systemic agents are collected as separate items.

Collection methods: This information should be obtained from the patient's medical record.

Comments: Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Note the distinction between the administration of systemic agents or drugs and systemic therapy procedures that affect the hormonal or immunologic balance of the patient.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references: See also Cancer treatment—systemic therapy procedure, code N[N] Health, Standard 07/12/2011

See also Systemic therapy procedure Health, Standard 07/12/2011

Implementation in Data Set Specifications: Systemic therapy procedure for cancer cluster Health, Standard 07/12/2011

Teaching status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—teaching status (university affiliation), code N
METeOR identifier:	270148
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator to identify the non-direct patient care activity of teaching for a particular establishment, as represented by a code.
Data Element Concept:	Establishment—teaching status (university affiliation)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Unknown

Data element attributes

Collection and usage attributes

Guide for use:

In this context, teaching relates to teaching hospitals affiliated with universities providing undergraduate medical education as advised by the relevant state health authority.

Comments:

The initial intention based on the Taskforce on National Hospital Statistics approach had been to have non-direct care activity indicators for all of the following non-direct patient care activities:

- teaching
- research
- group or community contacts
- public health activities
- mobile centre and/or part-time service.

However, the Resources Working Party decided to delete 2, 3, 4 and 5 and place the emphasis on teaching where teaching (associated with a university) was a major program activity of the hospital. The working party took the view that it was extremely difficult to identify research activities in health institutions because many staff consider that they do research as part of their usual duties. The research indicator was thus deleted and the teaching indicator was agreed to relate to teaching hospitals affiliated with universities providing undergraduate medical education, as advised by the relevant state health authority. If a teaching hospital is identified by a Yes/no indicator then it is not necessary to worry about research (based on the assumption that if you have teaching, you have research).

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Teaching status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Team Care Arrangement (MBS Item 723) indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—Team Care Arrangement (MBS Item 723) indicator, yes/no code N
METeOR identifier:	441521
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a person has received a Team Care Arrangement (MBS Item 723), as represented by a code.
Data Element Concept:	Person—Team Care Arrangement (MBS Item 723) indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A person has received a Team Care Arrangement.

CODE 2 No

A person has not received a Team Care Arrangement.

Comments:

The Chronic Disease Management Medicare items on the Medicare Benefits Schedule (MBS) enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers. The items are designed for patients who require a structured approach to their care. A ‘chronic medical condition’ is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular disease, diabetes mellitus and musculoskeletal conditions (Department of Health and Ageing 2011a).

Team Care Arrangements (TCAs) are required by legislation to include a document that describes:

- treatment and service goals for the patient
- treatment and services that collaborating providers will provide to the patient
- actions to be taken by the patient
- a date to review these matters (Department of Health and Ageing 2011b).

This chronic disease management service is for a patient who:

(a) has at least one medical condition that:

i. has been (or is likely to be) present for at least six months; or

ii. is terminal; and

(b) requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner (Department of Health and Ageing 2011c).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Origin: Department of Health and Ageing 2011a. Department of Health and Ageing, Canberra. Viewed 27 May 2011, <http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement>

Department of Health and Ageing 2011b. Team Care Arrangements (Medicare item 723). Department of Health and Ageing, Canberra. Viewed 27 May 2011, <http://www.health.gov.au/internet/main/publishing.nsf/Content/81BB2DB118217838CA2576710015F3B3/$File/Important%20Reminders%20About%20GPMPs%20Nov%2009.pdf>

Department of Health and Ageing 2011c. Medicare Benefits Schedule – Item 723. Department of Health and Ageing, Canberra. Viewed 27 May 2011, <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=723>

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS Health, Standard 07/12/2011

Conditional obligation:

This item is only collected for persons who have Type II diabetes.

Telephone number

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—telephone number, text [X(40)]

METeOR identifier: 270266

Registration status: Community Services, Superseded 06/02/2012
Health, Standard 01/03/2005

Definition: The person's contact telephone number, as represented by text.

Data Element Concept: Person—telephone number

Value domain attributes

Representational attributes

Representation class: Text

Data type: String

Format: [X(40)]

Maximum character length: 40

Data element attributes

Collection and usage attributes

Guide for use: More than one phone number may be recorded as required. Each phone number should have an appropriate telephone number type code assigned. Record the full phone number (including any prefixes) with no punctuation (hyphens or brackets).

Collection methods: Prefix plus telephone number:

Record the prefix plus telephone number. The default should be the local prefix with an ability to overtype with a different prefix.

For example, 08 8226 6000 or 0417 123456.

Punctuation:

Do not record punctuation.

For example, (08) 8226 6000 or 08-8226 6000 would not be correct.

Unknown:

Leave the field blank.

Comments: Concerned with the use of person identification data. For organisations that create, use or maintain records on people. Organisations should use this standard, where appropriate, for collecting data when registering people. The positive and unique identification of people is a critical event in service delivery, with direct implications for the safety and quality of care delivered by health and community services.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Committee

National Community Services Data Committee

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references: Supersedes Telephone number, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (15.4 KB)

Telephone number type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (telephone)—telephone number type, code A
METeOR identifier:	270299
Registration status:	Community Services, Standard 01/03/2005 Health, Standard 01/03/2005
Definition:	The type of telephone number recorded for a person, as represented by a code.
Data Element Concept:	Person (telephone)—telephone number type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
B	Business or work
H	Home
M	Personal mobile
N	Contact number (not own)
O	Business or work mobile
T	Temporary

Data element attributes

Collection and usage attributes

Guide for use: Where more than one telephone number has been recorded, then each telephone number should have the appropriate telephone number type code assigned.

Comments: Concerned with the use of person identification data. For organisations that create, use or maintain records on people. Organisations should use this standard, where appropriate, for collecting data when registering people. The positive and unique identification of people is a critical event in service delivery, with direct implications for the safety and quality of care delivered by health and community services.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee
Reference documents:	Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Telephone number type, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (15.5 KB)

Time C-reactive protein level measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—C-reactive protein level measured time, hhmm
Synonymous names:	CRP measured time
METeOR identifier:	343853
Registration status:	Health, Standard 01/10/2008
Definition:	The time the person's C-reactive protein (CRP) level is measured.
Data Element Concept:	Person—C-reactive protein level measured time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Collection methods:	The time C-reactive protein (CRP) is measured should be recorded from the laboratory report.

Relational attributes

Related metadata references:	See also Person—C-reactive protein level (measured), total milligrams per litre N[NN].N Health, Standard 01/10/2008 See also Person—C-reactive protein level measured date, DDMMYYYY Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time creatine kinase MB isoenzyme measured

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—creatine kinase myocardial band isoenzyme measured time, hhmm

METeOR identifier: 285179

Registration status: Health, Standard 04/06/2004

Definition: The time at which the person's creatine kinase myocardial band (CK-MB) isoenzyme was measured.

Data Element Concept: Person—creatine kinase myocardial band isoenzyme measured time

Value domain attributes

Representational attributes

Representation class: Time

Data type: Date/Time

Format: hhmm

Maximum character length: 4

Source and reference attributes

Reference documents: ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use: Record the time in 24-hour clock format.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Time creatine kinase MB isoenzyme (CK-MB) measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.2 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of acute coronary syndrome related clinical event

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person with acute coronary syndrome—acute coronary syndrome related clinical event time, hhmm

METeOR identifier: 349809

Registration status: Health, Standard 01/10/2008

Definition: The time a person experienced an acute coronary syndrome related clinical event.

Data Element Concept: Person with acute coronary syndrome—acute coronary syndrome related clinical event time

Value domain attributes

Representational attributes

Representation class: Time

Data type: Date/Time

Format: hhmm

Maximum character length: 4

Source and reference attributes

Reference documents: ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use: A time should be recorded for each of the specified clinical events that the person experiences.

Comments: An acute coronary syndrome (ACS) related clinical event is a clinical event which can affect the health outcomes of a person with ACS.

Information on the occurrence of these clinical events in people with ACS is required due to an emerging appreciation of their relationship with late mortality.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome clinical event cluster Health, Standard 01/10/2008

Conditional obligation:
If a clinical event has occurred, record the time when it was experienced by the person.

Time of diagnostic cardiac catheterisation

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—diagnostic cardiac catheterisation time, hhmm

Synonymous names: Time of coronary angiography

METeOR identifier: 359777

Registration status: Health, Standard 01/10/2008

Definition: The time when cardiac catheterisation is performed for diagnostic purposes.

Data Element Concept: Person—diagnostic cardiac catheterisation time

Value domain attributes

Representational attributes

Representation class: Time

Data type: Date/Time

Format: hhmm

Maximum character length: 4

Source and reference attributes

Reference documents: ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use: This metadata item includes coronary angiography which is performed using a catheter.

Source and reference attributes

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of electrocardiogram

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram— electrocardiogram time, hhmm
Synonymous names:	Time of ECG
METeOR identifier:	343831
Registration status:	Health, Standard 01/10/2008
Definition:	The time at which an electrocardiogram (ECG) is performed for a person.
Data Element Concept:	Electrocardiogram—electrocardiogram time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Collection methods:	The time of ECG should be recorded irrespective of the setting (e.g. pre-hospital setting, emergency department or inpatient ward). The time of ECG should be recorded each time an ECG is performed.

Relational attributes

Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008

Time of implantable cardiac defibrillator procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—implantable cardiac defibrillator procedure time, hhmm
Synonymous names:	ICD procedure time
METeOR identifier:	359678
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a procedure is performed for insertion of an implantable cardiac defibrillator (ICD).
Data Element Concept:	Person—implantable cardiac defibrillator procedure time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of intra-aortic balloon pump procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—intra-aortic balloon pump procedure time, hhmm
METeOR identifier:	359691
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a procedure is performed for insertion of an intra-aortic balloon pump.
Data Element Concept:	Person—intra-aortic balloon pump procedure time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of intravenous fibrinolytic therapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—intravenous fibrinolytic therapy time, hhmm
METeOR identifier:	360949
Registration status:	Health, Standard 01/10/2008
Definition:	The time intravenous (IV) fibrinolytic therapy was first administered to a person.
Data Element Concept:	Person—intravenous fibrinolytic therapy time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	If initiated by a bolus dose whether in a pre-hospital setting, emergency department or inpatient unit/ward, the time the initial bolus was administered should be recorded.
Comments:	This is used to calculate the time between initial presentation and reperfusion.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—intravenous fibrinolytic therapy time, hhmm Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008 *Conditional obligation:* If prescribed, provide the time when the fibrinolytic

therapy is administered.

Time of non-invasive ventilation administration

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—non-invasive ventilation administration time, hhmm
METeOR identifier:	359647
Registration status:	Health, Standard 01/10/2008
Definition:	The time of administration of non-invasive ventilation.
Data Element Concept:	Person—non-invasive ventilation administration time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of onset of acute coronary syndrome symptoms

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—acute coronary syndrome symptoms onset time, hhmm
METeOR identifier:	321211
Registration status:	Health, Standard 01/10/2008
Definition:	The time at which a person experienced acute coronary syndrome symptoms that prompted a person to seek medical attention, either at the hospital or from a general practitioner.
Data Element Concept:	Person—acute coronary syndrome symptoms onset time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:

Acute coronary syndrome symptoms may include:

- tightness, pressure, heaviness, fullness or squeezing in the chest which may spread to the neck and throat, jaw, shoulders, the back, upper abdomen, either or both arms and even into the wrists and hands
- dyspnoea, nausea/vomiting, cold sweat or syncope.

Seeking medical attention could include the person presenting to their GP who then refers them to hospital or the person presenting directly to hospital (via ambulance or own form of transport).

If the person is already a patient at the hospital for another reason then the time recorded would be when they advised hospital staff of their symptoms.

Collection methods: Record the time of onset of the most significant acute coronary syndrome symptom/s that prompted the person to seek medical attention (from the person's perspective).

Relational attributes

Related metadata references: See also Person—acute coronary syndrome symptoms onset date, DDMMYYYY Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of pacemaker insertion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—pacemaker insertion time, hhmm
METeOR identifier:	359662
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a procedure is performed for insertion of a pacemaker.
Data Element Concept:	Person—pacemaker insertion time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of primary percutaneous coronary intervention

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—primary percutaneous coronary intervention time, hhmm

Synonymous names: Primary PCI time

METeOR identifier: 359201

Registration status: Health, Standard 01/10/2008

Definition: The time of the primary percutaneous coronary intervention (PCI).

Data Element Concept: Person—primary percutaneous coronary intervention time

Value domain attributes

Representational attributes

Representation class: Time

Data type: Date/Time

Format: hhmm

Maximum character length: 4

Source and reference attributes

Reference documents: ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use: Primary PCI relates to the first balloon angioplasty inflation and/or stent implantation for reperfusion therapy of a ST-segment-elevation myocardial infarction (STEMI). The time of the first balloon inflation should be recorded, even if this includes the implantation of a stent.

Comments: This is used to calculate the time between initial presentation and reperfusion.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Related metadata references: Supersedes Person—first angioplasty balloon inflation or stenting time, hhmm Health, Superseded 01/10/2008

Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008 *Conditional obligation:* Record when a primary percutaneous coronary intervention is performed.

Time of rescue percutaneous coronary intervention

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—rescue percutaneous coronary intervention time, hhmm

Synonymous names: Rescue PCI time

METeOR identifier: 359569

Registration status: Health, Standard 01/10/2008

Definition: The time when rescue percutaneous coronary intervention (PCI) is performed.

Data Element Concept: Person—rescue percutaneous coronary intervention time

Value domain attributes

Representational attributes

Representation class: Time

Data type: Date/Time

Format: hhmm

Maximum character length: 4

Source and reference attributes

Reference documents: ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use: Rescue PCI relates to balloon angioplasty inflation and/or stent implantation performed following failed fibrinolysis in patients with continuing or recurrent myocardial ischaemia.

Source and reference attributes

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications: Coronary artery cluster Health, Standard 01/10/2008

Conditional obligation:

Record when a rescue percutaneous coronary intervention is performed.

Time of revascularisation percutaneous coronary intervention

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—revascularisation percutaneous coronary intervention time, hhmm

Synonymous names: Revascularisation PCI time

METeOR identifier: 359738

Registration status: Health, Standard 01/10/2008

Definition: The time when a percutaneous coronary intervention (PCI) is performed for revascularisation.

Data Element Concept: Person—revascularisation percutaneous coronary intervention time

Value domain attributes

Representational attributes

Representation class: Time

Data type: Date/Time

Format: hhmm

Maximum character length: 4

Source and reference attributes

Reference documents: ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use: Revascularisation PCI relates to balloon angioplasty inflation and/or stent implantation performed for subsequent restoration of blood flow.

Comments: Routine revascularisation PCI may be performed after ST-segment-elevation myocardial infarction for people with objective evidence of recurrent myocardial infarction in whom there is spontaneous or inducible ischaemia or haemodynamic instability. Revascularisation PCI may also be performed for treatment of high-risk non-ST-segment-elevation acute coronary syndrome.

Source and reference attributes

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Reference documents: National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specifications: Coronary artery cluster Health, Standard 01/10/2008

Conditional obligation:

Record when a percutaneous coronary intervention is performed for revascularisation.

Time of triage

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—triage time, hhmm
Synonymous names:	Triage time
METeOR identifier:	474193
Registration status:	Health, Standard 30/01/2012
Definition:	The time at which the patient is **triaged**, expressed as hhmm.
Context:	Emergency department care.
Data Element Concept:	Non-admitted patient emergency department service episode—triage time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	This data element should not be completed for patients who have a Type of visit of 'Dead on arrival'.
Collection methods:	Collected in conjunction with the data element 'Non-admitted patient emergency department service episode—triage date, DDMMYYYY'.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:	See also Non-admitted patient emergency department service episode—triage date, DDMMYYYY Health,

Standard 30/01/2012

Supersedes Non-admitted patient emergency department service episode—triage time, hhmm Health, Superseded 30/01/2012

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:

This data item is to be recorded for patients who have one of the following Type of visit values recorded:

- Emergency department presentation;
- Return visit, planned;
- Pre-arranged admission;
- Patient in transit.

Time of ventricular ejection fraction test

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Ventricular ejection fraction test—test time, hhmm
Synonymous names:	Time EF measured
METeOR identifier:	349817
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a person's ventricular ejection fraction is measured.
Data Element Concept:	Ventricular ejection fraction—test time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Relational attributes

Implementation in Data Set Specifications:

Ventricular ejection fraction cluster Health, Standard 01/10/2008

Conditional obligation:

To be provided when the ventricular ejection fraction is measured.

Time patient presents

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—presentation time, hhmm
METeOR identifier:	471889
Registration status:	Health, Standard 22/12/2011
Definition:	The time at which the patient presents for the delivery of an emergency department service, expressed as hhmm.
Data Element Concept:	Emergency department stay—presentation time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	The time of patient presentation at the emergency department is the time of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process, whichever happens first.

Source and reference attributes

Submitting organisation:	National Institution Based Ambulatory Model Reference Group
Origin:	National Health Data Committee

Relational attributes

Related metadata references:	See also Health service event—presentation time, hhmm Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011 Is used in the formation of Non-admitted patient

emergency department service episode—service episode length, total minutes NNNNN Health, Superseded 30/01/2012

Is used in the formation of Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN Health, Standard 30/01/2012

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Time patient presents

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Health service event—presentation time, hhmm

METeOR identifier: 270080

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: The time at which the patient presents for the delivery of a service.

Data Element Concept: Health service event—presentation time

Value domain attributes

Representational attributes

Representation class: Time

Data type: Date/Time

Format: hhmm

Maximum character length: 4

Source and reference attributes

Reference documents: ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use: For community health care, outreach services and services provided via telephone or telehealth, this may be the time at which the service provider presents to the patient or the telephone/telehealth session commences.

The time of patient presentation at the **emergency department** is the earliest occasion of being registered clerically or triaged.

The time that the patient presents is not necessarily:

- the listing time for care (see listing date for care for an analogous concept), nor
- the time at which care is scheduled to be provided, nor
- the time at which commencement of care actually occurs (for admitted patients see admission time, for hospital non-admitted patient care and community health care see service commencement time).

Source and reference attributes

Submitting organisation: National Institution Based Ambulatory Model Reference Group

Origin: National Health Data Committee

Relational attributes

Related metadata references:

See also Emergency department stay—presentation time, hhmm Health, Standard 22/12/2011

Is used in the formation of Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN Health, Superseded 23/05/2012

Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005

Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to service delivery), total minutes NNNNN Health, Superseded 22/12/2009

Supersedes Time patient presents, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.2 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time troponin measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin level measured time, hhmm
METeOR identifier:	359427
Registration status:	Health, Standard 01/10/2008
Definition:	The time at which the troponin (T or I) was measured.
Data Element Concept:	Person—troponin level measured time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item pertains to the measuring of troponin at any time point during this current event.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Person—troponin level measured time, hhmm Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Timing of ACE-inhibitor prescription

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—timing of ACE-inhibitor prescription, code N

METeOR identifier: 349385

Registration status: Health, Standard 01/10/2008

Definition: The timing of care when an ACE-inhibitor is prescribed to a person, as represented by a code.

Data Element Concept: Person—timing of ACE-inhibitor prescription

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Prior to presentation at hospital
	2	First 24 hours of presentation
	3	After 24 hours and before discharge
	4	At discharge
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed an ACE-inhibitor prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when an ACE-inhibitor is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when an ACE-inhibitor is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when an ACE-inhibitor is prescribed at discharge from the hospital.

Collection methods: Record each time an ACE-inhibitor is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome pharmacotherapy data cluster
Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide a phase for each time ACE-inhibitor therapy is prescribed.

Timing of angiotensin II receptor blocker prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of angiotensin II receptor blocker prescription, code N
METeOR identifier:	350421
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when an angiotensin II receptor blocker is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of angiotensin II receptor blocker prescription

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Prior to presentation at hospital
	2	First 24 hours of presentation
	3	After 24 hours and before discharge
	4	At discharge
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed an angiotensin II receptor blocker prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when an angiotensin II receptor blocker is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when an angiotensin II receptor blocker is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when an angiotensin II receptor blocker is prescribed at discharge from the hospital.

Collection methods: Record each time an angiotensin II receptor blocker is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide a phase for each time angiotensin II receptor blocker therapy is prescribed.

Timing of antithrombin therapy prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of antithrombin therapy prescription, code N
METeOR identifier:	350510
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when antithrombin therapy is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of antithrombin therapy prescription

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Initial medical management: preceding reperfusion therapy
	2	During reperfusion therapy
	3	Following reperfusion therapy
Supplementary values:	9	Not stated/inadequately described

Source and reference attributes

Reference documents: National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand, Guidelines for the management of acute coronary syndromes 2006, Med J Aust; 184; S1-S32. © MJA2006.

Data element attributes

Collection and usage attributes

Guide for use: Reperfusion therapy includes percutaneous coronary intervention and fibrinolytic therapy.

CODE 1 Initial medical management: preceding reperfusion therapy

Use this code when antithrombin therapy is prescribed before reperfusion therapy is to be performed.

CODE 2 During reperfusion therapy

Use this code when antithrombin therapy is prescribed while reperfusion therapy is being performed.

CODE 3 Following reperfusion therapy

Use this code when antithrombin therapy is prescribed after reperfusion therapy has been performed.

Collection methods: Record for each time antithrombin therapy is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:

If prescribed, provide a phase for each time antithrombin therapy is prescribed

Timing of aspirin prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of aspirin prescription, code N
METeOR identifier:	347829
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when aspirin is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of aspirin prescription

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Prior to presentation at hospital
	2	First 24 hours of presentation
	3	After 24 hours and before discharge
	4	At discharge
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed aspirin prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when aspirin is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when aspirin is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when aspirin is prescribed at discharge from the hospital.

Collection methods: Record each time aspirin is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome pharmacotherapy data cluster
Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide a phase for each time aspirin therapy is prescribed.

Timing of beta-blocker prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of beta-blocker prescription, code N
METeOR identifier:	349400
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when a beta-blocker is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of beta-blocker prescription

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	1	Prior to presentation at hospital
	2	First 24 hours of presentation
	3	After 24 hours and before discharge
	4	At discharge
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed a beta-blocker prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when a beta-blocker is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when a beta-blocker is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when a beta-blocker is prescribed at discharge from the hospital.

Collection methods: Record each time a beta-blocker is prescribed for a person.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome pharmacotherapy data cluster
Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide a phase for each time beta-blocker therapy is prescribed.

Timing of clopidogrel prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of clopidogrel prescription, code N
METeOR identifier:	350431
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when clopidogrel is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of clopidogrel prescription

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Prior to presentation at hospital
	2	First 24 hours of presentation
	3	After 24 hours and before discharge
	4	At discharge
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed clopidogrel prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when clopidogrel is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when clopidogrel is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when clopidogrel is prescribed at discharge from the hospital.

Collection methods: Record each time clopidogrel is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide a phase for each time clopidogrel therapy is prescribed.

Timing of glycoprotein IIb/IIIa inhibitor prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of glycoprotein IIb/IIIa inhibitor prescription, code N
METeOR identifier:	349367
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when a glycoprotein IIb/IIIa inhibitor is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of glycoprotein IIb/IIIa inhibitor prescription

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Initial medical management: preceding invasive management
	2	During invasive management
	3	Following invasive management
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Invasive management includes angiography, percutaneous coronary intervention and coronary artery bypass graft.

CODE 1 Initial medical management: preceding invasive management

Use this code when a glycoprotein IIb/IIIa inhibitor is prescribed before invasive management is to be performed.

CODE 2 During invasive management

Use this code when a glycoprotein IIb/IIIa inhibitor is prescribed while invasive management is being performed.

CODE 3 Following invasive management

Use this code when a glycoprotein IIb/IIIa inhibitor is prescribed after invasive management has been performed.

Collection methods:	Record each time a glycoprotein IIb/IIIa inhibitor is prescribed for a person.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008 *Conditional obligation:* If prescribed, provide a phase for each time glycoprotein IIb/IIIa inhibitor therapy is prescribed.

Timing of statin prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of statin prescription, code N
METeOR identifier:	350445
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when a statin is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of statin prescription

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	1	Prior to presentation at hospital
	2	First 24 hours of presentation
	3	After 24 hours and before discharge
	4	At discharge
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed a statin prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when a statin is prescribed for within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when an ACE-inhibitor is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when a statin is prescribed at discharge from the hospital.

Collection methods: Record each time a statin is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide a phase for each time statin therapy is prescribed.

Tobacco smoking frequency

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—tobacco smoking frequency, current tobacco smoking frequency code N

METeOR identifier: 416274

Registration status: Health, Standard 25/08/2011

Definition: How often a person now smokes a tobacco product, as represented by a code.

Data Element Concept: Person—tobacco smoking frequency

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Occasionally, but less than once a week
2	Occasionally, not every day, but at least once a week
3	Regularly, every day or most days

Collection and usage attributes

Guide for use: Only one option may be selected.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Person—current smoking status indicator, yes/no/not stated/inadequately described code N Health, Standard 25/08/2011

Implementation in Data Set Specifications: Smoking status cluster Health, Standard 25/08/2011

Conditional obligation:

Conditional on the person indicating that they currently smoke.

Tobacco smoking indicator, after 20 weeks of pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (pregnant)—tobacco smoking indicator (after twenty weeks of pregnancy), yes/no code N
METeOR identifier:	365417
Registration status:	Health, Standard 03/12/2008
Definition:	A self-reported indicator of whether a pregnant woman smoked tobacco at any time after the first 20 weeks of her pregnancy until the birth, as represented by a code
Context:	Perinatal Statistics
Data Element Concept:	Female (pregnant)—tobacco smoking indicator (after twenty weeks of pregnancy)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

Record if a woman smoked tobacco at any time after the first 20 weeks of pregnancy.

CODE 2 No

Record if a woman did not smoke tobacco at any time after the first 20 weeks of pregnancy.

Collection methods: Recommended question: 'Did the woman smoke at all after 20 weeks of pregnancy?', where after 20 weeks of pregnancy is defined as greater than or equal to 20 weeks + 0 days.

To ensure consistency of results, data should be collected after delivery.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also Female (pregnant)—tobacco smoking indicator (first twenty weeks of pregnancy), yes/no code N Health, Standard 03/12/2008

Implementation in Data Set Specifications: Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Tobacco smoking indicator, first 20 weeks of pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (pregnant)—tobacco smoking indicator (first twenty weeks of pregnancy), yes/no code N
METeOR identifier:	365404
Registration status:	Health, Standard 03/12/2008
Definition:	A self-reported indicator of whether a pregnant woman smoked tobacco at any time during the first 20 weeks of her pregnancy, as represented by a code
Context:	Perinatal Statistics
Data Element Concept:	Female (pregnant)—tobacco smoking indicator (first twenty weeks of pregnancy)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/ inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes Record if a woman smoked tobacco at any time during the first 20 weeks of pregnancy. CODE 2 No Record if a woman did not smoke tobacco at any time during the first 20 weeks of pregnancy.

Collection methods: Recommended question: 'Did the woman smoke at all during the first 20 weeks of pregnancy?', where the first 20 weeks of pregnancy is defined as less than or equal to 19 weeks + 6 days.

To ensure consistency of results, data should be collected after the first 20 weeks of pregnancy.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also Female (pregnant)—number of cigarettes smoked (per day after 20 weeks of pregnancy), number N[NN] Health, Standard 03/12/2008

See also Female (pregnant)—tobacco smoking indicator (after twenty weeks of pregnancy), yes/no code N Health, Standard 03/12/2008

Implementation in Data Set Specifications: Perinatal NMDS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Tobacco smoking start age

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking start age, total years N[NN]
METeOR identifier:	399292
Registration status:	Health, Standard 25/08/2011
Definition:	The age in years at which a person first started to smoke.
Data Element Concept:	Person—tobacco smoking start age

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[NN]	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	999	Unknown/not stated
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

Guide for use:

In this data collection, cigarette includes manufactured cigarettes, roll-your-own cigarettes, cigars, pipes and other tobacco products.

Comments:

The 2007 National Drug Strategy Household Survey includes a question on the age at which a person smoked their first full cigarette.

Questions on age first smoked full cigarette can provide some insight into the pattern of drug use among younger children (DHFS 1996).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin:

AIHW (Australian Institute of Health and Welfare) 2008. 2007 National Drug Strategy Household Survey: first results. Drug Statistics Series number 20.Cat. no. PHE 98. Canberra: AIHW

Reference documents:

AIHW 2009. From corrections to community: a set of indicators of the health of Australia’s prisoners. Bulletin 75. Cat no. AUS

120. Canberra: AIHW.

DHFS (Commonwealth Department of Health and Family Services) 1996. National Drug Strategy Household Survey: survey report 1995 Canberra: AGPS

Relational attributes

Implementation in Data Set Specifications:

Smoking status cluster Health, Standard 25/08/2011

Conditional obligation:

Conditional on the person indicating that they have ever smoked a full cigarette.

Tobacco smoking status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking status, code N
METeOR identifier:	270311
Registration status:	Health, Standard 01/03/2005
Definition:	A person's current and past smoking behaviour, as represented by a code.
Context:	Public health and health care
Data Element Concept:	Person—tobacco smoking status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Daily smoker
2	Weekly smoker
3	Irregular smoker
4	Ex-smoker
5	Never smoked

Collection and usage attributes

Guide for use:

CODE 1 Daily smoker

A person who smokes daily

CODE 2 Weekly smoker

A person who smokes at least weekly but not daily

CODE 3 Irregular smoker

A person who smokes less than weekly

CODE 4 Ex-smoker

A person who does not smoke at all now, but has smoked at least 100 cigarettes or a similar amount of other tobacco products in his/her lifetime.

CODE 5 Never-smoker

A person who does not smoke now and has smoked fewer than 100 cigarettes or similar amount of other tobacco products in his/her lifetime.

Source and reference attributes

Reference documents: Standard Questions on the Use of Tobacco Among Adults (1998)

Data element attributes

Collection and usage attributes

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults - interviewer administered (Questions 1 and 4) and self-administered (Questions 1 and 1a) versions. The questionnaires are designed to cover persons aged 18 years and over.

Comments: There are two other ways of categorising this information:

- Regular and irregular smokers where a regular smoker includes someone who is a daily smoker or a weekly smoker. 'Regular' smoker is the preferred category to be reported in prevalence estimates.
- Daily and occasional smokers where an occasional smoker includes someone who is a weekly or irregular smoker. The category of 'occasional' smoker can be used when the aim of the study is to draw contrast between daily smokers and other smokers.

  Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

Smoker type is used to define subpopulations of adults (age 18+ years) based on their smoking behaviour.

Smoking has long been known as a health risk factor. Population studies indicate a relationship between smoking and increased mortality/morbidity.

This data element can be used to estimate smoking prevalence. Other uses are:

- To evaluate health promotion and disease prevention programs (assessment of interventions)
- To monitor health risk factors and progress towards National Health Goals and Targets

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:	Supersedes Tobacco smoking status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.5 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Tobacco smoking status (diabetes mellitus)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—regular tobacco smoking indicator (last 3 months), code N
METeOR identifier:	302467
Registration status:	Health, Standard 21/09/2005
Definition:	Whether an individual has been a regular smoker (daily or weekly) of any tobacco material over the previous 3 months, as represented by a code.
Data Element Concept:	Person—regular tobacco smoking indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes: Record if the person has smoked daily or weekly over the previous 3 months.

CODE 2 No: Record if the person has not smoked daily or weekly over the previous 3 months or has been an irregular smoker.

Collection methods: Ask the individual if he/she has regularly smoked (daily or weekly) any tobacco material over the past 3 months.

Source and reference attributes

Submitting organisation: National diabetes data working group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Person—tobacco smoking status (previous three months), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Tobacco smoking—consumption/quantity (cigarettes)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—number of cigarettes smoked (per day), total N[N]
METeOR identifier:	270332
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of cigarettes (manufactured or roll-your-own) smoked per day by a person.
Context:	Public health and health care
Data Element Concept:	Person—number of cigarettes smoked

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item is relevant only for persons who currently smoke cigarettes daily or at least weekly. Daily consumption should be reported, rather than weekly consumption. Weekly consumption is converted to daily consumption by dividing by 7 and rounding to the nearest whole number.

Quantities greater than 98 (extremely rare) should be recorded as 98.

Collection methods:

The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Questions 3a and 3b) and self-administered (Questions 2a and 2b) versions.

The questions cover persons aged 18 and over.

Comments:

The number of cigarettes smoked is an important measure of the magnitude of the tobacco problem for an individual.

Research shows that of Australians who smoke, the overwhelming majority smoke cigarettes (manufactured or roll-your-own) rather than other tobacco products.

From a public health point of view, consumption level is relevant only for regular smokers (those who smoke daily or at least weekly).

Data on quantity smoked can be used to:

- evaluate health promotion and disease prevention programs
(assessment of interventions)
- monitor health risk factors and progress towards National Health
Goals and Targets
- ascertain determinants and consequences of smoking
- assess a person’s exposure to tobacco smoke.

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references: Supersedes Tobacco smoking - consumption/quantity (cigarettes), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Tobacco smoking—duration (daily smoking)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—tobacco smoking duration (daily smoking), total years N[N]

METeOR identifier: 270330

Registration status: Health, Standard 01/03/2005

Definition: The total duration in years, of daily smoking for a person who is now a daily smoker or has been a daily smoker in the past.

Context: Public health and health care

Data Element Concept: Person—tobacco smoking duration

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[N]

Maximum character length: 2

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Unit of measure: Year

Data element attributes

Collection and usage attributes

Guide for use: In order to estimate duration of smoking the person's date of birth or current age should also be collected. If a person reports that they smoke daily now then duration is the difference between the start-age and the person's current age. If a person reports that they smoked daily in the past but do not smoke daily now then duration is the difference between the quit age and the start age. Record duration of less than one year as 0.

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 1, 5, 6, 7) and self-administered (Question 1, 3, 3a, 4) versions. The questions cover persons aged 18 years and over.

Comments: Duration of daily smoking is an indicator of exposure to increased risk to health. In this data element, duration is measured as the years elapsed from the time the person first started smoking daily and when they most recently quit smoking daily (or the present for those persons who still smoke daily). There may have been intervening periods when the person did not smoke daily. However, as the negative health effects of smoking accumulate over time, the information on duration of daily smoking, as measured in this data element, remains useful, despite any intervening periods of non-daily smoking.

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Is formed using Person—tobacco smoking quit age (daily smoking), total years NN Health, Standard 01/03/2005

Is formed using Person—tobacco smoking start age (daily smoking), total years NN Health, Standard 01/03/2005

Supersedes Tobacco smoking - duration (daily smoking), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)

Tobacco smoking—ever daily use

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking daily use status, code N
METeOR identifier:	270329
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of whether a person has ever smoked tobacco in any form on a daily basis in their lifetime, as represented by a code.
Data Element Concept:	Person—tobacco smoking daily use status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Ever-daily
2	Never-daily

Collection and usage attributes

Guide for use:

CODE 1 Ever-daily

If a person reports that they now smoke cigarettes, cigars, pipes or any other tobacco products daily OR if they report that in the past they have been a daily smoker, they are coded to 1 (ever-daily).

CODE 2 Never-daily

If a person reports that they have never smoked cigarettes, cigars, pipes or any other tobacco products daily AND they have never in the past been a daily smoker then they are coded to 2 (never-daily).

Data element attributes

Collection and usage attributes

Collection methods:

The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 1 and 5) and self-administered (Question 1 and 3) versions. The questions cover persons aged 18 years and over.

Comments:

Whether a person has ever smoked on a daily basis can be used to assess an individual's health risk from smoking and to monitor population trends in smoking behaviour.

It can also be used to:

- evaluate health promotion and disease prevention programs (assessment of interventions);
- monitor health risk factors;
- ascertain determinants and consequences of smoking.

Where the information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - ever daily use, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.0 KB)

Tobacco smoking—frequency

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking frequency, code N
METeOR identifier:	270328
Registration status:	Health, Standard 01/03/2005
Definition:	How often a person now smokes a tobacco product, as represented by a code.
Data Element Concept:	Person—tobacco smoking frequency

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Smokes daily
2	Smokes at least weekly, but not daily
3	Smokes less often than weekly
4	Does not smoke at all

Data element attributes

Collection and usage attributes

Guide for use: To record multiple use data, repeat the data field as many times as necessary, viz: product1, product2 etc. In most instances, data on both product and frequency are needed. In such situations, repeat both fields as many times as necessary, viz: product1, frequency1, product2, frequency2 etc.

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 1) and self-administered (Question 1) versions. The questions relate to smoking of manufactured cigarettes, roll-your-own cigarettes, cigars, pipes and other tobacco products and are designed to cover persons aged 18 years and over.

Comments: The frequency of smoking helps to assess a person's exposure to tobacco smoke which is a known risk factor for cardiovascular disease and cancer. From a public health point of view, the level of consumption of tobacco as measured by frequency of smoking tobacco products is only relevant for regular smokers (persons who smoke daily or at least weekly).

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references: Supersedes Tobacco smoking - frequency, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)

Tobacco smoking—product

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco product smoked, code N
METeOR identifier:	270327
Registration status:	Health, Standard 01/03/2005
Definition:	The type of tobacco product smoked by a person, as represented by a code.
Data Element Concept:	Person—tobacco product smoked

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Cigarettes - manufactured
2	Cigarettes - roll-your-own
3	Cigars
4	Pipes
5	Other tobacco product
6	None

Data element attributes

Collection and usage attributes

Guide for use: To record multiple use data, repeat the data field as many times as necessary, viz: product1, product2 etc. In most instances, data on both product and frequency are needed. In such situations, repeat both fields as many times as necessary, viz: product1, frequency1, product2, frequency2 etc.

Collection methods: The recommended standard for collecting information about smoking the above tobacco products is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer or self-administered versions.

Comments: Tobacco smoking is a known risk factor for cardiovascular disease and cancer. The type of tobacco product smoked by a person in conjunction with information about the frequency of smoking assists with establishing a profile of smoking behaviour at the individual or population level and with monitoring shifts from cigarette smoking to other types of tobacco products and vice versa.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references: Supersedes Tobacco smoking - product, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.1 KB)

Tobacco smoking—quit age (daily smoking)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—tobacco smoking quit age (daily smoking), total years NN

METeOR identifier: 270323

Registration status: Health, Standard 01/03/2005

Definition: The age in years at which a person who has smoked daily in the past and is no longer a daily smoker most recently stopped smoking daily.

Context: Public health and health care

Data Element Concept: Person—tobacco smoking quit age

Value domain attributes

Representational attributes

Representation class: Total

Data type: String

Format: NN

Maximum character length: 2

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Unit of measure: Year

Data element attributes

Collection and usage attributes

Guide for use: In order to estimate quit-age, the person's date of birth or current age should also be collected. Quit-age may be directly reported, or derived from the date the person quit smoking or the length of time since quitting, once the person's date of birth (or current age) is known.

Quit-age is relevant only to persons who have been daily smokers in the past and are not current daily smokers.

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults - interviewer administered (Question 6) and self-administered (Question 3a) versions. The questions cover persons aged 18 years and over.

The relevant question in each version of the questionnaires refers to when the person finally stopped smoking daily, whereas the definition for this metadata item refers to when the person most recently stopped smoking daily. However, in order to provide information on when the person most recently stopped smoking daily, the most appropriate question to ask at the time of collecting the information is when the person finally stopped smoking daily.

Comments:

Quit-age and start-age provide information on the duration of daily smoking and exposure to increased risk to health.

Where the information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Is used in the formation of Person—time since quitting tobacco smoking (daily smoking), code NN Health, Standard 01/03/2005

Is used in the formation of Person—tobacco smoking duration (daily smoking), total years N[N] Health, Standard 01/03/2005

Supersedes Tobacco smoking - quit age (daily smoking), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.8 KB)

Tobacco smoking—start age (daily smoking)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking start age (daily smoking), total years NN
METeOR identifier:	270324
Registration status:	Health, Standard 01/03/2005
Definition:	The age in years at which a person who has ever been a daily smoker, first started to smoke daily.
Context:	Public health and health care
Data Element Concept:	Person—tobacco smoking start age

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

Guide for use:

Record age in completed years.

This information is relevant only if a person currently smokes daily or has smoked daily in the past.

Collection methods:

The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 7) and self-administered (Question 4) versions. The questions cover persons aged 18 years and over.

Comments:

Start-age may be used to derive duration of smoking, which is a much stronger predictor of the risks associated with smoking than is the total amount of tobacco smoked over time.

Where the information is collected by survey and the sample permits, population estimates should be presented by sex and age groups. The recommended age groups are:

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Is used in the formation of Person—tobacco smoking duration (daily smoking), total years N[N] Health, Standard 01/03/2005

Supersedes Tobacco smoking - start age (daily smoking), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.7 KB)

Tobacco smoking—time since quitting (daily smoking)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—time since quitting tobacco smoking (daily smoking), code NN
METeOR identifier:	270356
Registration status:	Health, Standard 01/03/2005
Definition:	The time since a person most recently quit daily smoking, as represented by a code.
Context:	Public health and health care
Data Element Concept:	Person—time since quitting tobacco smoking

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	12 months (1 year)
02	2 years etc. to 78
79	79+ years
80	Less than 1 month
81	1 month
82	2 months
83	3 months
84	4 months
85	5 months
86	6 months
87	7 months
88	8 months
89	9 months
90	10 months
91	11 months
92	months, not specified

	93	years, not specified
Supplementary values:	99	not stated

Data element attributes

Collection and usage attributes

Guide for use:

In order to estimate time since quitting for all respondents, the person’s date of birth or current age should also be collected.

For optimal flexibility of use, the time since quitting is coded as months or years. However, people may report the time that they quit smoking in various ways (e.g. age, a date, or a number of days or weeks ago). When the information is reported in weeks and is less than 4, or in days and is less than 28, then code 80.

When the person reports the time since quitting as weeks ago, convert into months by dividing by 4 (rounded down to the nearest month).

If days reported are between 28 and 59, then code 81.

Where the information is about age only, time since quitting (daily use) is the difference between quit-age and age at survey.

Collection methods:

The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 6) and self-administered (Question 3) versions.

Comments:

Time since quitting daily smoking may give an indication of improvement in the health risk profile of a person. It is also useful in evaluating health promotion campaigns.

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Is formed using Person—tobacco smoking quit age (daily smoking), total years NN Health, Standard 01/03/2005

Supersedes Tobacco smoking - time since quitting (daily smoking), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.0 KB)

Total blood units transfused

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—units of blood transfused, total N[NNN]
METeOR identifier:	344798
Registration status:	Health, Standard 01/10/2008
Definition:	The total number of units of blood that a person has received, either whole blood or packed red blood cells.
Data Element Concept:	Person—units of blood transfused

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described

Collection and usage attributes

Guide for use: 1 blood unit (or one bag of blood) = approx 500ml of blood

Data element attributes

Collection and usage attributes

Guide for use: Platelet transfusions or transfusions of fresh frozen plasma (FFP) should not be included in the total.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Conditional obligation:
Record the total number of blood units (either whole blood or packed red blood cells) that the person has received following a haemorrhagic event.

Total contract patient days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Admitted patient hospital stay—number of patient days (of contracted care), total N[NN]
METeOR identifier:	270301
Registration status:	Health, Standard 01/03/2005
Definition:	Sum of the number of contract patient days for all periods within the hospital stay.
Data Element Concept:	Admitted patient hospital stay—number of patient days (of contracted care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

Count number of days.

A day is measured from midnight to 2359 hours.

Contract patient days are included in the total count of patient days. If necessary, contract patient days can be distinguished from other patient days by using the following rules:

- The day the contract commences is counted as a contract patient day.
- If the patient is on contract from midnight to 2359 count as a contract patient day.
- The day a contract is completed is not counted as a contract patient day.
- If the patient is admitted and commences a contract on the same day, this is not counted as a contract patient day.
- If a contract is completed and the patient is separated on the same day, the day should not be counted as a

contract or other patient day.

Relational attributes

Related metadata references:	Supersedes Total contract patient days, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Total leave days

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of admitted patient care—number of leave days, total N[NN]

METeOR identifier: 270251

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.

Data Element Concept: Episode of admitted patient care—number of leave days

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NN]

Maximum character length: 3

Unit of measure: Day

Data element attributes

Collection and usage attributes

Guide for use: A day is measured from midnight to midnight.

The following rules apply in the calculation of leave days for both overnight and **same-day patients**:

- The day the patient goes on leave is counted as a leave day.
- The day the patient is on leave is counted as a leave day.
- The day the patient returns from leave is counted as a patient day.
- If the patient is admitted and goes on leave on the same day, this is counted as a patient day, not a leave day.
- If the patient returns from leave and then goes on leave again on the same day, this is counted as a leave day.
- If the patient returns from leave and is separated on the same day, the day should not be counted as either a patient day or a leave day.

Comments: It should be noted that for private patients in public and private hospitals, s.3 (12) of the Health Insurance Act 1973 (Cwlth) currently applies a different leave day count, Commonwealth Department of Human Services and Health HBF Circular 354 (31 March 1994). This metadata item was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005

Supersedes Total leave days, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.6 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Total psychiatric care days

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of care—number of psychiatric care days, total N[NNNN]

METeOR identifier: 270300

Registration status: Health, Standard 01/03/2005

Definition: The sum of the number of days or part days of stay that the person received care as an admitted patient or **resident** within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit.

Data Element Concept: Episode of care—number of psychiatric care days

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[NNNN]

Maximum character length: 5

Unit of measure: Day

Data element attributes

Collection and usage attributes

Guide for use: Designated psychiatric units are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder. The unit may or may not be recognised under relevant State and Territory legislation to treat patients on an involuntary basis. Patients are admitted patients in the acute and psychiatric hospitals and residents in community based residences.

Public acute care hospitals:

Designated psychiatric units in public acute care hospitals are normally recognised by the State/Territory health authority in the funding arrangements applying to those hospitals.

Private acute care hospitals:

Designated psychiatric units in private acute care hospitals normally require license or approval by the State/Territory health authority in order to receive benefits from health funds for the provision of psychiatric care.

Psychiatric hospitals:

Total psychiatric care days in stand-alone psychiatric hospitals are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Psychiatric hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the Health Insurance Act 1973 (Commonwealth) (now licensed/approved by each State/Territory health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Community-based residential services:

Designated psychiatric units refers to 24-hour staffed community-based residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. Special psychiatric units for the elderly are covered by this category, including psychogeriatric hostels or psychogeriatric nursing homes. Note that residences occupied by admitted patients located on hospital grounds, whether on the campus of a general or stand-alone psychiatric hospital, should be counted in the category of admitted patient services and not as community-based residential services.

Counting of patient days and leave days in designated psychiatric units should follow the standard definitions applying to these items.

For each period of care in a designated psychiatric unit, total days is calculated by subtracting the date on which care commenced within the unit from the date on which the specialist unit care was completed, less any leave days that occurred during the period.

Total psychiatric care days in 24-hour community-based residential care are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Admitted patients in acute care:

Commencement of care within a designated psychiatric unit may be the same as the date the patient was admitted to the hospital, or occur subsequently, following transfer of the patient from another hospital ward. Where commencement of psychiatric care occurs by transfer from another ward, a new episode of care may be recorded, depending on whether the care type has changed (see metadata item Care type). Completion of care within a designated psychiatric unit may be the same as the date the patient was discharged from the hospital, or occur prior to this on transfer of the patient to another hospital ward. Where completion of psychiatric care is followed by transfer to another hospital ward, a new episode of care may be recorded, depending on whether the care type has changed (see metadata item Care type. Total psychiatric care days may cover one or more periods in a designated psychiatric unit within the overall hospital stay.

Collection methods: Accurate counting of total days in psychiatric care requires periods in designated psychiatric units to be identified in the person-level data collected by state or territory health authorities. Several mechanisms exist for this data field to be implemented:

- Ideally, the new data field should be collected locally by hospitals and added to the unit record data provided to the relevant state/territory health authority.
- Acute care hospitals in most states and territories include details of the wards in which the patient was accommodated in the unit record data provided to the health authority. Local knowledge should be used to identify designated psychiatric units within each hospital's ward codes, to allow total psychiatric care days to be calculated for each episode of care.
- Acute care hospitals and 24-hour staffed community-based residential services should be identified separately at the level of the establishment.

Comments: This metadata item was originally designed to monitor trends in the delivery of psychiatric admitted patient care in acute care hospitals. It has been modified to enable collection of data in the community-based residential care sector. The metadata item is intended to improve understanding in this area and contribute to the ongoing evaluation of changes occurring in mental health services.

Source and reference attributes

Submitting organisation: National Mental Health Information Strategy Committee

Reference documents: Health Insurance Act 1973 (Commonwealth)

Relational attributes

Related metadata references:

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Is formed using Establishment—establishment type, sector and services provided code AN.N{.N} Health, Standard 01/03/2005

Is formed using Hospital service—care type, code N[N].N Health, Standard 01/03/2005

Supersedes Total psychiatric care days, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (23.8 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Transgender

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—transgender indicator, code N
METeOR identifier:	375985
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	An indicator of whether a person identifies as **transgender** or is currently undergoing gender reassignment, as represented by a code.
Data Element Concept:	Person—transgender indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Prison clinic contact DSS Health, Standard 25/08/2011

Prison entrants DSS Health, Standard 25/08/2011

Prisoners in custody repeat medications DSS Health, Standard 25/08/2011

Treatment delivery setting for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—service delivery setting, code N
METeOR identifier:	270068
Registration status:	Health, Standard 01/03/2005
Definition:	The main physical setting in which the type of treatment that is the principal focus of a client's alcohol and other drug treatment episode is actually delivered irrespective of whether or not this is the same as the usual location of the service provider, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—service delivery setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Non-residential treatment facility
2	Residential treatment facility
3	Home
4	Outreach setting
8	Other

Collection and usage attributes

Guide for use:

Only one code to be selected at the end of the alcohol and other drug treatment episode. Agencies should report the setting in which most of the main type of treatment was received by the client during the treatment episode.

CODE 1 Non-residential treatment facility

This code refers to any non-residential centre that provides alcohol and other drug treatment services, including hospital outpatient services and community health centres.

CODE 2 Residential treatment facility

This code refers to community-based settings in which clients reside either temporarily or long-term in a facility that is not their home or usual place of residence to receive alcohol and other drug treatment. This does not include ambulatory situations, but does include therapeutic community settings.

CODE 3 Home

This code refers to the client's own home or usual place of residence.

CODE 4 Outreach setting

This code refers to an outreach environment, excluding a client's home or usual place of residence, where treatment is provided. An outreach environment may be any public or private location that is not covered by Codes 1-3. Mobile/outreach alcohol and other drug treatment service providers would usually provide treatment within this setting.

Data element attributes

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Treatment delivery setting for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Triage category

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Non-admitted patient emergency department service episode—triage category, code N

METeOR identifier: 474185

Registration status: Health, Standard 30/01/2012

Definition: The urgency of the patient's need for medical and nursing care as assessed at **triage**, as represented by a code.

Context: Emergency department care.

Data Element Concept: Non-admitted patient emergency department service episode—triage category

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Resuscitation: immediate (within seconds)
2	Emergency: within 10 minutes
3	Urgent: within 30 minutes
4	Semi-urgent: within 60 minutes
5	Non-urgent: within 120 minutes

Data element attributes

Collection and usage attributes

Collection methods: This triage classification is to be used in the emergency departments of hospitals. Patients will be triaged into one of five categories on the National Triage Scale according to the triageur's response to the question: 'This patient should wait for medical care no longer than ...?'.

The triage category is allocated by an experienced **registered nurse** or medical practitioner. If the triage category changes, both triage categories can be captured, but the original category must be reported in this data element.

A triage category should not be assigned for patients who have a Type of visit of 'Dead on arrival, emergency department clinician certified the death of the patient'.

Source and reference attributes

Origin: National Triage Scale, Australasian College for Emergency Medicine

Relational attributes

Related metadata references: Supersedes Non-admitted patient emergency department service episode—triage category, code N Health, Superseded 30/01/2012

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:

This data item is to be recorded for patients who have one of the following Type of visit values recorded:

- Emergency department presentation;
- Return visit, planned;
- Pre-arranged admission;
- Patient in transit.

Triglyceride level (measured)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—triglyceride level (measured), total millimoles per litre N[N].N

METeOR identifier: 359411

Registration status: Health, Standard 01/10/2008

Definition: A person's triglyceride level measured in millimoles per litre.

Data Element Concept: Person—triglyceride level

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: N[N].N

Maximum character length: 3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described.

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use: Record the absolute result of the total triglyceride measurement.

Collection methods: Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.

- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.

Note that to calculate the low-density lipoprotein - cholesterol (LDL-C) from the Friedwald Equation (Friedwald et al, 1972):

- a fasting level of plasma triglyceride and knowledge of the levels of plasma total cholesterol and high-density lipoprotein - cholesterol (HDL-C) is required,
- the Friedwald equation becomes unreliable when the

plasma triglyceride exceeds 4.5 mmol/L, and

- that while levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 8 weeks after an event.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references: Supersedes Person—triglyceride level (measured), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Troponin assay type

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—troponin assay type, code N

METeOR identifier: 356929

Registration status: Health, Standard 01/10/2008

Definition: The type of troponin assay (I or T) used to assess the person’s troponin levels, as represented by a code.

Data Element Concept: Person—troponin assay type

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Cardiac troponin T (cTnT)
	2	Cardiac troponin I (cTnI)
Supplementary values:	9	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group.

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Person—troponin assay type, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Troponin assay—upper limit of normal range (micrograms per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for troponin assay, total micrograms per litre N[NNN]
METeOR identifier:	359315
Registration status:	Health, Standard 01/10/2008
Definition:	Laboratory standard for the value of 'troponin T' or 'troponin I' measured in micrograms per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range of troponin assay

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Unit of measure: Microgram per litre (µg/L)

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of normal (usually the ninety-ninth percentile of a normal population) for the individual laboratory.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Related metadata references: Supersedes Laboratory standard—upper limit of normal

	range for troponin assay, total micrograms per litre N[NNN] Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Troponin level (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin level (measured), total micrograms per litre NN.NN
METeOR identifier:	356934
Registration status:	Health, Standard 01/10/2008
Definition:	A person's troponin measured in micrograms per litre.
Data Element Concept:	Person—troponin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN.NN
Maximum character length:	4

Supplementary values:

Value	Meaning
88.88	Not measured
99.99	Not stated/inadequately described

Unit of measure: Microgram per litre (µg/L)

Collection and usage attributes

Guide for use: CODE 88.88 Not measured

This code is used if test for troponin (T or I) was not done.

Data element attributes

Collection and usage attributes

Guide for use: Measured in different assays dependant upon laboratory methodology.

When only one troponin level is recorded, this should be the peak level.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: See also Laboratory standard—upper limit of normal range

	for troponin assay, total micrograms per litre N[NNN] Health, Superseded 01/10/2008 Supersedes Person—troponin level (measured), total micrograms per litre NN.NN Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Tumour size at diagnosis (solid tumours)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—solid tumour size (at diagnosis), total millimetres NNN
METeOR identifier:	422642
Registration status:	Health, Standard 07/12/2011
Definition:	The largest dimension of a solid tumour, measured in millimetres.
Data Element Concept:	Person with cancer—solid tumour size

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Unknown

Unit of measure: Millimetre (mm)

Collection and usage attributes

Guide for use: Size in millimetres with valid values 001 to 997.

Data element attributes

Collection and usage attributes

Guide for use: The reporting standard for the size of solid tumours is:

- Breast cancer or other solid neoplasms - the largest tumour dimension, measured to a precision of 1mm
- Round to the nearest millimetre, rounding up if size is ≥ .5 mm (e.g. 1.50mm, 1.54mm recorded as 2mm, 1.47mm recorded as 1mm).

General coding rules:

Recorded size:

- Only record measured size if stated, otherwise record size as unknown. Do not attempt to estimate size from descriptions of the tumour, such as ‘tumour occupying three quarters of tissue’
- Do not take values for size from sources other than

histopathology (such as imaging, mammography or clinical examination).

Size reported for multiple specimens:

- If tumour is removed in more than one procedure (e.g. biopsy and excision, local excision and re-excision) do not sum the sizes across multiple pathology reports but rather use the larger of the measured sizes from the separate pathology reports
- If tumour is divided into several parts (in the same pathology report), do not sum sizes together but rather use the larger of the measured sizes. However, if the pathologist states an aggregate or composite size, record that size.

Multifocal tumour:

- If the tumour is multifocal, record the size of the largest measured focus. Do not attempt to sum sizes of different foci.

Macroscopic size:

- If only macroscopic size is given, record this value
- If the macroscopic and microscopic measurements differ, the microscopic measurement should be recorded.

Exclusions:

- Size is not recorded for Phyllodes tumours, sarcomas, or lymphomas.

Invasive breast cancer coding rules:

Note: These rules are to be used only when the record pertains to an invasive breast cancer (as per Person with cancer-primary site of cancer, topography code (ICD-O-3) ANN.N.

Invasive tumours with an in situ component:

- When an invasive tumour contains an in situ component, only record the size of the invasive component as stated
- If the size of the invasive tumour is not recorded separately to the in situ component, then record the total size of the tumour without any attempt to estimate the invasive component using percentage or size of the in situ component.

Microinvasive tumour:

- For microinvasive tumours, record size in millimetres if stated. If microinvasion is stated but no size is recorded, enter 990 in size field to enable these very small tumours to be differentiated from other tumours without measured sizes.

Bilateral breasts tumours:

- Bilateral tumours are recorded as two separate primary tumours each having their own size (and other data elements).

Multifocal tumours with different morphology:

- Foci with different morphology should be considered to be separate primary tumours each having their own size (and other data elements). The coder needs to ascertain whether two foci with differing morphology are separate primaries with different morphology or a single multifocal primary with a mixed histology. In the latter case the rule of taking the size from the larger focus would apply as stated.

Collection methods: This information should be obtained from the patient's pathology reports.

Comments: The diameter of the largest dimension of solid neoplasms is collected for patient management, population cancer statistics and research.

Source and reference attributes

Reference documents: Johnson CH & Adamo M (Editors) 2007. SEER Program Coding and Staging Manual 2007. MD 2007. Bethesda:National Cancer Institute, NIH Publication number 07-5581

National Breast and Ovarian Cancer Centre and Australian Cancer Network 2008. The pathology reporting of breast cancer: A guide for pathologists, surgeons, radiologists and oncologists, 3rd edition. Surry Hills, NSW: National Breast and Ovarian Cancer Centre

Relational attributes

Related metadata references: Supersedes Person with cancer—solid tumour size (at diagnosis), total millimetres NNN Health, Superseded 07/12/2011

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on the histopathological examination of the tumour, and excludes Phyllodes tumours, sarcomas or lymphomas.

Tumour thickness at diagnosis (melanoma)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—melanoma thickness (at diagnosis), total millimetres NNN.NN
METeOR identifier:	270185
Registration status:	Health, Standard 01/03/2005
Definition:	The measured thickness of a melanoma in millimetres.
Data Element Concept:	Person with cancer—melanoma thickness

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN.NN
Maximum character length:	5

Supplementary values:

Value	Meaning
999.99	Unknown

Unit of measure: Millimetre (mm)

Data element attributes

Collection and usage attributes

Guide for use:

The reporting standard for the thickness of melanoma is:

Primary cutaneous melanoma - the depth of penetration of tumour cells below the basal layer of the skin; measured to a precision of 0.01mm.

Size in millimetres - valid values are: 000.01 to 997.99

Relational attributes

Related metadata references:

Supersedes Tumour thickness at diagnosis - melanoma, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.3 KB)

Type of accommodation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—accommodation type (usual), code N[N]
METeOR identifier:	270088
Registration status:	Health, Standard 01/03/2005
Definition:	The type of accommodation setting in which a person usually lives/lived, as represented by a code.
Context:	Admitted patient mental health care: Permits analysis of the usual residential accommodation type of people prior to admission to institutional health care. The setting in which the person usually lives can have a bearing on the types of treatment and support required by the person and the outcomes that result from their treatment.
Data Element Concept:	Person—accommodation type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Private residence (e.g. house, flat, bedsitter, caravan, boat, independent unit in retirement village), including privately and publicly rented homes
2	Psychiatric hospital
3	Residential aged care service
4	Specialised alcohol/other drug treatment residence
5	Specialised mental health community-based residential support service
6	Domestic-scale supported living facility (e.g. group home for people with disability)
7	Boarding/rooming house/hostel or hostel type accommodation, not including aged persons' hostel

	8	Homeless persons' shelter
	9	Shelter/refuge (not including homeless persons' shelter)
	10	Other supported accommodation
	11	Prison/remand centre/youth training centre
	12	Public place (homeless)
	13	Other accommodation, not elsewhere classified
Supplementary values:	14	Unknown/unable to determine

Collection and usage attributes

Guide for use: CODE 3 Residential aged care service

Includes nursing home beds in acute care hospitals.

CODE 4 Specialised alcohol/other drug treatment residence

Includes alcohol/other drug treatment units in psychiatric hospitals.

CODE 5 Specialised mental health community-based residential support service

Specialised mental health community-based residential support services are defined as community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provides 24-hour support/rehabilitation on a residential basis.

CODE 6 Domestic-scale supported living facility (e.g. group home for people with disability)

Domestic-scale supported living facilities include group homes for people with disability, cluster apartments where a support worker lives on-site, community residential apartments (except mental health), congregate care arrangements. Support is provided by staff on either a live-in or rostered basis, and they may or may not have 24-hour supervision and care.

CODE 10 Other supported accommodation

Includes other supported accommodation facilities such as hostels for people with disability and Residential Services/Facilities (Victoria and South Australia only). These facilities provide board and lodging and rostered care workers provide client support services.

Data element attributes

Collection and usage attributes

Guide for use: 'Usual' is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to admission to institutional health care or first contact with a community service setting. If a person stays in a particular place of accommodation for four or more days a week over the period, that place of accommodation would be the person's type of usual accommodation. In practice, receiving an answer to questioning about a person's usual accommodation setting may be difficult to achieve. The place the person perceives as their usual accommodation will often prove to be the best approximation of their type of usual accommodation.

Comments: The changes made to this metadata item are in accordance with the requirements of the National Mental Health Information Strategy Committee and take into consideration corresponding definitions in other data dictionaries (e.g. Home and Community Care Data Dictionary Version 1 and National Community Services Data Dictionary Version 1).

Relational attributes

Related metadata references: Supersedes Type of accommodation, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.4 KB)

Implementation in Data Set Specifications: Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Type of augmentation of labour

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—labour augmentation type, code N
METeOR identifier:	270036
Registration status:	Health, Standard 01/03/2005
Definition:	Methods used to assist progress of labour, as represented by a code.
Data Element Concept:	Birth event—labour augmentation type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	0	None
	1	Oxytocin
	2	Prostaglandins
	3	Artificial rupture of membranes (ARM)
	4	Other
Supplementary values:	5	Not stated

Collection and usage attributes

Comments:

Prostaglandin is listed as a method of augmentation in the data domain. Advice from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the manufacturer indicates that vaginal prostaglandin use is not recommended or supported as a method of augmentation of labour as it may significantly increase the risk of uterine hyperstimulation. In spite of this, the method is being used and it is considered important to monitor its use for augmentation.

Data element attributes

Collection and usage attributes

Guide for use:

More than one method of augmentation can be recorded, except where 0=none applies.

Collection units need to edit carefully the use of prostaglandins as an augmentation method. Results from checking records have shown that either the onset of labour was incorrect or that the augmentation method was incorrectly selected.

Comments: Type of augmentation determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Type of augmentation of labour, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.4 KB)

Type of chronic condition

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—type of chronic condition, code N
METeOR identifier:	399218
Registration status:	Health, Standard 25/08/2011
Definition:	The type of chronic condition from which a person suffers, as represented by a code.
Data Element Concept:	Person—type of chronic condition

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Asthma
2	Cancer
3	Cardiovascular disease
4	Arthritis
5	Diabetes

Collection and usage attributes

Guide for use: CODE 1 Asthma

A chronic inflammatory disorder of the airways. In susceptible individuals, this inflammation causes recurrent episodes of wheezing, breathlessness, chest tightness, and coughing, particularly at night or in the early morning. These episodes are usually associated with widespread but variable airflow obstruction that is often reversible either spontaneously or with treatment. The inflammation also causes an associated increase in the existing bronchial hyperresponsiveness to a variety of stimuli.

CODE 2 Cancer

Cancer, also called malignancy, is a term for diseases in which abnormal cells divide without control and can invade nearby tissues. Cancer cells can also spread to other parts of the body through the blood and lymph systems. Cancer includes carcinoma, sarcoma, leukemia, lymphoma and multiple myeloma and central nervous system cancers. Excludes non-melanoma skin cancer.

CODE 3 Cardiovascular disease

A disease affecting the heart or blood vessels. Cardiovascular diseases include arteriosclerosis, coronary artery disease, heart valve disease, arrhythmia, heart failure, hypertension, orthostatic hypotension, shock, endocarditis, diseases of the aorta and its branches, disorders of the peripheral vascular system, and congenital heart disease.

CODE 4 Arthritis

An umbrella term for more than 100 medical conditions that affect the musculoskeletal system, specifically joints. The three most common forms of arthritis are osteoarthritis, rheumatoid arthritis and gout.

CODE 5 Diabetes

A disease marked by high blood glucose levels resulting from defective insulin production, insulin action or both. The three main types of diabetes are type 1 diabetes, type 2 diabetes and gestational diabetes.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Department of Health and Ageing 2010. Chronic disease. Canberra: Department of Health and Ageing.

MedicineNet 2010. Definition of cardiovascular disease. California: WebMD. National Asthma Council Australia 2007.

Asthma management handbook 2006. South Melbourne: National Asthma Council Australia. U.S. National Cancer Institute 2010.

NCI Dictionary of cancer terms. Bethesda MD: U.S. National Institutes of Health.

World Health Organization 1999. Definition, diagnosis and classification of diabetes mellitus and its complications. Part 1: Diagnosis and classification of diabetes mellitus. Geneva: World Health Organization Department of Noncommunicable Disease Surveillance.

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data elements: *Person – specific chronic condition indicator, yes/no code N* and *Person – chronic condition indicator, yes/no code N* to obtain information on a person's current and past chronic conditions.

For code 3 Cardiovascular disease instruct the respondent to include conditions which can be controlled by medication.

Comments: Arthritis, asthma, cancer, diabetes and cardiovascular disease contribute significantly to the burden of illness and injury in Australia. Consequently these chronic conditions have been identified as National Health Priority Areas. Targeting these areas can potentially reduce the burden of disease experienced by people with these conditions and reduce health care required and associated costs.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Department of Health and Ageing 2009. Chronic disease. Canberra: Department of Health and Ageing. Viewed 17 May 2010, <http://www.health.gov.au/internet/main/publishing.nsf/Content/chronic>

Relational attributes

Related metadata references: See also Person—chronic condition indicator, yes/no code N Health, Standard 25/08/2011

See also Person—specific chronic condition indicator, yes/no code N Health, Standard 25/08/2011

Implementation in Data Set Specifications: Chronic condition cluster Health, Standard 25/08/2011

Conditional obligation:
Conditional on the person being told they have a chronic condition.

Type of compensatory payment to other party

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim—type of compensatory payment to other party, code N[N]
METeOR identifier:	329798
Registration status:	Health, Standard 07/12/2011
Definition:	A description of the categories of loss for which an other party is compensated as a basis for a medical indemnity claim, as represented by a code.
Data Element Concept:	Medical indemnity claim—type of compensatory payment to other party

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

	Value	Meaning
Permissible values:	1	Care costs
	2	Other economic loss
	3	Nervous shock
	4	Other pain and suffering (excluding nervous shock)
	5	Loss of consortium
	9	Medical costs
	12	No payment to an other party
	88	Other loss
Supplementary values:	97	Not applicable—patient is the only claimant
	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Care costs

‘Care costs’ include long-term care costs, and covers both past and future care costs, whether provided gratuitously or otherwise.

CODE 2 Other economic loss

‘Other economic loss’ includes past and future economic loss and past and future out-of-pocket expenses. It also includes dependency claims following the death of the patient, that is loss of the economic benefits provided by the patient. Care and medical costs are excluded.

CODE 3 Nervous shock

'Nervous shock' applies to psychiatric damage severe enough to amount to a recognised mental illness, such as anxiety neurosis or reactive depression, extending beyond grief or emotional distress.

CODE 4 Other pain and suffering (excluding nervous shock)

'Other pain and suffering (excluding nervous shock)' includes general damages, but excludes nervous shock.

CODE 5 Loss of consortium

'Loss of consortium' refers to damages awarded to a family member (usually a spouse) for loss of companionship.

CODE 9 Medical costs

'Medical costs' include costs associated with medical treatment (both past and future), for example, doctor's fees or hospital expenses.

CODE 12 No payment to an other party

'No payment to an other party' should be recorded where a medical indemnity claim is closed and no compensatory payment has been made to another party.

CODE 88 Other loss

'Other loss' includes any other loss not covered by the other codes for which an other party is compensated.

CODE 97 Not applicable—patient is the only claimant

'Not applicable—patient is the only claimant' should be recorded where a medical indemnity claim is based on an allegation of loss to the patient, not to an other party.

CODE 99 Not stated/inadequately described

'Not stated/inadequately described' should be recorded when the information is not currently available.

More than one code (excluding Code 99) may be recorded.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Comments: During development of the Medical Indemnity National Collection it was decided that an item for recording broad categories of loss was needed. Where the medical indemnity claim relates to loss suffered by an other party or parties, whether solely or in combination with loss suffered by the patient, it is relevant to record the nature of this loss separately to the loss suffered by the patient.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Medical indemnity claim—type of compensatory payment to patient, code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Type of compensatory payment to patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim—type of compensatory payment to patient, code N[N]
METeOR identifier:	329796
Registration status:	Health, Standard 07/12/2011
Definition:	A description of the categories of loss for which the patient is compensated as a basis for a medical indemnity claim, as represented by a code.
Data Element Concept:	Medical indemnity claim—type of compensatory payment to patient

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Permissible values:	Value	Meaning
	1	Care costs
	2	Other economic loss
	3	Pain and suffering (including nervous shock)
	7	Medical costs
	8	Other loss
	9	No payment to patient
Supplementary values:	97	Not applicable—patient is not a claimant
	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Care costs

'Care costs' include long-term care costs, and covers both past and future care costs, whether provided gratuitously or otherwise.

CODE 2 Other economic loss

'Other economic loss' includes past and future economic loss and past and future out-of-pocket expenses; excluding care and medical costs.

CODE 3 Pain and suffering (including nervous shock)

'Pain and suffering (including nervous shock)' includes temporary or ongoing disability and general damages. 'Nervous shock' applies to psychiatric damage severe enough to amount to a recognised mental illness, such as anxiety neurosis or reactive depression, extending beyond grief or emotional distress.

CODE 7 Medical costs

'Medical costs' includes costs associated with medical treatment (both past and future), for example, doctor's fees or hospital expenses.

CODE 8 Other loss

'Other loss' includes any other loss, not covered by the other codes for which the patient is compensated.

CODE 9 No payment to patient

'No payment to patient' should be recorded where a medical indemnity claim is closed and no compensatory payment has been made to the patient.

CODE 97 Not applicable—patient is not a claimant

'Not applicable—patient is not a claimant' should be recorded where a medical indemnity claim is based on an allegation of loss to an other party, not the patient. For example, where the claimant ('other party') is a spouse claiming for nervous shock allegedly suffered as a result of the injuries to the patient.

CODE 99 Not stated/inadequately described

'Not stated/inadequately described' should be recorded when the information is not currently available.

More than one code (excluding Code 99) may be recorded.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Medical indemnity claim—type of compensatory payment to other party, code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specifications: Medical indemnity DSS Health, Standard 07/12/2011

Type of corrective services facility

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Prison entrant—type of corrective services facility, code N
METeOR identifier:	398999
Registration status:	Health, Standard 25/08/2011
Definition:	The type of corrective services facility in which a prison entrant has been detained, as represented by a code.
Data Element Concept:	Prison entrant—type of corrective services facility

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Adult prison
2	Juvenile detention centre

Collection and usage attributes

Guide for use:

CODE 1 Adult prison

A place which is the responsibility of a corrective services department, and may be operated by that department or by a private company, where individuals are detained while under the supervision on remand (pre–sentence) or a sentence of imprisonment.

CODE 2 Juvenile detention centre

A place administered and operated by a juvenile justice agency, where young people are detained while under the supervision of the relevant juvenile justice agency. Young people usually refers to people aged 10-17 years, however, it is possible for young people who are 18 years or older to be under juvenile justice supervision.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Australian Institute of Health and Welfare 2010. The health of Australia’s prisoners 2009. Cat. no. PHE 123. Canberra: AIHW

Data element attributes

Collection and usage attributes

Guide for use: This data element is used in conjunction with the data element: *Prison entrant—number of times in prison or juvenile detention, total number N[N]* to identify the number of prison entrants who have been in prison or juvenile detention previously.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Prison entrant—number of times in prison or juvenile detention, total number N[N] Health, Standard 25/08/2011

Implementation in Data Set Specifications: Incarceration history cluster Health, Standard 25/08/2011

Type of health or health related function

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—type of health or health related function, code NNN
METeOR identifier:	352187
Registration status:	Health, Standard 05/12/2007
Definition:	Describes the type of activities or programs with a health or health-related function provided by an organisation, as represented by a code.
Data Element Concept:	Organisation—type of health or health related function

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NNN
Maximum character length:	3

Permissible values:

Value	Meaning
101	Admitted patient care – Mental health program
102	Admitted patient care – Non-Mental health program
199	Admitted patient care – Not further defined
201	Residential care – Mental health program
202	Residential care – Non-Mental health program
299	Residential care – Not further defined
301	Ambulatory care – Mental health program
302	Ambulatory care – Emergency department
303	Ambulatory care – General practitioner
304	Ambulatory care – Medical specialist
305	Ambulatory care – Imaging/pathology
306	Ambulatory care – Dental service
307	Ambulatory care – Optometry service
308	Ambulatory care – Allied health service
309	Ambulatory care – Community health service
388	Ambulatory care – Other
399	Ambulatory care – Not further defined

401	Public health – Communicable disease control
402	Public health – Selected health promotion
403	Public health – Organised immunisation
404	Public health – Environmental health
405	Public health – Food standards and hygiene
406	Public health – Breast cancer screening
407	Public health – Cervical screening
408	Public health – Bowel cancer screening
409	Public health – Prevention of hazardous and harmful drug use
410	Public health – Public health research
488	Public health – Other public health
499	Public health – Not further defined
501	Health related care – Patient transport
502	Health related care – Patient transport subsidies
503	Health related care – Medications
504	Health related care – Aids and appliances
505	Health related care – Health administration
506	Health related care – Health research
588	Health related care – Other
599	Health related care – Not further defined
601	Other function – Home and Community Care
602	Other function – Aged care
603	Other function – Other welfare
688	Other function – Other
699	Other function – Not further defined

Collection and usage attributes

Guide for use:

CODE 101 Admitted patient care – Mental health program

An **admission** to a mental health program includes:

The component of the mental health program that provides admitted patient care. These services are delivered through specialised psychiatric hospitals and designated psychiatric units located within hospitals that are not specialised psychiatric hospitals.

NOTE: This is the admitted patient component of the mental health care program reported to the Mental Health Establishments NMDS.

Excludes residential care mental health programs, **ambulatory care** mental health programs which are provided as **outpatient** and **emergency department** care to non-admitted patients, and community-based (non-hospital) mental health programs.

CODE 102 Admitted patient care – Non-mental health program

An admitted patient non-mental health program includes:

All services, excluding mental health services, provided to admitted patients, including acute care, rehabilitative care, palliative care, geriatric evaluation and management, psychogeriatric care, maintenance care, newborn care and any other admitted patient care e.g. organ procurement – posthumous. Also includes admitted patient services where service delivery is contracted to private hospitals or treatment facilities and **hospital in the home** services.

Excludes emergency department and outpatient care provided to non-admitted patients, and community-based (non hospital) care.

CODE 199 Admitted patient care – Not further defined

Comprises admitted patient care services that could be a combination of categories 101 and 102 but which could not be further disaggregated.

State and territory health authorities are only to report admitted patient care under codes 101 or 102.

CODE 201 Residential care – Mental health program

A residential mental health care program includes:

The component of the specialised mental health program that provides residential care. A **resident** in one **residential mental health service** cannot be concurrently a resident in another residential mental health service. A resident in a residential mental health service can be concurrently a patient admitted to a hospital.

Comprises the residential component of the mental health care program reported to the Mental Health Establishments NMDS.

Excludes residential aged care services, residential disability, alcohol and other drug treatment health care services and residential type care provided to admitted patients in hospitals. Also excludes mental health programs provided to admitted patients, emergency and outpatient care patients, and community health (non-hospital) and other ambulatory care patients.

CODE 202 Residential care – Non-mental health program

A residential non-mental health care program includes alcohol and other drug treatment health care services.

Excludes residential mental health care program services, residential aged care services, residential disability services and residential type care provided to admitted patients in hospitals. Also excludes services provided to admitted patients and patients receiving ambulatory care.

CODE 299 Residential care – Not further defined

Comprises residential care services that could be a combination of categories 201 and 202 but which could not be further disaggregated.

State and territory health authorities are only to report residential care under codes 201 or 202.

CODE 301 Ambulatory care – Mental health program

The component of a specialised mental health program supplied by a specialised mental health service that provides **ambulatory health care**.

Comprises the ambulatory component of the mental health care program reported to the Mental Health Establishments NMDS, i.e. specialised mental health program services provided by emergency departments, outpatient clinics and community-based (non-hospital) services.

Excludes specialised mental health care provided to admitted and residential patients.

CODE 302 Ambulatory care – Emergency department

Comprises emergency department services provided in an **emergency department**.

Excludes specialised mental health services provided by emergency departments, outpatient clinics and community-based (non-hospital) services. Also excludes residential and admitted patient services.

CODE 303 Ambulatory care – General practitioner

This item is not currently required to be reported by state and territory health authorities.

The definition relates to the broad type of non-referred general practitioner services as specified on the Medicare Benefits Schedule website. These services comprise general practitioner attendances, including General Practitioner, Vocationally Registered General Practitioner (GP/VRGP) and other non-referred attendances, to non-admitted patients, and services provided by a practice nurse or registered Aboriginal Health Worker on behalf of a general practitioner.

This category is not limited to services funded by Medicare Australia. It also includes services funded from other sources such as Motor Vehicle Third Party Insurance and Workers Compensation Insurance, among others. Therefore, general or nurse practitioner services such as vaccinations for overseas travel are included regardless of their funding source. These non-referred general practitioner services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Excludes mental health care services reported under code 301 and services provided to non-admitted patients in an emergency department.

CODE 304 Ambulatory care – Medical specialist

This item is not currently required to be reported by state and territory health authorities.

Specialist attendances, obstetrics, anaesthetics, radiotherapy, operations and assistance at operations care. These services are defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Includes salaried medical officers.

Excludes mental health care services reported under code 301 and services provided to non-admitted patients in an emergency department.

CODE 305 Ambulatory care – Imaging/pathology service.

This item is not currently required to be reported by state and territory health authorities.

Pathology and diagnostic imaging services as defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Excludes services provided to admitted or residential care patients and non-admitted patients in an emergency department.

CODE 306 Ambulatory care – Dental service

Includes any non-admitted patient and community dental services, including dental assessments, preventative services and treatments, regardless of funding source. Oral and maxillofacial services and cleft lip and palate services, as defined in the current Medicare Benefits Schedule, are also included in this category.

Includes dental services funded from a range of sources such as Medicare Benefits Scheme, Motor Vehicle Third Party Insurance and dental services funded by vouchers for dental care.

These dental services are provided in private or group practices in dental clinics, community health care centres or hospital outpatient clinics.

Excludes dental care provided to admitted patients in hospitals (same day or overnight) or to non-admitted patients in an emergency department.

CODE 307 Ambulatory care – Optometry service

This item is not currently required to be reported by state and territory health authorities.

Optometry services as defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are mainly provided in private or group practices, but may be provided in hospital outpatient centres.

Excludes optometry services provided to admitted or residential care patients or to non-admitted patients in an emergency department.

CODE 308 Ambulatory care – Allied health service

Includes services provided by the following allied health items. Aboriginal health worker, diabetes educator, audiologists, exercise physiologist, dietician, mental health worker, occupational therapist, physiotherapist, podiatrist or chiropodist, chiropractor, osteopath, psychologist and speech pathologist. These services are defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments.

Excludes allied health services provided to admitted or residential care patients or to non-admitted patients in an emergency department.

CODE 309 Ambulatory care – Community health services

Includes community health services such as family, maternal, child and youth health (including well baby clinics) as well as Aboriginal and Torres Strait Islander and migrant health services. Also includes health care for people with acute, post-acute, chronic and end of life illnesses, alcohol and drug treatment services, child psychology services, community midwifery, community nursing, school and district nursing, community rehabilitation, continence services, telehealth, dietetics, family planning and correctional health services.

Excludes mental health services reported under code 301 and services provided to admitted and residential care patients and non-admitted patients in an emergency department. Also excludes services already reported under codes 303 to 308.

CODE 388 Ambulatory care – Other

Comprises ambulatory care services other than those reported under codes 301 to 309.

CODE 399 Ambulatory care – Not further defined

Comprises ambulatory care services that could be a combination of categories 301 to 309 and 388, but which could not be further disaggregated, such as public outpatient services.

CODE 401 Public health – Communicable disease control

This category includes all activities associated with the development and implementation of programs to prevent the spread of communicable diseases.

Communicable disease control is recorded using three sub-categories:

HIV/AIDS, hepatitis C and sexually transmitted infections

Needle and syringe programs

Other communicable disease control.

The **public health** component of the HIV/AIDS, hepatitis C and STI strategies includes all activities associated with the development and implementation of prevention and education programs to prevent the spread of HIV/AIDS, hepatitis C and sexually transmitted infections.

CODE 402 Public health – Selected health promotion

This category includes those activities fostering healthy lifestyle and a healthy social environment overall, and health promotion activities targeted at health risk factors which lead to injuries, skin cancer and cardiovascular disease (for example diet, inactivity) that are delivered on a population-wide basis. The underlying criterion for the inclusion of health promotion programs within this category was that they are population health programs promoting health and wellbeing.

The Selected health promotion programs are:

Healthy settings (for example municipal health planning)

Public health nutrition

Exercise and physical activity

Personal hygiene

Mental health awareness promotion

Sun exposure and protection

Injury prevention including suicide prevention and female genital mutilation.

CODE 403 Public health – Organised immunisation

This category includes immunisation clinics, school immunisation programs, immunisation education, public awareness, immunisation databases and information systems.

Organised immunisation is recorded using three sub-categories:

Organised childhood immunisation (as defined by the National Health and Medical Research Council Schedule/Australian Standard Vaccination Schedule)

Organised pneumococcal and influenza immunisation—the target groups for pneumococcal immunisation are Indigenous people over 50 years and high-risk Indigenous younger people aged 15–49 years. Influenza vaccine is available free to all Australians 65 years of age and over, Indigenous people over 50 years and high-risk Indigenous younger people aged 15–19 years.

All other organised immunisation (for example tetanus)—as opposed to ad hoc or opportunistic immunisation.

CODE 404 Public health – Environmental health

This category relates to health protection education (for example safe chemical storage, water pollutants), expert advice on specific issues, development of standards, risk management and public health aspects of environmental health protection. The costs of monitoring and regulating are to be included where costs are borne by a regulatory agency and principally have a public health focus (for example radiation safety, and pharmaceutical regulation and safety).

CODE 405 Public health – Food standards and hygiene

This category includes the development, review and implementation of food standards, regulations and legislation as well as the testing of food by the regulatory agency.

CODE 406 Public health – Breast cancer screening

This category relates to Breast cancer screening and includes the complete breast cancer screening pathway through organised programs.

The breast cancer screening pathway includes such activities as recruitment, screen taking, screen reading, assessment (this includes fine needle biopsy), core biopsy, open biopsy, service management and program management.

CODE 407 Public health – Cervical screening

This category relates to organised cervical screening programs such as the state cervical screening programs and rural access programs, including coordination, provision of screens and assessment services.

Cervical screening, funded through Medicare, for both screening and diagnostic services is also included. The methodology used in deriving the estimates is set out in the Jurisdictions' technical notes (section 11.2 of NPHER 2004-05).

CODE 408 Public health – Bowel screening

This category relates to organised bowel screening programs, such as the National Bowel Cancer Screening Program (NBCSP) and the Bowel Cancer Screening Pilot program. The screening pathway includes self administered home based tests by persons turning 55 years or 65 years of age across Australia who mail results in for analysis, the assessment/diagnostic service and program management.

CODE 409 Public health – Prevention of hazardous and harmful drug use

This category includes activities targeted at the general population with the aim of reducing the overuse or abuse of alcohol, tobacco, illicit and other drugs of dependence, and mixed drugs. The Australian Standard Classification of Drugs of Concern includes analgesics, sedatives and hypnotics, stimulants and hallucinogens, anabolic agents and selected hormones, antidepressants and anti-psychotics, and also miscellaneous drugs of concern.

Report for each sub-category as below, the aggregate of which will be total expenditure on Prevention of hazardous and harmful drug use:

Alcohol

Tobacco

Illicit and other drugs of dependence

Mixed.

CODE 410 Public health – Public health research

The basic criterion for distinguishing public health research and development from other public health activities is the presence in research and development of an appreciable element of novelty and resolution of scientific and/or technical uncertainty.

Includes mainly new or one-off research in the 8 core public health functions listed under codes 401 to 409.

General research and development work relating to the running of ongoing public health programs is included under the other relevant public health activities in codes 401 to 409.

CODE 488 Public health – Other public health

Comprises public health functions not reported to the National Public Health Expenditure Project.

CODE 499 Public health – Not further defined

Comprises public health services that could be a combination of categories 401 to 410 but which could not be further disaggregated.

State and territory health authorities are only to report public health services under codes 401 to 409.

CODE 501 Health related care – Patient transport

This item comprises transportation in a specially-equipped surface vehicle or in a designated air ambulance to and from facilities for the purposes of receiving medical and surgical care.

Includes all government ambulance services and transport provided by the Royal Flying Doctors Service, care flight and similar services, emergency transport services of public fire rescue departments or defence that operate on a regular basis for civilian emergency services (not only for catastrophe medicine).

Includes transport between hospitals or other medical facilities and transport to or from a hospital or other medical facility and a private residence or other non-hospital/medical services location.

The provider of this service could be a public or private hospital or an ambulance service.

CODE 502 Health related care – Patient transport subsidies

Government subsidies to private ambulance services e.g. patient transport vouchers, support programs to assist isolated patients with travel to obtain specialised health care.

It also includes transportation in conventional vehicles, such as taxi, when the latter is authorised and the costs are reimbursed to the patient (e.g. for patients undergoing renal dialysis or chemotherapy).

CODE 503 Health related care – Medications

This item is not currently required to be reported by state and territory health authorities.

Includes pharmaceuticals and other medical non-durables, prescribed medicines and over-the-counter pharmaceuticals. Included within these categories are: medicinal preparations, branded and generic medicines, drugs, patent medicines, serums and vaccines, vitamins and minerals and oral contraceptives, prescribed medicines exclusively sold to customers with a medical voucher, irrespective of whether it is covered by public or private funding. Includes branded and generic products, private households' non-prescription medicines and a wide range of medical non-durables such as bandages, condoms and other mechanical contraceptive devices, elastic stockings, incontinence articles and toothbrushes, toothpastes and therapeutic mouth washes.

CODE 504 Health related care – Aids and appliances

This item is not currently required to be reported by state and territory health authorities.

This item comprises glasses and other vision products, orthopaedic appliances & other prosthetics, hearing aids, medico-technical devices including wheelchairs and all other miscellaneous medical durables not elsewhere classified such as blood pressure instruments.

CODE 505 Health related care – Health administration

Administrative services which cannot be allocated to a specific health good and service. Those unallocatable services might include, for example, maintaining an office of the Chief Medical Officer; a Departmental liaison officer in the office of the Minister; or a number of other agency-wide items for which it is not possible to derive appropriate or meaningful allocations to particular health programs.

CODE 506 Health related care – Health research

Includes all research on health topics that is not included in public health research (code 410). That is, it includes all research classified under ABS Australian Standard Research Classification code 320000, excluding code 321200.

Excludes public health research and non-health related research.

CODE 588 Health related care – Other

Includes for example, services provided by health and health-related call centres and e-health information services.

Excludes health related care reported under codes 501 to 506 and health assessments provided under the Aged Care Assessment Program which are reported under code 602.

CODE 599 Health related care – Not further defined

Comprises health related care that could be a combination of categories 501 to 506 but which could not be further disaggregated.

State and territory health authorities are only to report health related care under codes 501 to 506.

CODE 601 Other function – Home and community care

This item is not currently required to be reported by state and territory health authorities.

Comprises Home and Community Care services reported under the HACC NMDS.

Information on these service categories is available in the following report:

National classifications of community services. Version 2.0. AIHW Cat. No. HWI 40. Canberra: Australian Institute of Health and Welfare, 2003.

Excludes services reported under codes 602 to 604.

CODE 602 Other function – Aged care

This item is not currently required to be reported by state and territory health authorities.

Includes residential care aged care programs, aged care assessment programs and other non-health aged care programs, such as respite care and day care activities.

Excludes services provided under the HACC program.

CODE 603 Other function – Other welfare

This item is not currently required to be reported by state and territory health authorities.

Includes services delivered to clients, or groups of clients with special needs such as the young or the disabled. Excludes aged care services reported under code 602.

CODE 688 Other function – Other

This item is not currently required to be reported by state and territory health authorities. Includes for example, car parking, accommodation for staff or for patients' relatives, or non-health related research.

CODE 699 Other function – Not further defined

This item is not currently required to be reported by state and territory health authorities.

Comprises other functions that could be a combination of categories 601 to 603 but which could not be further disaggregated.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents: Australian Bureau of Statistics 1998. Australian Standard Research Classification. Cat. no. 1297.0. Canberra: ABS.

Australian Government Department of Health and Ageing Medicare Benefits Schedule Book, 1 November 2006 available from http://www.health.gov.au/mbsonline

Australian Institute of Health and Welfare 2003. National classifications of community services. Version 2.0. AIHW cat. no. HWI 40. Canberra: AIHW.

Australian Institute of Health and Welfare 2007. National public health expenditure report 2004–05. Health and welfare series expenditure series no. 29. cat. no. HWE 36. Canberra: AIHW.

Data element attributes

Relational attributes

Implementation in Data Set Specifications: Government health expenditure function revenue data element cluster Health, Standard 03/12/2008

Government health expenditure organisation expenditure capital consumption data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure employee related data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure purchase of goods and services data element cluster Health, Standard 01/04/2009

Type of labour induction

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—labour induction type, code N
METeOR identifier:	270037
Registration status:	Health, Standard 01/03/2005
Definition:	Method used to induce labour, as represented by a code.
Data Element Concept:	Birth event—labour induction type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	None
1	Oxytocin
2	Prostaglandins
3	Artificial rupture of membranes (ARM)
4	Other

Data element attributes

Collection and usage attributes

Guide for use: More than one method of induction can be recorded, except where 0=none applies.

Comments: Type of induction determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Type of labour induction, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Type of opioid pharmacotherapy treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—type of opioid pharmacotherapy treatment, code N
METeOR identifier:	404753
Registration status:	Health, Standard 25/08/2011
Definition:	The type of opioid pharmacotherapy administered to a person, as represented by a code.
Data Element Concept:	Person—type of opioid pharmacotherapy treatment

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Methadone
2	Other opioid pharmacotherapy

Collection and usage attributes

Guide for use:

CODE 1 Methadone

Includes treatment programs whereby the administered opioid substitute is methadone.

CODE 2 Other opioid pharmacotherapy

Includes opioid replacement programs such as naltrexone, buprenorphine, suboxone or levacetylmethadyl (LAAM).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Kastelic A, Pont J & Stover H 2008. Opioid substitution treatment in custodial settings: a practical guide. Oldenburg: BIS-Verlag.

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data elements: *Person—previous opioid pharmacotherapy* *treatment program indicator, yes/no code N* and *Person—current opioid pharmacotherapy treatment program indicator, yes/no code N* to provide information on a person's history of opioid pharmacotherapy treatment.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	Dolan KA, Hall W & Wodak A 1996. Methadone maintenance reduces injecting in prison. British Medical Journal 312:1162. Kastelic A, Pont J & Stover H 2008. Opioid substitution treatment in custodial settings: a practical guide. Oldenburg: BIS-Verlag.

Relational attributes

Related metadata references:	See also Person—current opioid pharmacotherapy treatment program indicator, yes/no code N Health, Standard 25/08/2011 See also Person—previous opioid pharmacotherapy treatment program indicator, yes/no code N Health, Standard 25/08/2011
Implementation in Data Set Specifications:	Opioid pharmacotherapy treatment cluster Health, Standard 25/08/2011 *Conditional obligation:* Conditional on the respondent indicating that they are currently on, or have been on a pharmacotherapy for opioid dependence.

Type of service provider consulted

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—type of service provider consulted, occupation code (ANZSCO 1st edition) N[NNN]{NN}
METeOR identifier:	376361
Registration status:	Health, Standard 25/08/2011
Definition:	The type of service provider consulted during a health clinic visit, as represented by a code.
Data Element Concept:	Health service event—type of service provider consulted

Value domain attributes

Representational attributes

Classification scheme:	Australian and New Zealand Standard Classification of Occupations, First edition, 2006
Representation class:	Code
Data type:	Number
Format:	N[NNN]{NN}
Maximum character length:	6

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Prison clinic contact DSS Health, Standard 25/08/2011

Type of service provider consulted (prison entrant)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Prison entrant—type of service provider consulted, occupation code (ANZSCO 1st edition) N[NNN]{NN}

METeOR identifier: 402812

Registration status: Health, Standard 25/08/2011

Definition: The type of individual service provider consulted by a prison entrant for their own health, as represented by a code.

Data Element Concept: Prison entrant—type of service provider consulted

Value domain attributes

Representational attributes

Classification scheme: Australian and New Zealand Standard Classification of Occupations, First edition, 2006

Representation class: Code

Data type: Number

Format: N[NNN]{NN}

Maximum character length: 6

Data element attributes

Collection and usage attributes

Guide for use: This data element may be used in conjunction with the data element *Health service event – prisoner location, code N* and *Prison entrant – individual service provider consulted indicator, yes/no code N* to assess health seeking behaviours of prisoners prior to entering prison or whilst in prison.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Health service event—prisoner location, code N Health, Standard 25/08/2011

See also Prison entrant—individual service provider consulted indicator, yes/no code N Health, Standard 25/08/2011

Implementation in Data Set Specifications: Health service utilisation cluster Health, Standard 25/08/2011

Conditional obligation:
Conditional on the prison entrant indicating that they consulted a service provider for their own health in the last 12 months.

Type of service provider needed but not utilised

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Prison entrant—type of service provider needed but not utilised, occupation code (ANZSCO 1st edition) N[NNN]{NN}
METeOR identifier:	402820
Registration status:	Health, Standard 25/08/2011
Definition:	The type of service provider a prison entrant needed to consult, but did not, as represented by a code.
Data Element Concept:	Prison entrant—type of service provider needed but not utilised

Value domain attributes

Representational attributes

Classification scheme:	Australian and New Zealand Standard Classification of Occupations, First edition, 2006
Representation class:	Code
Data type:	Number
Format:	N[NNN]{NN}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	This data element should be used in conjunction with the data element *Health service event—prisoner location when service provider was needed, but not utilised, prisoner location code N* to provide information on the health seeking behaviours of prison entrants.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Health service event—prisoner location when service provider was needed, but not utilised, prisoner location code N Health, Standard 25/08/2011 See also Prison entrant—reason for non-utilisation of health service, code NN Health, Standard 25/08/2011
Implementation in Data Set	Health service non-utilisation cluster Health, Standard

Specifications:	25/08/2011 *Conditional obligation:* Conditional on the prison entrant indicating that he or she needed to consult with a service provider for their own health but did not.

Type of substance used illicitly

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—type of substance used illicitly, drug of concern (ASCDC 2000 extended) code NNNN
METeOR identifier:	365401
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	The type of substance used illicitly by a person, as represented by a code.
Data Element Concept:	Person—type of substance used illicitly

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Drugs of Concern 2011
Representation class:	Code
Data type:	String
Format:	NNNN
Maximum character length:	4

Supplementary values:

Value	Meaning
0005	Opioid analgesics not further defined
0006	Psychostimulants not further defined

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Drugs of Concern (ASCDC) provides a number of supplementary codes that have specific uses and these are detailed within the ASCDC, e.g. 0000 = inadequately described.

Other supplementary codes that are not already specified in the ASCDC may be used in National Minimum Data Sets (NMDS) when required. In the Alcohol and other drug treatment service NMDS, two additional supplementary codes have been created which enable a finer level of detail to be captured:

CODE 0005 Opioid analgesics not further defined

This code is to be used when it is known that the client's principal drug of concern is an opioid but the specific opioid used is not known. The existing code 1000 combines opioid analgesics and non-opioid analgesics together into Analgesics nfd and the finer level of detail, although known, is lost.

CODE 0006 Psychostimulants not further defined

This code is to be used when it is known that the client's principal drug of concern is a psychostimulant but not which type. The existing code 3000 combines stimulants and hallucinogens together into Stimulants and hallucinogens nfd and the finer level of detail, although known, is lost.

Psychostimulants refer to the types of drugs that would normally be coded to 3100-3199, 3300-3399 and 3400-3499 categories plus 3903 and 3905.

Data element attributes

Collection and usage attributes

Guide for use: This data element is used in conjunction with the data element: *Person—substance used illicitly indicator, yes/no/not stated/inadequately described code N* to provide information on the type of substances a person has used illicitly.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: AIHW (Australian Institute of Health and Welfare) 2008. 2007 National Drug Strategy Household Survey: first results. Drug Statistics Series number 20.Cat. no. PHE 98. Canberra: AIHW

Reference documents: AIHW 2010a. Alcohol and Other Drug Treatment Services National Minimum Data Set 2010–11: specifications and collection manual. Drug statistics series no. 24. Cat. no. PHE 125. Canberra: AIHW.

AIHW 2010b. The health of Australia's prisoners 2009. Cat. no. PHE 123. Canberra: AIHW.

Relational attributes

Related metadata references: See also Person—substance used illicitly indicator, yes/no/not stated/inadequately described code N Community Services, Standard 06/02/2012, Health, Standard 25/08/2011

Implementation in Data Set Specifications: Substances used illicitly cluster Health, Standard 25/08/2011

Conditional obligation:

Conditional on person using a substance in an illicit manner in the last 12 months.

Type of usual accommodation

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—accommodation type (prior to admission), code N

METeOR identifier: 270079

Registration status: Health, Standard 01/03/2005

Definition: The type of physical accommodation the person lived in prior to **admission**.

Context: Admitted patient mental health care:

Permits analysis of the prior residential accommodation type of people admitted to residential aged care services or other institutional care.

Data Element Concept: Person—accommodation type

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	House or flat
2	Independent unit as part of retirement village or similar
3	Hostel or hostel type accommodation
4	Psychiatric hospital
5	Acute hospital
6	Other accommodation
7	No usual residence

Collection and usage attributes

Collection methods: The above classifications have been based on Question 16 of Form NH5.

The Australian Government Department of Health and Aged Care has introduced a new Aged Care Application and Approval form which replaces the NH5.

Data element attributes

Collection and usage attributes

Collection methods: This metadata item is not available for New South Wales State nursing homes. As this item includes only details of physical accommodation before admission it was decided to have details of the relational basis of accommodation before admission collected as a separate metadata item (see metadata item Admission mode).

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of usual accommodation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Implementation in Data Set Specifications: Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Type of vaccine administered

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (prison)—type of vaccine administered, vaccine type, code N
METeOR identifier:	411908
Registration status:	Health, Standard 25/08/2011
Definition:	The type of vaccine administered in a prison establishment, as represented by a code.
Data Element Concept:	Establishment (prison)—type of vaccine administered

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Hepatitis B vaccine
2	Human papillomavirus (HPV) vaccine
3	Meningococcal vaccine

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: This data element is used in conjunction with the data element: *Establishment (prison) – number of vaccines administered, Number N[NN]* to gain information about the immunisation programs available in Australia's prisons.

Comments: Immunisation is highly effective in reducing morbidity and mortality caused by vaccine-preventable diseases.

The Prisoner Health Information Group agreed that it was of most interest to collect information regarding hepatitis B, human papillomavirus and meningococcal vaccinations.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Reference documents: National Health and Medical Research Council 2008. The Australian Immunisation Handbook (9th edn). Canberra: Department of Health and Ageing.

Relational attributes

Related metadata references: See also Establishment (prison)—number of vaccine doses administered, number N[NN] Health, Standard 25/08/2011

Implementation in Data Set Specifications: Vaccines administered cluster Health, Standard 25/08/2011

Type of visit to emergency department

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Emergency department stay—type of visit to emergency department, code N

METeOR identifier: 474195

Registration status: Health, Standard 30/01/2012

Definition: The reason the patient presents to an emergency department, as represented by a code.

Context: Emergency department care.

Data Element Concept: Emergency department stay—type of visit to emergency department

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Emergency presentation: attendance for an actual or suspected condition which is sufficiently serious to require acute unscheduled care.
2	Return visit, planned: presentation is planned and is a result of a previous emergency department presentation or return visit.
3	Pre-arranged admission: a patient who presents at the emergency department for either clerical, nursing or medical processes to be undertaken, and admission has been pre-arranged by the referring medical officer and a bed allocated.
4	Patient in transit: the emergency department is responsible for care and treatment of a patient awaiting transport to another facility.
5	Dead on arrival: a patient who is dead on arrival and an emergency department clinician certifies the death of the patient.

Data element attributes

Collection and usage attributes

Comments: Required for analysis of emergency department services.

Source and reference attributes

Submitting organisation: National Institution Based Ambulatory Model Reference Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Emergency department stay—type of visit to emergency department, code N Health, Superseded 30/01/2012

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS 2012-2013 Health, Standard 30/01/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Underlying cause of death

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—underlying cause of death, code (ICD-10 2nd edn) ANN-ANN

Synonymous names: UCOD code

METeOR identifier: 307931

Registration status: Health, Standard 01/10/2008

Definition: The disease or injury which initiated the train of morbid events leading directly to a person's death or the circumstances of the accident or violence which produced the fatal injury, as represented by a code. (WHO 2004)

Data Element Concept: Person—underlying cause of death

Value domain attributes

Representational attributes

Classification scheme: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, (2nd edition)

Representation class: Code

Data type: String

Format: ANN-ANN

Maximum character length: 6

Data element attributes

Collection and usage attributes

Guide for use: Underlying cause of death is central to mortality coding and comparable international mortality reporting.

Comments: The Australian Bureau of Statistics (ABS) codes and classifies the underlying cause of death (UCOD) according to the rules and guidelines for mortality coding adopted by the World Health Assembly and set out in the World Health Organisation's International Classification of Diseases and Related Health Problems (ICD).

The ABS uses the Mortality Medical Data System (MMDS) to process and code cause-of-death information reported on death certificates.

Source and reference attributes

Submitting organisation: Australian Bureau of Statistics

Origin:

Australian Bureau of Statistics 2004. Information Paper: Cause of death certification. Catalogue no. 1205.0.55.001. Canberra: Australian Bureau of Statistics. Viewed 31 August 2005.

National Center for Health Statistics 2005. About the Mortality Medical Data System. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Viewed 31 August 2005.

World Health Organisation 2004. The International statistical classification of diseases and related health problems, tenth revision, (2nd edn). Geneva: World Health Organisation.

Reference documents:

Australian Bureau of Statistics 2004. Information Paper: Cause of death certification. Catalogue no. 1205.0.55.001. Canberra: Australian Bureau of Statistics. Viewed 31 August 2005.

World Health Organisation 2004. The International statistical classification of diseases and related health problems, tenth revision, (2nd edn). Geneva: World Health Organisation.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Conditional obligation:

If a date of death is recorded, the cause of death must also be recorded. These data are recorded regardless of the cause of death.

Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:

Recorded when the patient has died.

Urgency of admission

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Episode of admitted patient care—admission urgency status, code N

METeOR identifier: 269986

Registration status: Health, Standard 01/03/2005

Definition: Whether the **admission** has an urgency status assigned and, if so, whether **admission** occurred on an emergency basis, as represented by a code.

Data Element Concept: Episode of admitted patient care—admission urgency status

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Urgency status assigned - emergency
	2	Urgency status assigned - elective
	3	Urgency status not assigned
Supplementary values:	9	Not known/not reported

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Urgency status assigned - emergency

Emergency admission:

The following guidelines may be used by health professionals, hospitals and health insurers in determining whether an emergency admission has occurred. These guidelines should not be considered definitive.

An emergency admission occurs if one or more of the following clinical conditions are applicable such that the patient required admission within 24 hours.

Such a patient would be:

- at risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation; or

- suffering from suspected acute organ or system failure; or
- suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
- suffering from a drug overdoes, toxic substance or toxin effect; or
- experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
- suffering severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- suffering acute significant haemorrhage and requiring urgent assessment and treatment; or
- suffering gynaecological or obstetric complications; or
- suffering an acute condition which represents a significant threat to the patient's physical or psychological wellbeing; or
- suffering a condition which represents a significant threat to public health.

If an admission meets the definition of emergency above, it is categorised as emergency, regardless of whether the admission occurred within 24 hours of such a categorisation being made, or after 24 hours or more.

CODE 2 Urgency status assigned - Elective

Elective admissions:

If an admission meets the definition of elective above, it is categorised as elective, regardless of whether the admission actually occurred after 24 hours or more, or it occurred within 24 hours. The distinguishing characteristic is that the admission could be delayed by at least 24 hours.

Scheduled admissions:

A patient who expects to have an elective admission will often have that admission scheduled in advance. Whether or not the admission has been scheduled does not affect the categorisation of the admission as emergency or elective, which depends only on whether it meets the definitions above. That is, patients both with and without a scheduled admission can be admitted on either an emergency or elective basis.

Admissions from elective surgery waiting lists:

Patients on waiting lists for elective surgery are assigned a Clinical urgency status which indicates the clinical assessment of the urgency with which a patient requires elective hospital care. On admission, they will also be assigned an urgency of admission category, which may or may not be elective:

- Patients who are removed from elective surgery waiting lists on admission as an elective patient for the procedure for which they were waiting (see code 1 in metadata item Reason for removal from an elective surgery waiting list code N) will be assigned an Admission urgency status code N code of 2. In that case, their clinical urgency category could be regarded as further detail on how urgent their admission was.
- Patients who are removed from elective surgery waiting lists on admission as an emergency patient for the procedure for which they were waiting (see code 2 in metadata item Reason for removal from an elective surgery waiting list code N), will be assigned an Admission urgency status code N code of 1.

CODE 3 Urgency status not assigned

Admissions for which an urgency status is usually not assigned are:

- admissions for normal delivery (obstetric)
- admissions which begin with the birth of the patient, or when it was intended that the birth occur in the hospital, commence shortly after the birth of the patient
- statistical admissions
- planned readmissions for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.

An urgency status can be assigned for admissions of the types listed above for which an urgency status is not usually assigned. For example, a patient who is to have an obstetric admission may have one or more of the clinical conditions listed above and be admitted on an emergency basis.

CODE 9 Not known/not reported

This code is used when it is not known whether or not an urgency status has been assigned, or when an urgency status has been assigned but is not known.

Source and reference attributes

Submitting organisation: Emergency definition working party

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Urgency of admission, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.4 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Vascular history

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—vascular condition status (history), code NN
METeOR identifier:	269958
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the person has had a history of vascular conditions, as represented by a code.
Context:	The vascular history of the patient is important as an element in defining future risk for a cardiovascular event and as a factor in determining best practice management for various cardiovascular risk factor(s). It may be used to map vascular conditions, assist in risk stratification and link to best practice management.
Data Element Concept:	Person—vascular condition status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Myocardial infarction
02	Unstable angina pectoris
03	Angina
04	Heart failure
05	Atrial fibrillation
06	Other dysrhythmia or conductive disorder
07	Rheumatic heart disease
08	Non-rheumatic valvular heart disease
09	Left ventricular hypertrophy
10	Stroke
11	Transient ischaemic attack
12	Hypertension
13	Peripheral vascular disease (includes abdominal aortic aneurism)
14	Deep vein thrombosis

	15	Other atherosclerotic disease
	16	Carotid stenosis
	17	Vascular renal disease
	18	Vascular retinopathy (hypertensive)
	19	Vascular retinopathy (diabetic)
	97	Other vascular
	98	No vascular history
Supplementary values:	99	Unknown/not stated /not specified

Collection and usage attributes

Comments: Can be mapped to the current version of ICD-10-AM.

Source and reference attributes

Origin: International Classification of Diseases - Tenth Revision - Australian Modification (3rd Edition 2000), National Centre for Classification in Health, Sydney

Data element attributes

Collection and usage attributes

Guide for use: More than one code can be recorded.

Collection methods: Ideally, vascular history information is derived from and substantiated by clinical documentation.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: National Centre for Classification in Health

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: Supersedes Vascular history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.8 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Vascular procedures

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—vascular procedures (history), code NN
METeOR identifier:	269962
Registration status:	Health, Standard 01/03/2005
Definition:	The vascular procedures the person has undergone, as represented by a code.
Data Element Concept:	Person—vascular procedure

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Permissible values:	Value	Meaning
	01	Amputation for arterial vascular insufficiency
	02	Carotid endarterectomy
	03	Carotid angioplasty/stenting
	04	Coronary angioplasty/stenting
	05	Coronary artery bypass grafting
	06	Renal artery angioplasty/stenting
	07	Heart transplant
	08	Heart valve surgery
	09	Abdominal aortic aneurism repair/bypass graft/stenting
	10	Cerebral circulation angioplasty/stenting
	11	Femoral/popliteal bypass/graft/stenting
	12	Congenital heart and blood vessel defect surgery
	13	Permanent pacemaker implantation
	14	Implantable cardiac defibrillator
	98	Other
Supplementary values:	99	Unknown/not recorded

Data element attributes

Collection and usage attributes

Collection methods: Ideally, Vascular procedure information is derived from and substantiated by clinical documentation.

Comments: In settings where the monitoring of a person's health is ongoing and where a history can change over time (such as general practice), the Service contact—service contact date, DDMMYYYY should be recorded.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: Australian Institute of Health and Welfare (AIHW) 2001. Heart, stroke and vascular diseases - Australian facts 2001. AIHW Cat. No. CVD 13. Canberra: AIHW, National Heart foundation of Australia, National Stroke Foundation of Australia (CVD Series No. 14)

Relational attributes

Related metadata references: Supersedes Vascular procedures, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Ventricular ejection fraction measurement indicator

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—ventricular ejection fraction test performed indicator, yes/no code N

Synonymous names: EF measurement indicator

METeOR identifier: 347672

Registration status: Health, Standard 01/10/2008

Definition: An indicator of whether a person's ventricular ejection fraction was measured, as represented by a code.

Data Element Concept: Person—ventricular ejection fraction test performed indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/ inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: Code 1 Yes

Record if a test was performed to measure the person's ventricular ejection fraction.

Code 2 No

Record if no test was performed to measure the person's ventricular ejection fraction.

Relational attributes

Related metadata references: See also Ventricular ejection fraction test—test type, code N Health, Standard 01/10/2008

Implementation in Data Set Specifications: Ventricular ejection fraction cluster Health, Standard 01/10/2008

Ventricular ejection fraction test result (percentage)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Ventricular ejection fraction—test result, percentage N[N].N
Synonymous names:	EF result (percentage)
METeOR identifier:	347002
Registration status:	Health, Standard 01/10/2008
Definition:	A person's ventricular ejection fraction result expressed as a percentage.
Data Element Concept:	Ventricular ejection fraction—test result

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	The person's ejection fraction result recorded should be between 0 and 80%.
Comments:	The patient is not alive or is in Pulseless Electrical Activity (PEA) if the result is 0%.

Relational attributes

Related metadata references:	See also Ventricular ejection fraction—test result, code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Ventricular ejection fraction cluster Health, Standard 01/10/2008 *Conditional obligation:* To be provided when the ventricular ejection fraction is measured.

Ventricular ejection fraction test result (code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Ventricular ejection fraction—test result, code N
Synonymous names:	EF result (code)
METeOR identifier:	346993
Registration status:	Health, Standard 01/10/2008
Definition:	The person's ventricular ejection fraction result, as represented by a code.
Data Element Concept:	Ventricular ejection fraction—test result

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:	Value	Meaning
	1	Normal
	2	Mild
	3	Moderate
	4	Severe
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Normal

Use this code when the ejection fraction is greater than 50%

CODE 2 Mild

Use this code when the ejection fraction is greater than or equal to 45% but less than or equal to 50%

CODE 3 Moderate

Use this code when the ejection fraction is greater than or equal to 35% but less than 45%

CODE 4 Severe

Use this code when the ejection fraction is less than 35%

CODE 9 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Relational attributes

Related metadata references: See also Ventricular ejection fraction—test result, percentage N[N].N Health, Standard 01/10/2008

Implementation in Data Set Specifications: Ventricular ejection fraction cluster Health, Standard 01/10/2008

Conditional obligation:

To be provided when the ventricular ejection fraction is measured.

Ventricular ejection fraction test type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Ventricular ejection fraction test—test type, code N
Synonymous names:	EF measurement test
METeOR identifier:	344253
Registration status:	Health, Standard 01/10/2008
Definition:	The type of test used to measure a person's ventricular ejection fraction, as represented by a code.
Data Element Concept:	Ventricular ejection fraction test—test type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	1	Echocardiography
	2	Angiography
	3	Gated blood pool scan
	4	Magnetic resonance imaging (MRI)
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Relational attributes

Related metadata references: See also Person—ventricular ejection fraction test performed indicator, yes/no code N Health, Standard 01/10/2008

Implementation in Data Set Specifications: Ventricular ejection fraction cluster Health, Standard 01/10/2008

Conditional obligation:
To be provided when the ventricular ejection fraction is measured.

Visa type - health professional

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—visa type, code AANNN
METeOR identifier:	381681
Registration status:	Health, Standard 10/12/2009
Definition:	The category of visa (or travel authority) granted by Australia for foreign nationals (excluding New Zealand citizens) who are registered as health professionals in Australia, to travel to, enter and remain in Australia, as represented by a code.
Data Element Concept:	Registered health professional—visa type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AANNN
Maximum character length:	5

Collection and usage attributes

Guide for use: Includes all 2-digit alphabetical classes and 3-digit numeric sub-classes as described in the Migration Regulations 1994 of the Migration Act 1958.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Further information regarding visas can be obtained from the Australian Department of Immigration and Citizenship or visit their website www.immi.gov.au

Reference documents: The Migration Regulations 1994 of the Migration Act 1958.

Data element attributes

Collection and usage attributes

Guide for use: A **visa** (or travel authority) is permission or authority granted by Australia for foreign nationals to travel to, enter and remain in Australia. Immigration law requires all travellers who are not Australian citizens to obtain authority, in the form of a visa or travel authority, to travel to, and stay in Australia.

A **temporary visa** is the permission or authority granted by the Australian government for foreign nationals to travel to and enter Australia, and stay up to a specified period of time.

A **permanent visa** is the permission or authority granted by the Australian government for foreign nationals to live in Australia permanently.

All applicants must meet the English language requirements based on their nominated occupation.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Further information regarding visas can be obtained from the Australian Department of Immigration and Citizenship or visit their website www.immi.gov.au

Reference documents: Registered Health labour force NMDS 2010-2011

Relational attributes

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Visual acuity (left eye)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—visual acuity (left eye), code NN

METeOR identifier: 269963

Registration status: Health, Standard 01/03/2005

Definition: A person's left eye visual acuity, as represented by a code.

Data Element Concept: Person—visual acuity

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: NN

Maximum character length: 2

	Value	Meaning
Permissible values:	01	6/5
	02	6/6
	03	6/9
	04	6/12
	05	6/18
	06	6/24
	07	6/36
	08	6/60
	09	CF (count fingers)
	10	HM (hand movement)
	11	PL (perceive light)
	12	BL (blind)
	13	6/7.5
Supplementary values:	99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: Record actual result for both right and left eyes:

- 1st field: Right eye
- 2nd field: Left eye.

Test wearing distance glasses if prescribed.

Use pinhole if vision less than 6/6.

Collection methods:

One of the most often utilised tests for visual acuity uses the Snellen chart.

- At a distance of 6 metres all subjects should be able to read the 6/6 line with each eye using the proper refractive correction.
- Both eyes are to be opened and then cover one eye with the ocular occluder.
- The observer has to read out the smallest line of letters that he/she can see from the chart.
- This is to be repeated with the other eye.

Eye examination should be performed by an ophthalmologist or a suitably trained clinician:

- within five years of **diagnosis** and then every 1-2 years for patients whose diabetes onset was at age under 30 years
- at diagnosis and then every 1-2 years for patients whose diabetes onset was at age 30 years or more.

Source and reference attributes

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents:

Vision Australia, No 2, 1997/8; University of Melbourne

World Health Organization

US National Library of Medicine

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus

Relational attributes

Related metadata references:

See also Person—visual acuity (right eye), code NN Health, Standard 01/03/2005

Supersedes Visual acuity, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.3 KB)

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Standard 21/09/2005

Visual acuity (right eye)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—visual acuity (right eye), code NN

METeOR identifier: 270381

Registration status: Health, Standard 01/03/2005

Definition: A person's right eye visual acuity, as represented by a code.

Data Element Concept: Person—visual acuity

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: NN

Maximum character length: 2

	Value	Meaning
Permissible values:	01	6/5
	02	6/6
	03	6/9
	04	6/12
	05	6/18
	06	6/24
	07	6/36
	08	6/60
	09	CF (count fingers)
	10	HM (hand movement)
	11	PL (perceive light)
	12	BL (blind)
	13	6/7.5
Supplementary values:	99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: Record actual result for both right and left eyes:

- 1st field: Right eye
- 2nd field: Left eye.

Test wearing distance glasses if prescribed.

Use pinhole if vision less than 6/6.

Collection methods: One of the most often utilised tests for visual acuity uses the Snellen chart.

- At a distance of 6 metres all subjects should be able to read the 6/6 line with each eye using the proper refractive correction.
- Both eyes are to be opened and then cover one eye with the ocular occluder.
- The observer has to read out the smallest line of letters that he/she can see from the chart.
- This is to be repeated with the other eye.

Eye examination should be performed by an ophthalmologist or a suitably trained clinician:

- within five years of **diagnosis** and then every 1-2 years for patients whose diabetes onset was at age under 30 years
- at diagnosis and then every 1-2 years for patients whose diabetes onset was at age 30 years or more.

Source and reference attributes

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents: Vision Australia, No 2, 1997/8; University of Melbourne

World Health Organization

US National Library of Medicine

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus

Relational attributes

Related metadata references: See also Person—visual acuity (left eye), code NN Health, Standard 01/03/2005

Supersedes Visual acuity, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.3 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Waist circumference (measured)

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Person—waist circumference (measured), total centimetres NN[N].N

METeOR identifier: 270129

Registration status: Health, Standard 01/03/2005

Definition: A person's waist circumference measured in centimetres.

Data Element Concept: Person—waist circumference

Value domain attributes

Representational attributes

Representation class: Total

Data type: Number

Format: NN[N].N

Maximum character length: 4

Supplementary values:

Value	Meaning
999.9	Not measured

Unit of measure: Centimetre (cm)

Data element attributes

Collection and usage attributes

Collection methods: The collection of anthropometric measurements, particularly in those who are overweight or obese or who are concerned about their weight, should be performed with great sensitivity, and without drawing attention to an individual's weight.

The measurement protocol described below is that recommended by the World Health Organization (WHO Expert Committee 1995) which was adapted from Lohman et al. (1988) and the International Society for the Advancement of Kinanthropometry as described by Norton et al. (1996).

In order to ensure consistency in measurement, the following measurement protocol should be used.

Measurement protocol:

The measurement of waist circumference requires a narrow (7 mm wide), flexible, inelastic tape measure. The kind of tape used should be described and reported. The graduations on the tape measure should be at 0.1 cm intervals and the tape should have the capacity to measure up to 200 cm. Measurement intervals and labels should be clearly readable under all conditions of use of the tape measure.

The subject should remove any belts and heavy outer clothing. Measurement of waist circumference should be taken over at most one layer of light clothing. Ideally the measure is made directly over the skin.

The subject stands comfortably with weight evenly distributed on both feet, and the feet separated about 25-30 cm. The arms should hang loosely at the sides. Posture can affect waist circumference. The measurement is taken midway between the inferior margin of the last rib and the crest of the ilium, in the mid-axillary plane. Each landmark should be palpated and marked, and the midpoint determined with a tape measure and marked.

The circumference is measured with an inelastic tape maintained in a horizontal plane, at the end of normal expiration. The tape is snug, but does not compress underlying soft tissues. The measurer is positioned by the side of the subject to read the tape. To ensure contiguity of the two parts of the tape from which the circumference is to be determined, the cross-handed technique of measurement, as described by Norton et al. (1996), should be used. Ideally an assistant will check the position of the tape on the opposite side of the subject's body.

The measurement is recorded at the end of a normal expiration to the nearest 0.1 cm. Take a repeat measurement and record it to the nearest 0.1 cm. If the two measurements disagree by more than 1 cm, take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured waist circumference is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over-reporting (Armitage & Berry 1994). For example, a mean value of 72.25 cm would be rounded to 72.2 cm, while a mean value of 72.35 cm would be rounded to 72.4 cm.

Validation and quality control measures:

Steel tapes should be checked against a 1 metre engineer's rule every 12 months. If tapes other than steel are used they should be checked daily against a steel rule.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within -) or different (between-) observers repeating the measurement, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996) between observers should not exceed 2% and be less than 1.5% within observers.

Extreme values at the lower and upper end of the distribution of measured waist circumference should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last-digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Comments:

This metadata item is recommended for use in population surveys and health care settings.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For reporting purposes, it may be desirable to present waist circumference in categories. It is recommended that 5-cm groupings are used for this purpose. Waist circumference should not be rounded before categorisation. The following categories may be appropriate for describing the waist circumferences of Australian men, women children and adolescents, although the range will depend on the population.

Waist

35 cm = Waist

40 cm = Waist

... in 5 cm categories

105 cm = Waist

Waist => 110 cm

Source and reference attributes

Submitting organisation: World Health Organization International Society for the Advancement of Kinanthropometry

Relational attributes

Related metadata references: Is used in the formation of Adult—waist-to-hip ratio, N.NN Health, Standard 01/03/2005

Supersedes Waist circumference - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Waist circumference risk indicator - adults

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Adult—waist circumference risk indicator, Caucasian adult code N

METeOR identifier: 270205

Registration status: Health, Standard 01/03/2005

Definition: The sex specific category of risk of metabolic complications associated with excess abdominal adiposity in adult Caucasians, as represented by a code.

Data Element Concept: Adult—waist circumference risk indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

	Value	Meaning
Permissible values:	1	Not at risk (male waist circumference less than 94 cm, female waist circumference less than 80 cm)
	2	Increased (male waist □ircumfer□nce ≥ 94 cm, fe□al□ waist ci□cumf□rence ≥ 80 cm)
	3	Substantially increased (male waist circumference ≥ 102 cm, female waist circumference ≥ 88 cm)
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use: This metadata item cannot be determined if waist circumference measured has not been collected (i.e. is coded to 999.9) and/or sex is not stated (i.e. coded to 9).

This metadata item applies to persons aged 18 years or older.

Collection methods: This metadata item should be derived after the data entry of waist circumference measured. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.

Comments: This metadata item is recommended for use in population surveys and health care settings.

Recent evidence suggests that waist circumference may provide a more practical correlate of abdominal fat distribution and associated ill health.

The identification of risk using waist circumference is population-specific and will depend on levels of obesity and other risk factors for cardiovascular disease and non-insulin dependent diabetes mellitus.

Populations differ in the level of risk associated with a particular waist circumference, so that globally applicable cut-off points cannot be developed. For example, complications associated with abdominal fat in black women and those of South Asian descent are markedly higher for a given level of BMI than in Europeans. Also, although women have almost the same absolute risk of coronary heart disease as men at the same WHR, they show increases in relative risk of coronary heart disease at lower waist circumferences than men. Thus, there is a need to develop sex-specific waist circumference cut-off points appropriate for different populations. Hence, the cut-off points used for this metadata item are associated with obesity in Caucasians. This issue is being investigated further.

Cut-off points for children and adolescents are also being developed. Research shows that a high childhood BMI and high trunk skin fold values are predictive of abdominal obesity as an adult and waist circumference measures in childhood track well into adulthood.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health metadata item currently exist for sex, date of birth, country of birth and Indigenous status and smoking. Metadata items are being developed for physical activity.

Source and reference attributes

Origin: World Health Organization

Reference documents: Obesity: Preventing and Managing the Global Epidemic: Report of a World Health Organization (WHO) Expert Committee. Geneva: WHO, 2000 as described by Han TS et al (1995)

Relational attributes

Related metadata references: Supersedes Waist circumference risk indicator - adults, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (20.5 KB)

Waist-to-hip ratio

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Adult—waist-to-hip ratio, N.NN

METeOR identifier: 270207

Registration status: Health, Standard 01/03/2005

Definition: A ratio calculated by dividing the waist circumference of an adult person by the hip circumference of that same person.

Data Element Concept: Adult—waist-to-hip ratio

Value domain attributes

Representational attributes

Representation class: Ratio

Data type: Number

Format: N.NN

Maximum character length: 3

Data element attributes

Collection and usage attributes

Guide for use: Formula:

WHR = waist circumference (cm) divided by hip circumference (cm).

Adult WHR is a continuous variable. Adult WHR cannot be calculated if either component necessary for its calculation (i.e. abdominal circumference or hip circumference) has not been collected (i.e. is coded to 999.9).

Collection methods: As there are no cut-off points for waist to hip ratio for children and adolescents, it is not necessary to calculate this item for those aged under 18 years.

Waist-to-hip ratio (WHR) should be derived after the data entry of waist circumference and hip circumference. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.

Comments: Adult cut-off points for WHR, that may define increased risk of cardiovascular disease and all cause mortality, range from 0.9 to 1.0 for men and 0.8 to 0.9 for women (Croft et al. 1995, Bray 1987, Bjorntorp 1985). These values are based primarily on evidence of increased risk of death in

European populations, and may not be appropriate for all age and ethnic groups.

In Australia and New Zealand, the cutoffs of >0.9 for males and >0.8 for females were used in the Australian Bureau of Statistics' 1995 National Nutrition Survey.

This metadata item applies to persons aged 18 years or older as no cut off points have been developed for children and adolescents. It is recommended for use in population surveys and health care settings.

More recently it has emerged that waist circumference alone, or in combination with other metabolic measures, is a better indicator of risk and reduces the errors in WHR measurements. WHR is therefore no longer a commonly used measure.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Body fat distribution has emerged as an important predictor of obesity-related morbidity and mortality. Abdominal obesity, which is more common in men than women, has, in epidemiological studies, been closely associated with conditions such as coronary heart disease, stroke, non-insulin dependent diabetes mellitus and high blood pressure.

Waist- to-hip ratio (WHR) can be used:

- to indicate the prevalence of abdominal obesity and its sociodemographic distribution (problem identification)
- to evaluate health promotion and disease prevention programs (assessment of interventions)
- to monitor progress towards national public health policy
- to ascertain determinants and consequences of abdominal obesity - in nutrition and physical activity surveillance and long-term planning.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

Source and reference attributes

Origin:

National Health Data Committee
National Centre for Monitoring Cardiovascular Disease
Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Is formed using Person—hip circumference (measured), total centimetres NN[N].N Health, Standard 01/03/2005

Is formed using Person—waist circumference (measured), total centimetres NN[N].N Health, Standard 01/03/2005

Supersedes Waist-to-hip ratio, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.0 KB)

Waiting list category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective care waiting list episode—elective care type, code N
METeOR identifier:	470208
Registration status:	Health, Standard 13/12/2011
Definition:	The type of elective hospital care that a patient requires, as represented by a code.
Data Element Concept:	Elective care waiting list episode—elective care type

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 7th edition
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Elective surgery
2	Other

Collection and usage attributes

Guide for use:

Elective surgery comprises elective care where the procedures required by patients are listed in the surgical operations section of the Medicare benefits schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians.

Elective care is care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least twenty-four hours.

CODE 1 Elective surgery

All elective surgery, that is excluding procedures listed in exclusion list for Code 2, should be included in this code.

CODE 2 Other

Patients awaiting the following procedures should be classified as Code 2 - other:

- biopsy of:

  kidney (needle only)

lung (needle only)
liver and gall bladder (needle only)

- bronchoscopy (including fibre-optic bronchoscopy) organ or tissue transplant procedures
- colonoscopy
- cosmetic surgery, i.e. when the procedure will not attract a Medicare rebate
- dental procedures not attracting a Medicare rebate
- endoscopic retrograde cholangio-pancreatography (ERCP)
- endoscopy of:
  biliary tract and pancreas
  oesophagus
  small intestine
  stomach
- endovascular interventional procedures
- gastroscopy
- haemodialysis
- in vitro fertilisation
- miscellaneous cardiac procedures
- miscellaneous lower urinary tract procedures
- oesophagoscopy
- organ or tissue transplant
- procedures associated with obstetrics (e.g. elective caesarean section, cervical suture)
- panendoscopy (except when involving the bladder)
- peritoneal and renal dialysis;
- proctosigmoidoscopy (including sigmoidoscopy, anoscopy)
- other diagnostic and non-surgical procedures.

These procedure terms are also defined by the Australian Classification of Health Interventions (ACHI) codes which are listed under Comments below. This coded list is the recommended, but optional, method for determining whether a patient is classified as requiring elective surgery or other care.

Comments: The table of Australian Classification of Health Interventions (ACHI) (7th edition) procedure codes was prepared by the National Centre for Classification in Health. Some codes were excluded from the list on the basis that they are usually performed by non-surgeon clinicians. A more extensive and detailed listing of procedure descriptors is under development. This will replace the list in the Guide for use to facilitate more readily the identification of the exclusions when the list of codes is not used.

ACHI CODES FOR THE EXCLUDED PROCEDURES:

Biopsy (needle) of:
• kidney: 36561-00 [1047]
• lung: 38812-00 [550]
• liver and gall bladder: 30409-00 [953] 30412-00 [953] 90319-01 [951] 30094-04 [964]

Bronchoscopy:
41889-00 [543] 41892-00 [544] 41904-00 [546] 41764-02 [416] 41895-00 [544] 41764-04 [532] 41892-01 [545] 41901-00 [545] 41898-00 [543] 41898-01 [544] 41889-01 [543] 41849-00 [520] 41764-03 [520] 41855-00 [520]

Dental:
Blocks [450] to [490] 97022-00 [451] 97025-00 [451] 97113-00 [453] 97121-01 [454] 97123-01 [454] 97165-01 [455] 97221-00 [456]
97222-00 [456] 97231-00 [456] 97232-00 [456] 97233-00 [456] 97234-00 [456] 97384-00 [461] 97386-01 [461] 97415-00 [462] 97417-00 [462] 97431-00 [463] 97433-00 [463] 97434-00 [463] 97437-00 [463] 97445-00 [464] 97455-00 [464] 97511-01 [465] 97512-01 [465] 97513-01 [465] 97514-02 [465] 97515-02 [465] 97541-01 [465] 97542-01 [465] 97543-01 [465] 97544-00 [465] 97545-00 [465] 97521-01 [466] 97522-01 [466] 97523-01 [466] 97524-00 [466] 97525-00 [466] 97531-00 [466] 97532-00 [466] 97533-00 [466] 97534-00 [466] 97535-00 [466] 97551-01 [466] 97552-01 [466] 97553-01 [466] 97554-01 [466] 97555-01 [466] 97572-01 [469] 97574-01 [469] 97575-00 [469] 97578-00 [469] 97582-01 [469] 97583-01 [469] 97631-00 [470] 97632-00 [471] 97649-00 [471] 97671-00 [473] 97672-00 [473] 97673-00 [473] 97732-00 [474] 97733-00 [474] 97739-00 [474] 97741-00 [475] 97762-00 [476] 97765-00 [476] 97768-00 [476] 97825-00 [479]

Endoscopy of biliary tract and pancreas:
30484-00 [957] 30484-01 [957] 30484-02 [974] 30494-00 [971] 30452-00 [971] 30491-00 [958] 30491-02 [975] 30485-00 [963] 30485-01 [963] 30452-01 [958] 30450-00 [959] 30452-02 [959] 90349-00 [975]

Endoscopy of oesophagus:
30473-03 [850] 30473-04 [861] 41822-00 [861] 30478-11 [856] 41819-00 [862] 30478-10 [852] 30478-13 [861] 41816-00 [850] 41822-00 [861] 41825-00 [852] 30478-12 [856] 41831-00 [862] 30478-12 [856] 30490-00 [853] 30479-00 [856]

Endoscopy of large intestine, rectum and anus:
32075-00 [904] 32090-00 [905] 32084-00 [905] 30479-02 [908] 90308-00 [908] 32075-01 [910] 32078-00 [910] 32081-00 [910] 32090-01 [911] 32093-00 [911] 32084-01 [911] 32087-00 [911] 30479-01 [931] 90315-00 [933]

In vitro fertilisation:

13209-00 [1297] 13206-00 [1297] 13200-00 [1297] 13203-00 [1297] 13212-00 [1297] 13212-01 [1297] 13215-00 [1297] 13215-01 [1297]
13215-02 [1297] 13215-03 [1297]

Endovascular interventional:
38300-01 [670] 38303-00 [670] 38300-00 [670] 38303-01 [670] 38306-00 [671] 38306-01 [671]38306-03 [671] 38306-04 [671] 38306-02 [671] 38306-05 [671] 34524-00 [694] 13303-00 [694] 34521-01 [694] 32500-01 [722] 32500-00 [722] 13300-01 [738] 13300-02 [738] 13319-00 [738]13300-00 [738] 13815-00 [738] 13815-01 [738] 34521-02 [738] 34530-04 [738] 90220-00 [738]

Miscellaneous cardiac:
38603-00 [642] 38600-00 [642] 38256-00 [647] 38256-01 [647] 38256-00 [647] 38350-00 [648] 90202-00 [649] 38470-00 [649] 38473-00 [649] 38353-00 [650] 38358-00 [654] 38358-01 [654] 38368-02 [654] 90203-00 [654] 38350-02 [654] 90219-00 [663] 38353-02 [655] 38212-00 [665] 38209-00 [665] 38200-00 [667] 38203-00 [667] 38206-00 [667] 35324-00 [740] 35315-00 [758] 35315-01 [758] 38368-00 [648] 90202-01 [649] 38358-00 [654] 38358-01 [654] 38358-02 [654]
38654-02 [654] 38456-26 [654] 38456-27 [654] 90203-04 [654] 38456-25 [654] 38353-02 [654] 38287-01 [601] 38287-02 [601] 38213-00 [665]

Miscellaneous lower urinary tract procedure:
36800-00 [1090] 36800-01 [1090] 37011-00 [1093] 37008-01 [1093] 37008-00 [1093] 37315-00 [1112] 37318-01 [1116] 36815-01 [1116] 37854-00 [1116]
35527-00 [1116] 37318-04 [1117] 36800-03 [1090] 37318-02 [1116] 37318-03 [1116]

Organ or tissue transplant:
90172-00 [555] 90172-01 [555] 90204-00 [659] 90204-01 [659] 90205-00 [660] 90205-01 [660] 13700-00 [801] 13706-08 [802] 13706-00 [802] 13706-06 [802] 13706-07 [802] 13706-09 [802] 13706-10 [802] 30375-21 [817] 90317-00 [954] 90324-00 [981] 36503-00 [1058] 36503-01 [1058] 14203-01 [1906]

Panendoscopy:
30476-03 [874] 32095-00 [891] 30568-00 [893] 30569-00 [894] 30473-05 [1005] 30473-00 [1005] 30473-02 [1005] 30478-00 [1006] 30478-14 [1006]
30478-01 [1007] 30478-02 [1007] 30478-03 [1007] 30478-15 [1007] 30478-16 [1007] 30478-17 [1007] 30478-20 [1007] 30478-21 [1007] 30473-01 [1008]
30478-04 [1008] 30473-06 [1008] 30478-18 [1008]

Peritoneal and renal dialysis:
13100-06 [1061] 13100-07 [1061] 13100-08 [1061] 13100-00 [1060]

Procedures associated with obstetrics:
16511-00 [1274]

Obstetric:
Blocks [1330] to [1345] and [1347] 90463-01 [1330] 90488-00 [1330]

Other diagnostic and non-surgical:
90347-01 [983] 30406-00 [983] 90347-02 [983] 30408-00 [983]

Blocks [1820] to [1939], [1940] to [2016]

11003-00 [1825] 11018-00 [1826] 11018-01 [1826] 11614-00 [1851] 11602-00 [1852] 11604-00 [1852] 11605-00 [1852] 11610-00 [1852]
11611-00 [1852] 11612-00 [1852] 11709-00 [1853] 11917-00 [1860] 11919-00 [1860] 96209-00 [1920] 96209-01 [1920] 96209-02 [1920]
96209-03 [1920] 96209-04 [1920] 13706-05 [1893] 96209-06 [1920] 96209-07 [1920] 96209-08 [1920] 96209-09 [1920] 55084-00 [1943]
55600-00 [1943] 60000-01 [1992] 60048-00 [1996] 60060-00 [1997] 60060-01 [1997] 61442-00 [2012] 96196-00 [1920] 96196-01 [1920]
96196-02 [1920] 96196-03 [1920] 96196-04 [1920] 13706-05 [1893] 96196-06 [1920] 96196-07 [1920] 96196-08 [1920] 96196-09 [1920]
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96199-07 [1920] 96199-08 [1920] 96199-09 [1920] 96200-00 [1920] 96200-01 [1920] 96200-02 [1920] 96200-03 [1920] 96200-04 [1920]
96200-06 [1920] 96200-07 [1920] 96200-08 [1920] 96200-09 [1920] 96201-00 [1920] 96201-01 [1920] 96201-02 [1920] 96201-03 [1920]
96201-04 [1920] 96201-06 [1920] 96201-07 [1920] 96201-08 [1920] 96201-09 [1920] 96202-00 [1920] 96202-01 [1920] 96202-02 [1920]
96202-03 [1920] 96202-04 [1920] 96202-06 [1920] 96202-07 [1920] 96202-08 [1920] 96202-09 [1920] 96203-00 [1920] 96203-01 [1920]
96203-02 [1920] 96203-03 [1920] 96203-04 [1920] 96203-06 [1920] 96203-07 [1920] 96203-08 [1920] 96203-09 [1920] 96199-00 [1920]
96199-01 [1920] 96199-02 [1920] 96199-03 [1920] 96199-04 [1920] 13706-05 [1893] 96199-06 [1920] 96199-07 [1920] 96199-08 [1920]
96199-09 [1920] 96205-00 [1920] 96205-01 [1920] 96205-02

[1920] 96205-03 [1920] 96205-04 [1920] 96205-06 [1920]
96205-07 [1920]
96205-08 [1920] 96205-09 [1920] 96206-00 [1920] 96206-01
[1920] 96206-02 [1920] 96206-03 [1920] 96206-04 [1920]
96206-06 [1920]
96206-07 [1920] 96206-08 [1920] 96206-09 [1920]

Source and reference attributes

Reference documents: National Centre for Classification in Health (NCCH) 2010. The Australian Classification of Health Interventions (ACHI) – Seventh Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.

Data element attributes

Collection and usage attributes

Collection methods: This data element is necessary for determining whether patients are in scope for both the Elective surgery waiting times (census data) NMDS 2012-2013 and the Elective surgery waiting times (removals data) NMDS 2012-2013 but is not explicitly included in either NMDS.

Source and reference attributes

Submitting organisation: Hospital Access Program Waiting Lists Working Group
Waiting Times Working Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Elective care waiting list episode—elective care type, code N Health, Superseded 13/12/2011

See also Elective surgery waiting times (census data) NMDS 2012-2013 Health, Standard 13/12/2011

See also Elective surgery waiting times (removals data) NMDS 2012-2013 Health, Standard 13/12/2011

Waiting time at a census date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN]
METeOR identifier:	471715
Registration status:	Health, Standard 22/12/2011
Definition:	The time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list to a designated census date.
Context:	Elective surgery
Data Element Concept:	Elective surgery waiting list episode—waiting time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

The number of days is calculated by subtracting the *'Elective care waiting list episode—listing date for care, DDMMYYYY'* from the Hospital census (of elective surgery waitlist patients)—census date, DDMMYYYY, minus any days when the patient was 'not ready for care', and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at the census date.

Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as 'not ready for care' from the date(s) the person was subsequently recorded as again being 'ready for care'.

If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at the census date, then the number of days waited at the less urgent *'Elective surgery waiting list episode—clinical urgency,* *code N'* category should be subtracted from the total number of days waited.

In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at census date) the number of days at the less urgent clinical urgency category should be calculated by subtracting the *'Elective care waiting list episode—listing date for care, DDMMYYYY'* from the *'Elective care waiting list episode—category reassignment date, DDMMYYYY'*. If the patient's clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at the census date should be calculated by subtracting one *'Elective care waiting list episode—category reassignment date, DDMMYYYY'* from the subsequent *'Elective care waiting list episode—category reassignment date, DDMMYYYY'*, and then adding the days together.

When a patient is admitted from an elective surgery waiting list but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue. Therefore at the census date the patient's waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient.

Comments:

Elective surgery waiting times data collections include measures of waiting times at removal and at designated census dates. This metadata item is used to measure waiting times at a designated census date whereas the metadata item Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] measures waiting times at removal.

The calculation of waiting times for patients who are transferred from an elective surgery waiting list managed by one public acute hospital to another will be investigated in the future. In this case, the amount of time waited on previous lists should follow the patient to the next. Therefore at the census date, their waiting time includes the total number of days on all lists (less days not ready for care and days in lower urgency categories).

This is a critical elective surgery waiting times metadata item. It is used to determine whether patients are overdue. It is used to assist doctors and patients in making decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Is formed using Elective care waiting list episode—category reassignment date, DDMMYYYY Health, Standard 01/03/2005 Is formed using Elective care waiting list episode—listing date for care, DDMMYYYY Health, Standard 01/03/2005 Is formed using Elective surgery waiting list episode—patient listing status, readiness for care code N Health, Standard 01/03/2005 Supersedes Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Superseded 13/12/2011 Is formed using Hospital census (of elective surgery waitlist patients)—census date, DDMMYYYY Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Elective surgery waiting times (census data) NMDS 2012-2013 Health, Standard 13/12/2011 *Implementation start date:* 30/09/2012

Waiting time at removal from elective surgery waiting list

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—waiting time (at removal), total days N[NNN]
METeOR identifier:	471744
Registration status:	Health, Standard 13/12/2011
Definition:	The time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure to the date they were removed from the waiting list.
Context:	Elective surgery
Data Element Concept:	Elective surgery waiting list episode—waiting time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

The number of days is calculated by subtracting the listing date for care from the removal date, minus any days when the patient was 'not ready for care', and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at removal.

Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as 'not ready for care' from the date(s) the person was subsequently recorded as again being 'ready for care'.

If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at removal, then the number of days waited at the less urgent clinical urgency category should be subtracted from the total number of days waited.

In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at removal) the number of days at the less urgent clinical urgency category should be calculated by subtracting the listing date for care from the category reassignment date. If the patient's clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at removal should be calculated by subtracting one category reassignment date from the subsequent category reassignment date, and then adding the days together.

When a patient is removed from an elective surgery waiting list, for admission on an elective basis for the procedure they were awaiting, but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue.

Therefore at the removal date, the patient's waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient.

Comments: Elective surgery waiting times data collections include measures of waiting times at removal and at designated census dates. This metadata item is used to measure waiting times at removal whereas the metadata item waiting time at a census date measures waiting times at a designated census date.

The calculation of waiting times for patients, who are transferred from an elective surgery waiting list managed by one public acute hospital to another, will be investigated in the future. In this case, the amount of time waited on previous lists would follow the patient to the next. Therefore when the patient is removed from the waiting list (for admission or other reason), their waiting time would include the total number of days on all lists (less days not ready for care and days in lower urgency categories).

This is a critical elective surgery waiting times metadata item. It is used to determine whether patients were overdue. It is used to assist doctors and patients in makign decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Elective care waiting list episode—category reassignment date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Elective care waiting list episode—listing date for care, DDMMYYYY Health, Standard 01/03/2005

Is formed using Elective surgery waiting list episode—waiting list removal date, DDMMYYYY Health, Standard 01/03/2005

Supersedes Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Superseded 13/12/2011

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Proposed 28/09/2011

Implementation in Data Set Specifications:

Elective surgery waiting times (removals data) NMDS 2012-2013 Health, Standard 13/12/2011

Implementation start date: 01/07/2012

Elective surgery waiting times cluster Health, Standard 07/12/2011

Weight (self-reported)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—weight (self-reported), total kilograms NN[N]
METeOR identifier:	302365
Registration status:	Health, Standard 14/07/2005
Definition:	A person's self-reported weight (body mass).
Data Element Concept:	Person—weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
888	Unknown
999	Not stated

Unit of measure: Kilogram (Kg)

Collection and usage attributes

Guide for use:

CODE 888 Unknown

Use this code if self-reported body mass (weight) is unknown.

CODE 999 Not stated

Use this code if self-reported body mass (weight) is not responded to.

Data element attributes

Collection and usage attributes

Collection methods:

The method of data collection, e.g. face to face interview, telephone interview or self-completion questionnaire, can affect survey estimates and should be reported.

The data collection form should include a question asking the respondent what their weight is. For example, the ABS National Health Survey 1989-90 included the question 'How much do you weigh without clothes and shoes?'. The data collection form should allow for both metric (to the nearest 1 kg) and imperial (to the nearest 1 lb) units to be recorded.

If practical, it is preferable to enter the raw data into the data base before conversion of measures in imperial units to metric. However, if this is not possible, weight reported in imperial units can be converted to metric prior to data entry using a conversion factor of 0.454 kg to the lb.

Rounding to the nearest 1 kg will be required for measures converted to metric prior to data entry, and may be required for data reported in metric units to a greater level of precision than the nearest 1 kg. The following rounding conventions are desirable to reduce systematic over reporting (Armitage and Berry 1994):

nnn.x where x

nnn.x where x > 5 - round up, e.g. 72.7 kg would be rounded to 73 kg.

nnn.x where x = 5 - round to the nearest even number, e.g. 72.5 kg would be rounded to 72 kg, while 73.5 kg would be rounded to 74 kg.

Comments:

This metadata item is recommended for persons aged 18 years or older. It is recommended for use in population surveys when it is not possible to measure weight.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables. Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means and 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present weight data in categories. It is recommended that 5 kg groupings are used for this purpose. Weight data should not be rounded before categorisation. The following categories may be appropriate for describing the weights of

Australian men and women, although the range will depend on the population. The World Health Organization's range for weight is 30-140 kg.

Weight

30 kg = Weight

35 kg = Weight

... in 5 kg categories

135 kg = Weight

Weight => 140 kg

On average, body mass (weight) tends to be underestimated when self-reported by respondents. Data for men and women aged 20-69 years in 1989 indicated that men underestimated by an average of 0.2 kg (sem of 0.05 kg) and women by an average of 0.4 kg (sem of 0.04 kg) (Waters 1993). The extent of underestimation varied with age.

Source and reference attributes

Origin:

National Centre for Monitoring Cardiovascular Disease

Australian Institute of Health and Welfare

National Health Data Committee

Relational attributes

Related metadata references:

Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Supersedes Adult—weight (self-reported), total kilograms NN[N] Health, Superseded 14/07/2005

Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Supersedes Weight - self-reported, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (20.5 KB)

Weight in grams (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—weight (measured), total grams NNNN
Synonymous names:	Infant weight, neonate, stillborn
METeOR identifier:	310245
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The weight (body mass) of a person measured in grams.
Data Element Concept:	Person—weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Gram (g)

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011 Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009 Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009, Tasmanian Health, Proposed 28/09/2011 Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009
Implementation in Data Set Specifications:	Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:
Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000g and age is less than 365 days.

Weight in kilograms (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—weight (measured), total kilograms N[NN].N
Synonymous names:	Infant weight, neonate, stillborn
METeOR identifier:	270208
Registration status:	Health, Standard 01/03/2005
Definition:	The weight (body mass) of a person measured in kilograms.
Data Element Concept:	Person—weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not collected

Unit of measure:	Kilogram (Kg)
Unit of measure precision:	1

Collection and usage attributes

Guide for use:

A continuous variable measured to the nearest 0.1 kg.

CODE 999.9 Not collected

Use this code if measured weight is not collected.

Data element attributes

Collection and usage attributes

Guide for use:

In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.

Collection methods:

The collection of anthropometric measurements, particularly in those who are overweight or obese or who are concerned about their weight, should be performed with great sensitivity and without drawing attention to an individual's weight.

The measurement protocol described below is that recommended by the WHO Expert Committee (1995).

Measurement protocol:

Equipment used should be described and reported. Scales should have a resolution of at least 0.1kg and should have the capacity to weigh up to at least 200 kg. Measurement intervals and labels should be clearly readable under all conditions of use of the instrument. Scales should be capable of being calibrated across the entire range of measurements. Precision error should be no more than 0.1kg. Scales should be calibrated on each day of use. Manufacturers' guidelines should be followed with regard to the transportation of the scales.

Adults and children who can stand:

The subject stands over the centre of the weighing instrument, with the body weight evenly distributed between both feet.

Heavy jewellery should be removed and pockets emptied. Light indoor clothing can be worn, excluding shoes, belts, and sweater. Any variations from light indoor clothing (e.g. heavy clothing, such as kaftans or coats worn because of cultural practices) should be noted on the data collection form. Adjustments for non-standard clothing (i.e. other than light indoor clothing) should only be made in the data checking/cleaning stage prior to data analysis.

If the subject has had one or more limbs amputated, record this on the data collection form and weigh them as they are. If they are wearing an artificial limb, record this on the data collection form but do not ask them to remove it. Similarly, if they are not wearing the limb, record this but do not ask them to put it on.

The measurement is recorded to the nearest 0.1 kg. If the scales do not have a digital readout, take a repeat measurement. If the two measurements disagree by more than 0.5 kg, then take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured weight is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 kg. If so, rounding should be to the nearest even digit to reduce systematic over reporting (Armitage and Berry 1994). For example, a mean value of 72.25 kg would be rounded to 72.2 kg, while a mean value of 72.35 kg would be rounded to 72.4 kg.

Infants:

Birth weight and gender should be recorded with gestational age. During infancy a levelled pan scale with a bean and movable weights or digital scales capable of measuring to two decimal places of a kilogram are acceptable. Birth weight should be determined within 12 hours of birth. The infant, with or without a nappy or diaper is placed on the scales so that the weight is distributed equally about the centre of the pan. When the infant is lying or suspended quietly, weight is recorded to the nearest 10 grams. If the nappy or diaper is worn, its weight is subtracted from the observed weight i.e. reference data for infants are based on nude weights.

Validation and quality control measures:

If practical, equipment should be checked daily using one or more objects of known weight in the range to be measured. It is recommended that the scale be calibrated at the extremes and in the mid range of the expected weight of the population being studied.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within -) or different (between-) observers repeating the measurement of weight, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement) between observers should not exceed 0.5 kg and be less than 0.5 kg within observers.

Extreme values at the lower and upper end of the distribution of measured height should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Comments:

This metadata item applies to persons of all ages. It is recommended for use in population surveys and health care settings.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means and 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present weight data in categories. It is recommended that 5 kg groupings are used for this purpose. Weight data should not be rounded before categorisation. The following categories may be appropriate for describing the weights of Australian men, women, children and adolescents, although the range will depend on the population.

Weight

10 kg = Weight

15 kg = Weight

... in 5 kg categories

135 kg = Weight

Weight => 140 kg

Source and reference attributes

Submitting organisation: World Health Organization The consortium to develop standard methods for the collection and collation of anthropometric data in children as part of the National Food and Nutrition Monitoring and Surveillance Project, funded by the Commonwealth Department of Health and Ageing

Reference documents: Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults (US National Heart, Lung and Blood Institute (NHLBI) in cooperation with the National Institute of Diabetes and Digestive and Kidney Diseases).
Chronic Diseases and Associated Risk Factors in Australia 2001 (AIHW).

Relational attributes

Related metadata references: Is used in the formation of Adult—body mass index (measured), ratio NN[N].N[N] Health, Standard

01/03/2005

Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Supersedes Weight - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (29.3 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Diabetes (clinical) DSS Health, Standard 21/09/2005

Work sector - health professional

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work sector in health profession, code N
METeOR identifier:	375388
Registration status:	Health, Standard 10/12/2009
Definition:	The sector in which a health professional works in their registered profession, as represented by a code.
Data Element Concept:	Registered health professional—work sector in registered health profession

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Public
2	Private

Data element attributes

Collection and usage attributes

Comments:

This data element is used to differentiate between establishments run by the government sector (code 1) and establishments that receive some government funding but are run by the non-government sector (code 2).

Code 1 Public

To be used when the establishment:

- operates from the public accounts of a Commonwealth, state or territory government or is part of the executive, judicial or legislative arms of government,
- is part of the general government sector or is controlled by some part of the general government sector,
- provides government services free of charge or at nominal prices, and
- is financed mainly from taxation.

Code 2 Private

To be used only when the establishment:

- is not controlled by government,
- is directed by a group of officers, an executive committee or a similar body elected by a majority of members, and
- may be an income tax exempt charity.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered chiropractor cluster Health, Standard 10/12/2009

Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Main job of registered medical professional cluster Health, Standard 10/12/2009

Main job of registered midwife cluster Health, Standard 10/12/2009

Main job of registered nursing professional cluster Health, Standard 10/12/2009

Main job of registered optometrist cluster Health, Standard 10/12/2009

Main job of registered osteopath cluster Health, Standard 10/12/2009

Main job of registered pharmacist cluster Health, Standard 10/12/2009

Main job of registered physiotherapist cluster Health, Standard 10/12/2009

Main job of registered podiatrist cluster Health, Standard 10/12/2009

Main job of registered psychologist cluster Health, Standard 10/12/2009

Second job of registered chiropractor cluster Health, Standard 10/12/2009

Second job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Second job of registered medical professional cluster Health, Standard 10/12/2009

Second job of registered midwife cluster Health, Standard 10/12/2009

Second job of registered nursing professional cluster Health, Standard 10/12/2009

Second job of registered optometrist cluster Health, Standard 10/12/2009

Second job of registered osteopath cluster Health, Standard 10/12/2009

Second job of registered pharmacist cluster Health, Standard 10/12/2009

Second job of registered physiotherapist cluster Health, Standard 10/12/2009

Second job of registered podiatrist cluster Health, Standard 10/12/2009

Second job of registered psychologist cluster Health, Standard 10/12/2009

Work setting hours cluster Health, Standard 10/12/2009

Work setting - chiropractor

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Registered health professional—work setting, chiropractor code ANN

METeOR identifier: 377909

Registration status: Health, Standard 10/12/2009

Definition: The type of health service setting or other organisation arrangement in which the work was undertaken by the chiropractor, as represented by a code.

Data Element Concept: Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: ANN

Maximum character length: 3

	Value	Meaning
Permissible values:	A01	Solo private practice
	A02	Group private practice
	A03	Locum private practice
	B00	Aboriginal health service
	C00	Community health care service
	D00	Hospital
	E00	Residential health care facility
	F00	Commercial/business service
	G00	Educational facility
	H00	Correctional services
	I00	Defence forces
	J00	Other government department or agency
	Y00	Other
Supplementary values:	Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use: CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum

practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICE

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G00 EDUCATIONAL FACILITY

Educational facilities include schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:
Main job of registered chiropractor cluster Health, Standard 10/12/2009
Second job of registered chiropractor cluster Health, Standard 10/12/2009

Work setting - dental

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, dental code ANN
METeOR identifier:	377911
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service or other organisation in which the work was undertaken by the dental health professional, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	ANN	
Maximum character length:	3	
Permissible values:	Value	Meaning
	A01	Solo private practice
	A02	Group private practice
	A03	Locum private practice
	B00	Aboriginal health service
	C05	Health promotion service
	C07	Other community health care service
	D00	Hospital
	E00	Residential health care facility
	F00	Commercial/business service
	G01	Tertiary educational facility
	G02	School
	G03	Other educational facility
	H00	Correctional services
	I00	Defence forces
	J00	Other government department or agency
	Y00	Other
Supplementary values:	Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C05 HEALTH PROMOTION SERVICE

Health promotion service includes those services primarily engaged in the provision of information and education to improve dental health and prevent disease.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICE

Other community health care service includes all non-residential health care services not mentioned above.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G01 TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE G02 SCHOOL

Schools include all pre-primary, primary and secondary schools.

CODE G03 OTHER EDUCATIONAL FACILITY

Other educational facility includes all organisations primarily involved in the delivery of education and training but not mentioned above.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE SERVICES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Second job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Work setting - medical practitioner

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, medical practitioner code ANN
METeOR identifier:	377814
Registration status:	Health, Standard 10/12/2009
Definition:	The type of service setting or other organisation arrangement in which health care was delivered by the medical practitioner, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Solo private practice
A02	Group private practice
A03	Locum private practice
B00	Aboriginal health service
C02	Community mental health service
C03	Community drug and alcohol service
C07	Other community health care services
D01	Outpatient services
D02	Other hospital services
E02	Residential mental health care services
E05	Other residential health care facility
F00	Commercial/business services
G01	Tertiary educational facility
G02	School
G03	Other educational facility
H00	Correctional services
I00	Defence forces
J00	Other government department or agency

	Y00	Other
Supplementary values:	Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C02 COMMUNITY MENTAL HEALTH SERVICE

Community mental health service includes all non-residential health care services that engage primarily in mental health care.

CODE C03 COMMUNITY DRUG AND ALCOHOL SERVICE

Community drug and alcohol service includes all non-residential health care services that engage primarily in drug and alcohol treatment.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICES

Other community health care service includes all non-residential health care services not mentioned above.

CODE D01 OUTPATIENT SERVICES

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department

CODE E02 RESIDENTIAL MENTAL HEALTH CARE SERVICES

Residential mental health care services include all residential health care services that primarily engage in the delivery of specialist mental health care.

CODE E05 OTHER RESIDENTIAL HEALTH CARE

FACILITY

This category includes all other residential health care facilities not specified above.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices

CODE G01 TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE G02 SCHOOL

Schools include all pre-primary, primary and secondary schools.

CODE G03 OTHER EDUCATIONAL FACILITY

Other educational facility includes all organisations primarily involved in the delivery of education and training but not mentioned above.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Main job of registered medical professional cluster Health, Standard 10/12/2009

Second job of registered medical professional cluster Health,

Work setting - midwife

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Registered health professional—work setting, midwife code ANN

METeOR identifier: 380121

Registration status: Health, Standard 10/12/2009

Definition: The type of health service setting or other organisation arrangement in which the health care was delivered by the midwife, as represented by a code.

Data Element Concept: Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: ANN

Maximum character length: 3

	Value	Meaning
Permissible values:	A03	Locum private practice
	A06	Other private practice
	B00	Aboriginal health service
	C00	Community health care service
	D01	Outpatient service
	D02	Other hospital service
	G01	Tertiary educational facility
	Y00	Other
Supplementary values:	Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use: CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE A06 OTHER PRIVATE PRACTICE

Other private practice includes all other private practices not included above.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICE

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department, and aboriginal health services.

CODE D01 OUTPATIENT SERVICES

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department.

CODE G01 TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered midwife cluster Health, Standard 10/12/2009

Second job of registered midwife cluster Health, Standard 10/12/2009

Work setting - nurse

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, nurse code ANN
METeOR identifier:	377913
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the health care was delivered by the nursing professional, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A03	Locum private practice
A05	General Practitioner (GP) practice
A06	Other private practice
B00	Aboriginal health service
C02	Community mental health service
C03	Community drug and alcohol service
C07	Other community health care service
D01	Outpatient service
D02	Other hospital service
E01	Residential aged care facility
E02	Residential mental health care service
E04	Hospice
E05	Other residential health care facility
F00	Commercial/business service
G01	Tertiary educational facility
G02	School
G03	Other educational facility
H00	Correctional services
I00	Defence forces

	J00	Other government agency or department
	Y00	Other
Supplementary values:	Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE A05 GENERAL PRACTITIONER (GP) PRACTICE

General Practitioner (GP) practice includes all solo, group and other GP private practices.

CODE A06 OTHER PRIVATE PRACTICE

Other private practice includes all other private practices not included above.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C02 COMMUNITY MENTAL HEALTH SERVICE

Community mental health service includes all non-residential health care services that engage primarily in mental health care.

CODE C03 COMMUNITY DRUG AND ALCOHOL SERVICE

Community drug and alcohol service includes all non-residential health care services that engage primarily in drug and alcohol treatment.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICES

Other community health care services include all non-residential health care services not mentioned above.

CODE D01 OUTPATIENT SERVICE

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department.

CODE E01 RESIDENTIAL AGED CARE FACILITIES

Residential aged care facilities include all residential health care facilities that primarily engage in the delivery of aged health care.

CODE E02 RESIDENTIAL MENTAL HEALTH CARE SERVICES

Residential mental health care services include all residential health care services that primarily engage in the delivery of specialist mental health care.

CODE E04   HOSPICE

Hospice includes all residential facilities primarily designed to provide palliative care for terminally ill patients.

CODE E05   OTHER RESIDENTIAL HEALTH CARE FACILITY

This category includes all other residential health care facilities not specified above.

CODE F00   COMMERCIAL/BUSINESS

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G01   TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE G02   SCHOOL

Schools include all pre-primary, primary and secondary schools.

CODE G03   OTHER EDUCATIONAL FACILITY

Other educational facility includes all organisations primarily involved in the delivery of education and training but not mentioned above.

CODE H00   CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00   DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00   OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00   OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: Nursing professionals include enrolled nurses, registered nurses and nurse practitioners.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Main job of registered nursing professional cluster Health, Standard 10/12/2009

Second job of registered nursing professional cluster Health, Standard 10/12/2009

Work setting - optometrist

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Registered health professional—work setting, optometrist code ANN

METeOR identifier: 377915

Registration status: Health, Standard 10/12/2009

Definition: The type of health service setting or other organisation arrangement in which the health care was delivered by the optometrist, as represented by a code.

Data Element Concept: Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class: Code

Data type: String

Format: ANN

Maximum character length: 3

	Value	Meaning
Permissible values:		
	A01	Solo private practice
	A02	Group private practice
	A03	Locum private practice
	B00	Aboriginal health service
	C00	Community health care service
	D00	Hospital
	E00	Residential health care facility
	F00	Commercial/business services
	G00	Educational facility
	H00	Correctional services
	I00	Defence forces
	J00	Other government department or agency
	Y00	Other
Supplementary values:	Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use: CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum

practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICES

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered optometrist cluster Health, Standard 10/12/2009

Second job of registered optometrist cluster Health, Standard 10/12/2009

Work setting - osteopath

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, osteopath code ANN
METeOR identifier:	377917
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the health care was delivered by the osteopath, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	ANN	
Maximum character length:	3	
Permissible values:	Value	Meaning
	A01	Solo private practice
	A02	Group private practice
	A03	Locum private practice
	B00	Aboriginal health service
	C00	Community health care service
	D00	Hospital
	E00	Residential health care facility
	F00	Commercial/business service
	G00	Educational facility
	H00	Correctional services
	I00	Defence forces
	J00	Other government department or agency
	Y00	Other
Supplementary values:	Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use: CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum

practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICES

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department, and Aboriginal health services.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered osteopath cluster Health, Standard 10/12/2009

Second job of registered osteopath cluster Health, Standard 10/12/2009

Work setting - pharmacist

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, pharmacist code ANN
METeOR identifier:	377919
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the health care was delivered by the pharmacist, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:	Value	Meaning
	A04	Medical centre
	A06	Other private practice
	B00	Aboriginal health service
	C00	Community health care service
	D00	Hospital
	E00	Residential health care facility
	F01	Retail pharmacy
	F02	Wholesale pharmacy
	F03	Pharmaceutics manufacturing
	F05	Other commercial/business
	G00	Educational facility
	H00	Correctional services
	I00	Defence forces
	J00	Other government department or agency
	Y00	Other
Supplementary values:	Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A04 MEDICAL PRACTICE

Medical practice includes all forms of private medical practice including medical centres.

CODE A06 OTHER PRIVATE PRACTICE

Other private practice includes all other private practices not included above.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICES

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department, and aboriginal health services.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F01 RETAIL PHARMACY

Businesses mainly engaged in retailing prescription drugs or patent medicines, cosmetics and/or toiletries.

CODE F02 WHOLESALE PHARMACY

Businesses mainly engaged in wholesaling prescription drugs or patent medicines, cosmetics or toiletries.

CODE F03 PHARMACEUTICS MANUFACTURING

Businesses mainly engaged in manufacturing pharmaceutical and medicinal products. It also includes businesses mainly engaged in manufacturing diagnostic substances for antibodies, antigens and chemical/diagnostic testing agents.

CODE F05 OTHER COMMERCIAL/BUSINESS

Other commercial/business includes all other commercial/business settings not included above.

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian

Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered pharmacist cluster Health, Standard 10/12/2009

Second job of registered pharmacist cluster Health, Standard 10/12/2009

Work setting - physiotherapist

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, physiotherapist code ANN
METeOR identifier:	377921
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the health care was delivered by the physiotherapist, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Solo private practice
A02	Group private practice
A03	Locum private practice
B00	Aboriginal health service
C01	Domiciliary service
C06	Rehabilitation/physical developmental service
C07	Other community health care service
D01	Outpatient service
D02	Other hospital service
E01	Residential aged care facility
E05	Other residential health care facility
F04	Sports centre/clinic
F05	Other commercial/business service
G00	Educational facility
H00	Correctional services
I00	Defence forces
J00	Other government department or agency
Y00	Other

Supplementary values: Z99 Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use: CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people

CODE C01 DOMICILIARY SERVICE

Domiciliary service includes all services primarily providing nursing or other professional paramedical care or treatment and non-qualified domestic assistance to people in their own homes.

CODE C06 REHABILITATION/PHYSICAL DEVELOPMENT SERVICE

Rehabilitation/physical development service includes all organisations that primarily engage in specialist rehabilitation and physical development assistance services.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICES

Other community health care services includes all non-residential health care services not mentioned above.

CODE D01 OUTPATIENT SERVICE

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department.

CODE E01 RESIDENTIAL AGED CARE FACILITIES

Residential aged care facilities include all residential health care facilities that primarily engage in the delivery of aged health care.

CODE E05 OTHER RESIDENTIAL HEALTH CARE FACILITY

This category includes all other residential health care facilities not specified above.

CODE F04 SPORTS CENTRE/CLINIC

Sports centres/clinics primarily provide professional services for the prevention and treatment of injuries and diseases related to participation in sports.

CODE F05 OTHER COMMERCIAL/BUSINESS SERVICE

Other commercial/business includes all other commercial/business settings not included above

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Main job of registered physiotherapist cluster Health, Standard 10/12/2009

Second job of registered physiotherapist cluster Health, Standard 10/12/2009

Work setting - podiatrist

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, podiatrist code ANN
METeOR identifier:	377923
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the health care was delivered by the podiatrist, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Solo private practice
A02	Group private practice
A03	Locum private practice
B00	Aboriginal health service
C06	Rehabilitation/physical developmental service
C07	Other community health care service
D01	Outpatient service
D02	Other hospital service
E01	Residential aged care facility
E03	Disability institution
E04	Hospice
E05	Other residential health care service
F04	Sports centre/clinic
F05	Other commercial/business service
G00	Educational facility
H00	Correctional services
I00	Defence forces
J00	Other government department or agency

	Y00	Other
Supplementary values:	Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C06 REHABILITATION/PHYSICAL DEVELOPMENTAL SERVICE

Rehabilitation/physical development service includes all organisations that primarily engage in specialist rehabilitation and physical development assistance services.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICE

Other community health care service includes all non-residential health care services not mentioned above.

CODE D01 OUTPATIENT SERVICE

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department.

CODE E01 RESIDENTIAL AGED CARE FACILITY

Residential aged care facilities include all residential health care facilities that primarily engage in the delivery of aged health care.

CODE E03 DISABILITY INSTITUTION

Disability institution includes all residential services that primarily engage in the delivery of disability support services.

CODE E04 HOSPICE

Hospice includes all residential facilities primarily designed to provide palliative care for terminally ill patients.

CODE E05 OTHER RESIDENTIAL HEALTH CARE FACILITY

This category includes all other residential health care facilities not specified above.

CODE F04 SPORTS CENTRE/CLINIC

Sports centres/clinics primarily provide professional services for the prevention and treatment of injuries and diseases related to participation in sports.

CODE F05 OTHER COMMERCIAL/BUSINESS

Other commercial/business includes all other commercial/business settings not included above.

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered podiatrist cluster Health, Standard 10/12/2009

Second job of registered podiatrist cluster Health, Standard 10/12/2009

Work setting - psychologist

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, psychologist code ANN
METeOR identifier:	377925
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the health care was delivered by the psychologist, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Solo private practice
A02	Group private practice
A05	General practitioner (GP) practice
A06	Other private practice
B00	Aboriginal health service
C02	Community mental health service
C04	Drug and alcohol service
C06	Rehabilitation/physical developmental service
C07	Other community health care service
D00	Hospital
E03	Disability institution
E05	Other residential health care facility
F05	Commercial/business service
G01	Tertiary educational facility
G02	School
G03	Other educational facility
H00	Correctional services
I00	Defence forces

	J00	Other government department or agency
	Y00	Other
Supplementary values:	Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A05 GENERAL PRACTITIONER (GP) PRACTICE

General Practitioner (GP) practice includes all solo, group and other GP private practices.

CODE A06 OTHER PRIVATE PRACTICE

Other private practice includes all other private practices not included above.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C02 COMMUNITY MENTAL HEALTH

Community mental health service includes all non-residential health care services that engage primarily in mental health care.

CODE C04 DRUG AND ALCOHOL SERVICE

Drug and alcohol service includes all non-residential health care services that engage primarily in drug and alcohol treatment.

CODE C06 REHABILITATION/PHYSICAL DEVELOPMENTAL SERVICE

Rehabilitation/physical development service includes all organisations that primarily engage in specialist rehabilitation and physical development assistance services.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICE

Other community health care service includes all non-residential health care services not mentioned above.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E03 DISABILITY INSTITUTION

Disability institution includes all residential services that primarily engage in the delivery of disability support services.

CODE E05 OTHER RESIDENTIAL HEALTH CARE FACILITY

This category includes all other residential health care facilities not specified above.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G01 TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE G02 SCHOOL

Schools include all pre-primary, primary and secondary schools.

CODE G03 OTHER EDUCATIONAL FACILITY

Other educational facility includes all organisations primarily involved in the delivery of education and training but not mentioned above.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Main job of registered psychologist cluster Health, Standard 10/12/2009

Second job of registered psychologist cluster Health, Standard

Work setting - registered health professional

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, code ANN
METeOR identifier:	375402
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which health care was delivered by the registered health professional, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	ANN
Maximum character length:	3

Permissible values:	Value	Meaning
	A00	Private practice
	B00	Aboriginal health service
	C00	Community health care service
	D00	Hospital
	E00	Residential health care facility
	F00	Commercial/business services
	G00	Educational facility
	H00	Correctional services
	I00	Defence forces
	J00	Other government department or agency
	Y00	Other
Supplementary values:	Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A00 PRIVATE PRACTICE

Private practice includes private practitioner rooms/ surgeries and 24-hour medical clinics.

CODE B00 ABORIGINAL HEALTH SERVICES

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICES

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes aboriginal health services and non-residential health care provided by private practices and the Australian Government Department of Defence.

CODE D00 HOSPITALS

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business services include insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G00 EDUCATIONAL FACILITY

Educational facilities include schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Comments: This data element is used in conjunction with work sector and hours worked to collect data on the distribution of hour worked by registered health professionals.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Comments:	This data element is used in conjunction with work sector and hours worked to collect data on the distribution of hours worked by registered health professionals.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Health professional—establishment type (employment), industry code NN Health, Superseded 10/12/2009
Implementation in Data Set Specifications:	Work setting hours cluster Health, Standard 10/12/2009

Working partnership indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—working partnership indicator, yes/no code N
METeOR identifier:	290696
Registration status:	Health, Standard 05/12/2007
Definition:	Whether a service provider organisation has formal working partnership(s) with other service provider(s) or organisation(s), as represented by a code.
Data Element Concept:	Service provider organisation—working partnership indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

A formal working partnership involves arrangements between a service provider organisation and another service provider or organisation, aimed at providing integrated and seamless care, so that clients are able to move smoothly between services and service settings.

A formal working partnership is a verbal or written agreement between two or more parties. It specifies the roles and responsibilities of each party, including the expected outcomes of the agreement.

Key elements of a formal working partnership are that it is organised, routine, collaborative, and systematic. It excludes ad hoc arrangements. Examples of formal working partnerships include the existence of: written service agreements; formal liaison; referral and discharge planning processes; formal and routine consultation; protocols; partnership working groups; memoranda of understanding with other providers; and case conferencing.

CODE 1 Yes

The service provider organisation has formal working partnership(s) with other service provider(s) or organisation(s) in place.

CODE 2 No

The service provider organisation has no formal working partnership(s) with other service provider(s) or organisation(s) in place.

Collection methods: Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Year insulin started

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—insulin start date, YYYY
METeOR identifier:	269928
Registration status:	Health, Standard 01/03/2005
Definition:	The year the patient started insulin injections.
Context:	Public health, health care and clinical settings.
Data Element Concept:	Patient—insulin start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	YYYY
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use:	Record the year that insulin injections were started. This data element has to be completed for all patients who use insulin. It is used to cross check diabetes type assignment.
Collection methods:	Ask the individual the year when he/ she started to use insulin. Alternatively obtain this information from appropriate documentation, if available.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Year insulin started, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Year of arrival in Australia

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—year of first arrival in Australia, date YYYY
METeOR identifier:	269929
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 23/08/2010 Health, Standard 04/05/2005 Homelessness, Standard 23/08/2010
Definition:	The year a person (born outside of Australia) first arrived in Australia, from another country, with the intention of staying in Australia for one year or more.
Data Element Concept:	Person—year of first arrival in Australia

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	YYYY
Maximum character length:	4

Data element attributes

Collection and usage attributes

Collection methods:

Actual year of arrival in Australia.

Recommended question:

In what year did you/the person first arrive in Australia to live here for one year or more?

(Write in the calendar year of arrival or mark the box if here less than one year)

Calendar year of arrival

Will be here less than one year

It is anticipated that for the majority of people their response to the question will be the year of their only arrival in Australia. However, some respondents may have multiple arrivals in Australia. To deal with these cases in self-enumerated collections, an instruction such as 'Please indicate the year of first arrival only' should be included with the question.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, the recommended question should be used wherever practically possible.

Source and reference attributes

Origin: The Australian Bureau of Statistics Standard for Year of Arrival in Australia. (last viewed 05/12/2006)

Reference documents: The ABS standard for Year of arrival in Australia appears on the ABS website http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4AD888364A44E87DCA25697E0018FE4C?opendocument select Other ABS Statistical Standards/Standards for Social, Labour and Demographic Variables/Cultural Diversity Variable.

Relational attributes

Related metadata references: Supersedes Year of arrival in Australia, version 2, DE, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (15.5 KB)

Implementation in Data Set Specifications: Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Conditional obligation:

Conditional on respondent being from a country that is not Australia.

Year of diagnosis of diabetes mellitus

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date (diabetes mellitus), YYYY
METeOR identifier:	269930
Registration status:	Health, Standard 01/03/2005
Definition:	The year a patient was first diagnosed as having diabetes
Context:	Public health, health care and clinical settings.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	YYYY
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use:	Record the year that the patient was first diagnosed as having diabetes.
Collection methods:	Ask the individual the year when he/ she was diagnosed with diabetes. Alternatively obtain this information from appropriate documentation, if available.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Year of diagnosis of diabetes mellitus, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

NMDS

Admitted patient care NMDS 2012-2013

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 466132

Registration status: Health, Standard 11/04/2012

DSS type: National Minimum Data Set (NMDS)

Scope: The purpose of the Admitted patient care national minimum data set (APC NMDS) is to collect information about care provided to admitted patients in Australian hospitals.

The scope of the APC NMDS is episodes of care for admitted patients in all public and private acute and psychiatric hospitals, free standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories may also be included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

Hospital boarders and still births are not included as they are not admitted to hospital. Posthumous organ procurement episodes are also not included.

Collection and usage attributes

Statistical unit: Episodes of care for admitted patients

Collection methods: Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant state or territory health authority on a regular basis (e.g. monthly).

National reporting arrangements

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated

Financial years ending 30 June each year.

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Comments: *Scope links with other NMDS*

Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:

- Admitted patient mental health care NMDS.

Episodes of care for admitted patients where care type is palliative care:

- Admitted patient palliative care NMDS.

Glossary items

Some previous Knowledgebase data element concepts are available in the METeOR glossary. Glossary items are available online through links in the relevant metadata items. In addition, links to the glossary terms that are relevant to this national minimum data set are listed below.

Admission

Diagnosis

Episode of acute care

Hospital boarder

Hospital-in-the-home care

Live birth

Neonate

Newborn qualification status

Organ procurement - posthumous

Same-day patient

Separation

Relational attributes

Related metadata references: Supersedes Admitted patient care NMDS 2011-2012 Health, Superseded 11/04/2012

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Elective surgery waiting times cluster	Conditional	99
-	Activity when injured	Mandatory	99

-	Additional diagnosis	Conditional	99
-	Admission date	Mandatory	1
-	Admitted patient election status	Mandatory	1
-	Area of usual residence	Mandatory	1
-	Area of usual residence (SA2)	Mandatory	1
-	Australian postcode (address)	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Care type	Mandatory	1
-	Condition onset flag	Mandatory	99
-	Contract establishment identifier	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Diagnosis related group	Mandatory	1
-	Establishment number	Mandatory	1
-	Establishment sector	Mandatory	1
-	External cause	Mandatory	99
-	Funding source for hospital patient	Mandatory	1
-	Geographic remoteness	Mandatory	1
-	Hospital insurance status	Mandatory	1
-	Indigenous status	Mandatory	1
-	Intended length of hospital stay	Mandatory	1
-	Inter-hospital contracted patient	Mandatory	1
-	Major diagnostic category	Mandatory	1
-	Medicare eligibility status	Mandatory	1
-	Mental health legal status	Mandatory	1
-	Mode of admission	Mandatory	1
-	Mode of separation	Mandatory	1
-	Number of days of hospital-in-the-home care	Mandatory	1
-	Number of qualified days for newborns	Conditional	1

-	Person identifier	Mandatory	1
-	Place of occurrence of external cause of injury (ICD-10-AM)	Mandatory	99
-	Principal diagnosis	Mandatory	1
-	Procedure	Mandatory	99
-	Record identifier	Mandatory	1
-	Region code	Mandatory	1
-	Separation date	Mandatory	1
-	Sex	Mandatory	1
-	Source of referral to public psychiatric hospital	Conditional	1
-	Total leave days	Mandatory	1
-	Total psychiatric care days	Mandatory	1
-	Urgency of admission	Mandatory	1
-	Weight in grams (measured)	Conditional	1

Admitted patient mental health care NMDS 2012-2013

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	471383
Registration status:	Health, Standard 07/12/2011
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of the Admitted patient mental health care national minimum data set (NMDS) is restricted to admitted patients receiving care in psychiatric hospitals or in designated psychiatric units in acute hospitals. The scope does not currently include patients who may be receiving treatment for psychiatric conditions in acute hospitals who are not in psychiatric units.

Collection and usage attributes

Statistical unit: Episodes of care for admitted patients

Collection methods: Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant state or territory health authority on a regular basis (for example, monthly).

National reporting arrangements

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated

Financial years ending 30 June each year.

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Comments: Number of days of hospital in the home care data will be collected from all states and territories except Western

Australia from 1 July 2001. Western Australia will begin to collect data from a later date.

Scope links with other NMDSs:

Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:

- Admitted patient care NMDS
- Admitted patient palliative care NMDS

Glossary items

Glossary terms that are relevant to this National Minimum Data Set are included here.

Resident

Residential mental health care service

Same-day patients

Separation

Source and reference attributes

Submitting organisation: National Health Information Group

Relational attributes

Related metadata references: Supersedes Admitted patient mental health care NMDS 2011-2012 Health, Superseded 07/12/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Additional diagnosis	Mandatory	1
-	Admission date	Mandatory	1
-	Area of usual residence	Mandatory	1
-	Area of usual residence (SA2)	Mandatory	1
-	Care type	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Diagnosis related group	Mandatory	1
-	Employment status (admitted patient)	Mandatory	1
-	Employment status—public psychiatric hospital admissions	Mandatory	1

-	Establishment identifier	Mandatory	1
-	Indigenous status	Mandatory	1
-	Major diagnostic category	Mandatory	1
-	Marital status	Conditional	1
-	Mental health legal status	Mandatory	1
-	Mode of separation	Mandatory	1
-	Person identifier	Mandatory	1
-	Previous specialised treatment	Mandatory	1
-	Principal diagnosis	Mandatory	1
-	Referral destination to further care (psychiatric patients)	Mandatory	1
-	Separation date	Mandatory	1
-	Sex	Mandatory	1
-	Source of referral to public psychiatric hospital	Mandatory	1
-	Total leave days	Mandatory	1
-	Total psychiatric care days	Mandatory	1
-	Type of accommodation	Mandatory	1
-	Type of usual accommodation	Mandatory	1

Admitted patient palliative care NMDS 2012-13

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 471819

Registration status: Health, Standard 07/03/2012

DSS type: National Minimum Data Set (NMDS)

Scope: The scope of this data set is admitted patients receiving palliative care in all public and private acute hospitals, and free standing day hospital facilities. Hospitals operated by the Australian Defence Force, correctional authorities and Australia's external territories are not currently included.

Palliative care patients are identified by the data element *Hospital service—care type, code N[N].N.*

Collection and usage attributes

Statistical unit: Episodes of care for admitted patients.

Collection methods: *National reporting arrangements*

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data collected and collated nationally

Financial years ending 30 June each year.

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Comments: *Scope links with other NMDSs*

Episodes of care for admitted patients receiving palliative care in all public and private acute hospitals and free standing day hospital facilities:

- Admitted patient care NMDS.
- Admitted patient mental health care NMDS.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Admitted patient palliative care NMDS 2011-12 Health, Superseded 07/03/2012

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Additional diagnosis	Conditional	1
-	Admission date	Mandatory	1
-	Area of usual residence (SA2)	Mandatory	1
-	Care type	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Funding source for hospital patient	Mandatory	1
-	Indigenous status	Mandatory	1
-	Mode of admission	Mandatory	1
-	Mode of separation	Mandatory	1
-	Number of days of hospital-in-the-home care	Mandatory	1
-	Person identifier	Mandatory	1
-	Previous specialised treatment	Mandatory	1
-	Principal diagnosis	Mandatory	1
-	Separation date	Mandatory	1
-	Sex	Mandatory	1

Alcohol and other drug treatment services NMDS 2012-2013

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	466861
Registration status:	Health, Standard 07/12/2011
DSS type:	National Minimum Data Set (NMDS)

Scope:

This metadata set is nationally mandated for collection and reporting.

Publicly funded government and non-government agencies providing alcohol and/or drug treatment services. Including community-based ambulatory services and outpatient services.

The following services are currently not included in the coverage:

- services based in prisons and other correctional institutions;
- agencies that provide primarily accommodation or overnight stays such as 'sobering-up shelters' and 'half-way houses';
- agencies that provide services concerned primarily with health promotion;
- needle and syringe programs;
- agencies whose sole function is to provide prescribing and/or dosing of methadone; and
- acute care and psychiatric hospitals, or alcohol and drug treatment units that report to the Admitted patient care National Minimum Data Set and do not provide treatment to non-admitted patients.

Clients who are on a methadone maintenance program may be included in the collection where they also receive other types of treatment.

Collection and usage attributes

Statistical unit:

Completed treatment episodes for clients who participate in a treatment type as specified in the data element *Episode of treatment for alcohol and other drugs—treatment type (main), code N.*

Collection methods:

Data to be reported in each agency on completed treatment episode and then forwarded to state/territory authorities for collation.

National reporting requirements

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated

Financial years ending 30 June each year.

Implementation start date:	01/07/2012
Implementation end date:	30/06/2013

Source and reference attributes

Submitting organisation:	National Health Information Group

Relational attributes

Related metadata references:	Supersedes Alcohol and other drug treatment services NMDS 2011-2012 Health, Superseded 07/12/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Statistical linkage key 581 cluster	Mandatory	1
-	Client type (alcohol and other drug treatment services)	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of cessation of treatment episode for alcohol and other drugs	Mandatory	1
-	Date of commencement of treatment episode for alcohol and other drugs	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Geographical location of service delivery outlet	Mandatory	1
-	Indigenous status	Mandatory	1
-	Injecting drug use status	Conditional	1
-	Main treatment type for alcohol and other drugs	Mandatory	1
-	Method of use for principal drug of concern	Conditional	1

-	Other drug of concern	Conditional	4
-	Other treatment type for alcohol and other drugs	Mandatory	4
-	Person identifier	Mandatory	1
-	Preferred language	Mandatory	1
-	Principal drug of concern	Conditional	1
-	Reason for cessation of treatment episode for alcohol and other drugs	Mandatory	1
-	Sex	Mandatory	1
-	Source of referral to alcohol and other drug treatment service	Mandatory	1
-	Statistical area level 2 (SA2)	Mandatory	1
-	Treatment delivery setting for alcohol and other drugs	Mandatory	1

Community mental health care NMDS 2012-2013

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	468200
Registration status:	Health, Standard 07/03/2012
DSS type:	National Minimum Data Set (NMDS)
Scope:	This NMDS includes data about service contacts provided by specialised mental health services for patients/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24 hour staffed specialised residential mental health services.

Collection and usage attributes

Statistical unit:	Mental health service contact
Implementation start date:	01/07/2012
Implementation end date:	30/06/2013

Relational attributes

Related metadata references:	Supersedes Community mental health care NMDS 2011-2012 Health, Superseded 07/03/2012

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Ambulatory service unit identifier	Mandatory	1
-	Ambulatory service unit name	Mandatory	1
-	Area of usual residence (SA2)	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Establishment sector	Mandatory	1
-	Indigenous status	Mandatory	1
-	Marital status	Mandatory	1

-	Mental health legal status	Mandatory	1
-	Mental health service contact date	Mandatory	1
-	Mental health service contact duration	Mandatory	1
-	Mental health service contact—patient/client participation indicator	Mandatory	1
-	Mental health service contact—session type	Mandatory	1
-	Organisation identifier	Mandatory	1
-	Organisation name	Mandatory	1
-	Person identifier	Mandatory	1
-	Principal diagnosis	Mandatory	1
-	Region code	Mandatory	1
-	Region name	Mandatory	1
-	Service unit cluster identifier	Mandatory	1
-	Service unit cluster name	Mandatory	1
-	Sex	Mandatory	1
-	Specialised mental health service target population	Mandatory	1

Elective surgery waiting times (census data) NMDS 2012-2013

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 472477

Registration status: Health, Standard 13/12/2011

DSS type: National Minimum Data Set (NMDS)

Scope:

The scope of this national minimum data set (NMDS) is patients on waiting lists for elective surgery (as defined in the Elective care waiting list episode—elective care type, code N data element (also referred to by the short name 'Waiting list category') which are managed by public acute hospitals. This will include private patients treated in public hospitals, and may include public patients treated in private hospitals.

Hospitals may also collect information for other care (as defined in the Waiting list category data element), but this is not part of the NMDS for Elective surgery waiting times.

Patients on waiting lists managed by hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included.

Census data:

Data are collected for patients on elective surgery waiting lists who are yet to be admitted to hospital or removed for another reason. The scope is patients on elective surgery waiting lists on a census date who are 'ready for care' and patients who are 'not ready for care', as defined in the Elective surgery waiting list episode—patient listing status, readiness for care code N data element.

Collection and usage attributes

Statistical unit: Patients on waiting lists on census dates.

Collection methods:

Elective care waiting list episode—category reassignment date, DDMMYYYY is not required for reporting to the NMDS, but is necessary for the derivation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN].

Elective care waiting list episode—elective care type, code N is not required for reporting to the NMDS, but is necessary for determining whether patients are in scope for the NMDS. These data elements should be collected at the local level and reported to state and territory health authorities as required.

National reporting arrangements

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated

Census dates are 30 September, 31 December, 31 March and 30 June.

Implementation start date: 30/09/2012

Comments: There are two different types of data collected for this national minimum data set (census data and removals data) and the scope and list of data elements associated with each is different.

For the purposes of this NMDS, public hospitals include hospitals which are set up to provide services for public patients (as public hospitals do), but which are managed privately.

The inclusion of public patients removed from elective surgery waiting lists managed by private hospitals will be investigated in the future.

Source and reference attributes

Submitting organisation: National Health Information Management Group

Relational attributes

Related metadata references: See also Elective care waiting list episode—elective care type, code N Health, Standard 13/12/2011

See also Elective surgery waiting times (census data) DSS 1 January 2012-30 June 2012 Health, Retired 13/12/2011

Supersedes Elective surgery waiting times (census data) NMDS 2009-2012 Health, Superseded 13/12/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Census date	Mandatory	1
-	Clinical urgency	Mandatory	1

-	Establishment identifier	Mandatory	1
-	Indicator procedure	Mandatory	1
-	Indigenous status	Mandatory	1
-	Listing date for care	Mandatory	1
-	Overdue patient	Mandatory	1
-	Patient listing status	Mandatory	1
-	Surgical specialty	Mandatory	1
-	Waiting time at a census date	Mandatory	1

Elective surgery waiting times (removals data) NMDS 2012-2013

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	472497
Registration status:	Health, Standard 13/12/2011
DSS type:	National Minimum Data Set (NMDS)

Scope:

The scope of this national minimum data set is patients removed from waiting lists for elective surgery (as defined in Elective care waiting list episode—elective care type, code N) which are managed by public acute hospitals. This will include private patients treated in public hospitals, and may include public patients treated in private hospitals. Hospitals may also collect information for other care (as defined in Elective care waiting list episode—elective care type, code N), but this is not part of the National Minimum Data Set (NMDS) for elective surgery waiting times.

Patients removed from waiting lists managed by hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included.

Removals data:

Data are collected for patients who have been removed from an elective surgery waiting list (for admission or another reason). Patients who were 'ready for care' and patients who were 'not ready for care' at the time of removal are included.

Collection and usage attributes

Statistical unit:

Patients removed from waiting lists (for admission or other reason) during each financial year.

Collection methods:

Elective care waiting list episode—category reassignment date, DDMMYYYY is not required for reporting to the NMDS, but is necessary for the derivation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN]. Elective care waiting list episode—elective care type, code N is not required for reporting to the NMDS, but is necessary for determining whether patients are in scope for the NMDS. These data elements should be collected at the local level and reported to state and territory health authorities as required.

National reporting arrangements

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated

Financial years ending 30 June each year for removals data.

Implementation start date: 01/07/2012

Comments: There are two different types of data collected for this national minimum data set (census data and removals data) and the scope and list of data elements associated with each is different.

For the purposes of this NMDS, public hospitals include hospitals which are set up to provide services for public patients (as public hospitals do), but which are managed privately.

The inclusion of public patients removed from elective surgery waiting lists managed by private hospitals will be investigated in the future.

Source and reference attributes

Submitting organisation: Department of Health and Ageing

Relational attributes

Related metadata references: See also Elective care waiting list episode—elective care type, code N Health, Standard 13/12/2011

See also Elective surgery waiting times (removals data) DSS 1 January 2012-30 June 2012 Health, Retired 13/12/2011

Supersedes Elective surgery waiting times (removals data) NMDS 2009-2012 Health, Superseded 13/12/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Clinical urgency	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Indicator procedure	Mandatory	1
-	Indigenous status	Mandatory	1
-	Listing date for care	Mandatory	1

-	Overdue patient	Conditional	1
-	Reason for removal from elective surgery waiting list	Mandatory	1
-	Removal date	Mandatory	1
-	Surgical specialty	Mandatory	1
-	Waiting time at removal from elective surgery waiting list	Mandatory	1

Government health expenditure NMDS 2009-2010

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 376403

Registration status: Health, Standard 01/04/2009

DSS type: National Minimum Data Set (NMDS)

Scope: The scope of this dataset is direct government and government-funded expenditure on health and health–related goods and services.

The purpose of this NMDS is to provide an enhanced understanding of the overall financial resources (recurrent and capital) used by the health system, and of unit costs and performance; to enable greater comparability of health expenditure data between jurisdictions and over time; and to provide a more efficient compilation of national reports and analyses on government funded health expenditure.

Collection and usage attributes

Statistical unit: Providers of health or health related goods and services or non-health services that support the health services industry; health or health related functions; and the sources of funds for these providers or functions.

Guide for use: The GHE NMDS consists of 5 mandatory data clusters and 1 conditional data cluster.

The first two data elements named in each data cluster form one of the two axes of a matrix that combine to provide all data in Australian dollars.

Data are to be reported in Australian dollars except when reporting the State/Territory identifier of the Jurisdiction.

Collection methods: Data are collected by a number of providers from their administrative systems and forwarded to the relevant state or territory health authority on a regular basis (for example, monthly).

Hospitals forward data obtained from patient administrative and clinical record systems to the relevant state or territory health authority on a regular basis (for example, monthly). Other data are obtained either directly from annual reports or through surveys.

National reporting arrangements

State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated:

Financial years ending 30 June each year.

Implementation start date: 01/07/2009

Comments: Scope links with other NMDSs

- National Public Hospital Establishments NMDS
- Mental Health Establishments NMDS

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Relational attributes

Related metadata references: Supersedes Government health expenditure NMDS 2008-2009 Health, Superseded 03/12/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Government health expenditure organisation revenue data element cluster	Mandatory	1
2	Government health expenditure organisation expenditure data element cluster	Mandatory	1
3	Government health expenditure organisation expenditure purchase of goods and services data element cluster	Mandatory	1
4	Government health expenditure organisation expenditure employee related data element cluster	Mandatory	1
5	Government health expenditure organisation expenditure capital consumption data element cluster	Mandatory	1
6	Government health expenditure function revenue data element cluster	Conditional	1
7	Australian State/Territory identifier (jurisdiction)	Mandatory	1

Mental health establishments NMDS 2012-2013

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 468195

Registration status: Health, Standard 07/12/2011

DSS type: National Minimum Data Set (NMDS)

Scope: The scope of the Mental health establishments National Minimum Data Set (MHE NMDS) is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities.

Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.

The concept of a specialised mental health service is not dependent on the inclusion of the service within the state or territory mental health budget.

A service is not defined as a specialised mental health service solely because its clients include people affected by a mental illness or psychiatric disability. The definition excludes specialist drug and alcohol services for people with intellectual disabilities, except where they are established to assist people affected by a mental disorder who also have drug and alcohol related disorders or intellectual disability.

These services can be a sub-unit of a hospital even where the hospital is not a specialised mental health establishment itself (e.g. designated psychiatric units and wards, outpatient clinics etc).

The statistical units are specialised mental health services. These are the specialised mental health components of the state and territory health authorities, and of regions within states and territories; specialised mental health service organisations; service units within those organisations; and private hospital and non-government residential service units funded by specialised mental health services.

Non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding are included as service units for this NMDS.

There is a hierarchy of statistical units used within the MHE NMDS. Information is provided at each level: State/Territory; Region; Organisation; Hospital/Service unit cluster; and Service unit (Admitted patient services, Residential services and Ambulatory services). Each level has a unique set of attributes which comprise the NMDS data elements and additional supplementary information.

Collection and usage attributes

Statistical unit: Specialised mental health service

Collection methods: *National reporting arrangements*

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated

Financial years ending 30 June each year.

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Comments: *Glossary items*

Glossary terms that are relevant to this National minimum data set are included here.

Episode of residential care end

Episode of residential care start

Mental health-funded non-government organisation

Residential mental health care service

Relational attributes

Related metadata references: Supersedes Mental health establishments NMDS 2011-2012 Health, Superseded 07/12/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Accrued mental health care days	Mandatory	1

-	Admitted patient service unit identifier	Mandatory	1
-	Admitted patient service unit name	Mandatory	1
-	Ambulatory service unit identifier	Mandatory	1
-	Ambulatory service unit name	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Average available beds for overnight-stay patients	Mandatory	1
-	Average available beds for residential mental health patients	Mandatory	1
-	Carer participation arrangements—carer consultants employed	Mandatory	1
-	Carer participation arrangements—carer satisfaction surveys	Mandatory	1
-	Carer participation arrangements—formal complaints mechanism	Mandatory	1
-	Carer participation arrangements—formal participation policy	Mandatory	1
-	Carer participation arrangements—regular discussion groups	Mandatory	1
-	Co-location status of mental health service	Mandatory	1
-	Consumer committee representation arrangements	Mandatory	1
-	Consumer participation arrangements—consumer consultants employed	Mandatory	1
-	Consumer participation arrangements—consumer satisfaction surveys	Mandatory	1
-	Consumer participation arrangements—formal complaints mechanism	Mandatory	1
-	Consumer participation arrangements—formal participation policy	Mandatory	1
-	Consumer participation arrangements—regular discussion groups	Mandatory	1
-	Establishment sector	Mandatory	1
-	Full-time equivalent staff—administrative and clerical staff	Mandatory	1
-	Full-time equivalent staff—carer consultants	Conditional	1

-	Full-time equivalent staff—consultant psychiatrists and psychiatrists	Mandatory	1
-	Full-time equivalent staff—consumer consultants	Conditional	1
-	Full-time equivalent staff—diagnostic and health professionals	Mandatory	1
-	Full-time equivalent staff—domestic and other staff	Mandatory	1
-	Full-time equivalent staff—enrolled nurses	Mandatory	1
-	Full-time equivalent staff—nurses	Mandatory	1
-	Full-time equivalent staff—occupational therapists	Mandatory	1
-	Full-time equivalent staff—other diagnostic and health professionals	Mandatory	1
-	Full-time equivalent staff—other medical officers	Mandatory	1
-	Full-time equivalent staff—other personal care staff	Mandatory	1
-	Full-time equivalent staff—psychiatry registrars and trainees	Mandatory	1
-	Full-time equivalent staff—psychologists	Mandatory	1
-	Full-time equivalent staff—registered nurses	Mandatory	1
-	Full-time equivalent staff—salaried medical officers	Mandatory	1
-	Full-time equivalent staff—social workers	Mandatory	1
-	Grants to non-government organisations—accommodation services	Mandatory	1
-	Grants to non-government organisations—advocacy services	Mandatory	1
-	Grants to non-government organisations—community awareness/health promotion services	Mandatory	1
-	Grants to non-government organisations—counselling services	Mandatory	1
-	Grants to non-government organisations—independent living skills support services	Mandatory	1
-	Grants to non-government organisations—other and unspecified mental health services	Mandatory	1
-	Grants to non-government organisations—pre-vocational training services	Mandatory	1
-	Grants to non-government organisations—psychosocial	Mandatory	1

	support services		
-	Grants to non-government organisations—recreation services	Mandatory	1
-	Grants to non-government organisations—respite services	Mandatory	1
-	Grants to non-government organisations—self-help support group services	Mandatory	1
-	Hospital identifier	Mandatory	1
-	Hospital name	Mandatory	1
-	Mental health services grants to non-government organisations by non-health departments	Mandatory	1
-	National standards for mental health services review status	Mandatory	1
-	Non-government non-profit indicator	Mandatory	1
-	Number of clients receiving services	Mandatory	1
-	Number of episodes of residential care	Mandatory	1
-	Number of service contacts	Mandatory	1
-	Organisation identifier	Mandatory	1
-	Organisation name	Mandatory	1
-	Recurrent expenditure (mental health)—non-salary operating costs	Mandatory	1
-	Recurrent expenditure (mental health)—salaries and wages	Mandatory	1
-	Recurrent expenditure (salaries and wages)—administrative and clerical staff	Mandatory	1
-	Recurrent expenditure (salaries and wages)—carer consultants	Mandatory	1
-	Recurrent expenditure (salaries and wages)—consultant psychiatrists and psychiatrists	Mandatory	1
-	Recurrent expenditure (salaries and wages)—consumer consultants	Mandatory	1
-	Recurrent expenditure (salaries and wages)—domestic and other staff	Mandatory	1
-	Recurrent expenditure (salaries and wages)—enrolled nurses	Mandatory	1

-	Recurrent expenditure (salaries and wages)—occupational therapists	Mandatory	1
-	Recurrent expenditure (salaries and wages)—other diagnostic and health professionals	Mandatory	1
-	Recurrent expenditure (salaries and wages)—other medical officers	Mandatory	1
-	Recurrent expenditure (salaries and wages)—other personal care staff	Mandatory	1
-	Recurrent expenditure (salaries and wages)—psychiatry registrars and trainees	Mandatory	1
-	Recurrent expenditure (salaries and wages)—psychologists	Mandatory	1
-	Recurrent expenditure (salaries and wages)—registered nurses	Mandatory	1
-	Recurrent expenditure (salaries and wages)—social workers	Mandatory	1
-	Recurrent expenditure—administrative expenses	Mandatory	1
-	Recurrent expenditure—Department of Veterans' Affairs funded	Mandatory	1
-	Recurrent expenditure—depreciation	Mandatory	1
-	Recurrent expenditure—domestic services	Mandatory	1
-	Recurrent expenditure—drug supplies	Mandatory	1
-	Recurrent expenditure—food supplies	Mandatory	1
-	Recurrent expenditure—interest payments	Mandatory	1
-	Recurrent expenditure—medical and surgical supplies	Mandatory	1
-	Recurrent expenditure—other Commonwealth Government funded	Mandatory	1
-	Recurrent expenditure—other patient revenue funded	Mandatory	1
-	Recurrent expenditure—other recurrent expenditure	Mandatory	1
-	Recurrent expenditure—other revenue funded	Mandatory	1
-	Recurrent expenditure—other State or Territory funded	Mandatory	1
-	Recurrent expenditure—patient transport	Mandatory	1
-	Recurrent expenditure—payments to visiting medical officers	Mandatory	1

-	Recurrent expenditure—recoveries funded	Mandatory	1
-	Recurrent expenditure—repairs and maintenance	Mandatory	1
-	Recurrent expenditure—State or Territory health authority funded	Mandatory	1
-	Recurrent expenditure—superannuation employer contributions	Mandatory	1
-	Region code	Mandatory	1
-	Region name	Mandatory	1
-	Residential service unit identifier	Mandatory	1
-	Residential service unit name	Mandatory	1
-	Residual expenditure (mental health service)—academic positions	Mandatory	1
-	Residual expenditure (mental health service)—education and training	Mandatory	1
-	Residual expenditure (mental health service)—insurance	Mandatory	1
-	Residual expenditure (mental health service)—Mental Health Act Regulation or related legislation	Mandatory	1
-	Residual expenditure (mental health service)—mental health promotion	Mandatory	1
-	Residual expenditure (mental health service)—mental health research	Mandatory	1
-	Residual expenditure (mental health service)—other indirect expenditure	Mandatory	1
-	Residual expenditure (mental health service)—patient transport services	Mandatory	1
-	Residual expenditure (mental health service)—program administration	Mandatory	1
-	Residual expenditure (mental health service)—property leasing costs	Mandatory	1
-	Residual expenditure (mental health service)—service development	Mandatory	1
-	Residual expenditure (mental health service)—superannuation	Mandatory	1
-	Residual expenditure (mental health service)—support services	Mandatory	1

-	Residual expenditure (mental health service)—workers compensation	Mandatory	1
-	Separations	Mandatory	1
-	Service unit cluster identifier	Mandatory	1
-	Service unit cluster name	Mandatory	1
-	Specialised mental health service program type	Mandatory	1
-	Specialised mental health service setting	Conditional	1
-	Specialised mental health service target population	Mandatory	1
-	Specialised mental health service—hours staffed	Mandatory	1
-	Statistical area level 2 (SA2)	Mandatory	1
-	Supported mental health housing places	Mandatory	1

Non-admitted patient emergency department care NMDS 2012-2013

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 474371

Registration status: Health, Standard 30/01/2012

DSS type: National Minimum Data Set (NMDS)

Scope: The scope of the Non-admitted patient emergency department care national minimum data set specification (NAPEDC NMDS) is non-admitted patients registered for care in emergency departments in selected public hospitals that are classified as either Peer Group A or B in the Australian Institute of Health and Welfare's Australian Hospital Statistics publication from the preceding financial year (see also Scope links with other metadata sets in the Comments section below).

Patients who were dead on arrival are in scope if an emergency department clinician certified the death of the patient. Patients who leave the emergency department after being triaged and then advised of alternative treatment options are in scope.

The scope includes only physical presentations to emergency departments. Advice provided by telephone or videoconferencing is not in scope, although it is recognised that advice received by telehealth may form part of the care provided to patients physically receiving care in the emergency department.

The care provided to patients in emergency departments is, in most instances, recognised as being provided to 'non-admitted' patients. Patients being treated in emergency departments may subsequently become 'admitted' (including admission to a short stay unit, admission to elsewhere in the emergency department, admission to another hospital ward, or admission to hospital-in-the-home). All patients remain in scope for this collection until they are recorded as having physically departed the emergency department, regardless of whether they have been admitted. For this reason there is an overlap in scope of this NMDS and the Admitted patient care national minimum data set (APC NMDS).

Collection and usage attributes

Statistical unit: Emergency department stay.

Guide for use: The definition of a 'short stay unit' is as per clause C48 of the National Health Reform Agreement—National Partnership Agreement on Improving Public Hospital Services (NPA IPHS), as follows:

a) Designated and designed for the short term treatment, observation, assessment and reassessment of patients initially triaged and assessed in the emergency department (ED);

b) Have specific admission and discharge criteria and policies;

c) Designed for short term stays no longer than 24 hours;

d) Physically separated from the ED acute assessment area;

e) Have a static number of beds with oxygen, suction, patient ablution facilities; and

f) Not a temporary ED overflow area nor used to keep patients solely awaiting an inpatient bed nor awaiting treatment in the ED.

Collection methods: **National reporting arrangements**

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on a quarterly basis within one month of the end of a reporting period and an annual basis within three months of the reporting period.

The Institute and the Commonwealth Department of Health and Ageing will agree on a data quality and timeliness protocol. Once cleaned, a copy of the data and a record of the changes made will be forwarded by the Institute to the Commonwealth Department of Health and Ageing. A copy of the cleaned data for each jurisdiction should also be returned to that jurisdiction on request.

Periods for which data are collected and nationally collated

Quarterly and financial year. Extraction of data for each quarter or year should be based on the date of the end of the emergency department stay. For example, a presentation that commences at 11pm on 30 June and ends at 2am 1 July is not in scope for the April to June quarter.

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Comments: **Scope links with other metadata sets**

Episodes of care for admitted patients are reported through the Admitted patient care NMDS.

National Health Reform Agreement—National Partnership Agreement on Improving Public Hospital Services

The scope for reporting against the National Emergency Access Target is all hospitals reporting to the NAPEDC NMDS (Peer groups A, B and other) as at August 2011 (when the Agreement was signed). For the duration of the Agreement, hospitals that have not previously reported to the NAPEDC NMDS can come into scope, subject to agreement between the jurisdiction and the Commonwealth.

Source and reference attributes

Submitting organisation: National Health Information Management Principal Committee

Relational attributes

Related metadata references: See also Non-admitted patient emergency department care DSS 1 January 2012-30 June 2012 Health, Retired 30/01/2012

Supersedes Non-admitted patient emergency department care NMDS 2011-2012 Health, Superseded 30/01/2012

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of usual residence	Mandatory	1
-	Area of usual residence (SA2)	Mandatory	1
-	Compensable status	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of triage	Conditional	1
-	Date patient presents	Mandatory	1
-	Department of Veterans’ Affairs patient	Mandatory	1
-	Emergency department arrival mode - transport	Mandatory	1
-	Emergency department clinical care commencement date	Conditional	1

-	Emergency department clinical care commencement time	Conditional	1
-	Emergency department episode end date	Mandatory	1
-	Emergency department episode end time	Mandatory	1
-	Emergency department physical departure date	Mandatory	1
-	Emergency department physical departure time	Mandatory	1
-	Emergency department service episode end status	Mandatory	1
-	Emergency department waiting time to clinical care commencement	Conditional	1
-	Establishment identifier	Mandatory	1
-	Indigenous status	Mandatory	1
-	Length of non-admitted patient emergency department service episode	Mandatory	1
-	Person identifier	Mandatory	1
-	Sex	Mandatory	1
-	Time of triage	Conditional	1
-	Time patient presents	Mandatory	1
-	Triage category	Conditional	1
-	Type of visit to emergency department	Mandatory	1

Outpatient care NMDS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 336862

Registration status: Health, Standard 04/07/2007

DSS type: National Minimum Data Set (NMDS)

Scope: The scope of this National Minimum Data Set (NMDS) is for services provided to non-admitted, non-emergency department, patients registered for care by specialist outpatient clinics of public hospitals that are classified as either principal referral and specialist women's and children's hospitals and large hospitals (Peer Group A or B) as reported in the Australian Institute of Health and Welfare's Australian Hospital Statistics publication from the preceding financial year.

Hospitals use the term 'clinic' to describe various arrangements under which they deliver specialist outpatient services to non-admitted non-emergency department patients. **Outpatient clinic services** should be interpreted as encompassing services provided through specific organisational units staffed to administer and provide a certain range of outpatient care:

- in defined locations;
- at regular or irregular times; and
- where one or more specialist providers deliver care to booked patients.

Generally, in such clinics, a booking system is administered and patient records are maintained to document patient attendances and care provided.

The scope includes all arrangements made to deliver specialist care to non-admitted, non-emergency department patients whose treatment has been funded through the hospital, regardless of the source from which the hospital derives these funds. In particular, Department of Veterans' Affairs, compensable and other patients **funded through the hospital** (including Medicare ineligible patients) are included.

For the purposes of the Outpatient care NMDS, outreach services are counted at the specialist clinic where the patient is booked. Outreach services involve travel by the service provider, or services provided by a service provider via ICT (including but not limited to telephone and telehealth consultations). Such services may also be provided in the home, place of work or other non-hospital site.

Within the scope as defined, and subject to specific counting rules, occasions of service to be counted include outreach clinic services, services delivered in a multidisciplinary mode. A separate count of services delivered in group sessions is also collected.

Excluded from scope are:

- Outreach services which are not funded through the hospital and/or which deliver non- clinical care (activities such as home cleaning, meals on wheels, home maintenance); and
- All private specialist services delivered under private practice arrangements which are not funded through the hospital, regardless of whether or how these services may be funded by third party arrangements.
- All services covered by NMDS for:
  Admitted Patient Care,
  Admitted patient mental health care,
  Alcohol and other drug treatment services,
  Community mental health care,
  Non-admitted patient emergency department.

Admitted patient services are excluded from scope. However, outpatient services booked for reasons independent of, or distinct from the admitted patient episode are in scope.

Collection and usage attributes

Statistical unit: Occasions of service.

Group sessions.

Collection methods: **National reporting arrangements:**

State and territory Health authorities provide the data to the Department of Health and Ageing and Australian Institute of

Health and Welfare on an annual basis by 31 December each calendar year, for the previous financial year.

Periods for which data are collected and nationally collated:

Each financial year ending 30 June.

Implementation start date: 01/07/2007

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Party, 2006

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Establishment identifier	Mandatory	1
-	Number of group sessions	Mandatory	1
-	Number of occasions of service	Mandatory	1
-	Outpatient clinic type	Mandatory	1

Perinatal NMDS 2012-2013

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 461787

Registration status: Health, Standard 07/03/2012

DSS type: National Minimum Data Set (NMDS)

Scope: The scope of Perinatal national minimum data set (NMDS) is all births in Australia in hospitals, birth centres and the community. The data set includes information on all births, both live and stillborn, of at least 20 weeks gestation or 400 grams birth weight.

These data have two dimensions, which are the baby and the mother. All data relevant to the birth are conveyed in relation to one of these.

Collection and usage attributes

Collection methods: *National reporting arrangements*

State and territory health authorities provide the data to the Australian Institute of Health and Welfare's National Perinatal Epidemiology and Statistics Unit for national collation, on an annual basis.

Periods for which data are collected and nationally collated

Financial years ending 30 June each year.

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Relational attributes

Related metadata references: Supersedes Perinatal NMDS 2011-2012 Health, Superseded 07/03/2012

Implementation in Data Set Specification: Perinatal DSS 2012-2013 Health, Standard 07/03/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*

-	Actual place of birth	Mandatory	1
-	Apgar score at 5 minutes	Mandatory	1
-	Area of usual residence (SA2)	Mandatory	1
-	Birth order	Mandatory	1
-	Birth plurality	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	2
-	Establishment identifier	Mandatory	1
-	Gestational age	Mandatory	1
-	Indigenous status	Mandatory	2
-	Infant weight, neonate, stillborn	Mandatory	1
-	Method of birth	Mandatory	1
-	Number of tobacco cigarettes smoked per day after 20 weeks of pregnancy	Conditional	1
-	Onset of labour	Mandatory	1
-	Person identifier	Mandatory	2
-	Pregnancy duration at the first antenatal care visit	Mandatory	1
-	Presentation at birth	Mandatory	1
-	Separation date	Mandatory	2
-	Sex	Mandatory	1
-	State/Territory of birth	Mandatory	1
-	Status of the baby	Mandatory	1
-	Tobacco smoking indicator, after 20 weeks of pregnancy	Mandatory	1
-	Tobacco smoking indicator, first 20 weeks of pregnancy	Mandatory	1

Public hospital establishments NMDS 2012-2013

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 470656

Registration status: Health, Standard 07/12/2011

DSS type: National Minimum Data Set (NMDS)

Scope: The scope of the Public hospital establishments national minimum data set (NMDS) is establishment-level data for public acute and psychiatric hospitals, including hospitals operated for or by the Department of Veterans' Affairs, and alcohol and drug treatment centres.

Similar data for private hospitals and free standing day hospital facilities is collected by the Australian Bureau of Statistics in the Private Health Establishments Collection.

Hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

Collection and usage attributes

Statistical unit: Public hospital establishments.

Collection methods: Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant state or territory health authority on a regular basis (for example, monthly).

National reporting arrangements

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated

Financial years ending 30 June each year.

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Comments: *Scope links with other NMDSs*

Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:

- Admitted patient care NMDS
- Admitted patient mental health care NMDS
- Admitted patient palliative care NMDS

Source and reference attributes

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Public hospital establishment address details DSS Health, Standard 07/12/2011

Supersedes Public hospital establishments NMDS 2011-2012 Health, Superseded 07/12/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Average available beds for overnight-stay patients	Mandatory	1
-	Average available beds for same-day patients	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Establishment type	Mandatory	1
-	Full-time equivalent staff—administrative and clerical staff	Mandatory	1
-	Full-time equivalent staff—diagnostic and health professionals	Mandatory	1
-	Full-time equivalent staff—domestic and other staff	Mandatory	1
-	Full-time equivalent staff—enrolled nurses	Mandatory	1
-	Full-time equivalent staff—other personal care staff	Mandatory	1
-	Full-time equivalent staff—registered nurses	Mandatory	1
-	Full-time equivalent staff—salaried medical officers	Mandatory	1
-	Full-time equivalent staff—student nurses	Mandatory	1

-	Full-time equivalent staff—trainee/pupil nurses	Mandatory	1
-	Geographical location of establishment	Mandatory	1
-	Gross capital expenditure (accrual accounting)—buildings and building services	Mandatory	1
-	Gross capital expenditure (accrual accounting)—constructions	Mandatory	1
-	Gross capital expenditure (accrual accounting)—equipment	Mandatory	1
-	Gross capital expenditure (accrual accounting)—information technology	Mandatory	1
-	Gross capital expenditure (accrual accounting)—intangible assets	Mandatory	1
-	Gross capital expenditure (accrual accounting)—land	Mandatory	1
-	Gross capital expenditure (accrual accounting)—major medical equipment	Mandatory	1
-	Gross capital expenditure (accrual accounting)—other equipment	Mandatory	1
-	Gross capital expenditure (accrual accounting)—transport	Mandatory	1
-	Gross capital expenditure—computer equipment/installations	Mandatory	1
-	Gross capital expenditure—intangible assets	Mandatory	1
-	Gross capital expenditure—land and buildings	Mandatory	1
-	Gross capital expenditure—major medical equipment	Mandatory	1
-	Gross capital expenditure—other	Mandatory	1
-	Gross capital expenditure—plant and other equipment	Mandatory	1
-	Group sessions (public psychiatric, alcohol and drug hospital)—emergency and outpatient	Mandatory	1
-	Group sessions (public psychiatric, alcohol and drug hospital)—outreach and community	Mandatory	1
-	Group sessions—alcohol and other drug	Mandatory	1
-	Group sessions—allied health services	Mandatory	1
-	Group sessions—community health services	Mandatory	1
-	Group sessions—dental	Mandatory	1
-	Group sessions—dialysis	Mandatory	1

-	Group sessions—district nursing services	Mandatory	1
-	Group sessions—emergency services	Mandatory	1
-	Group sessions—endoscopy and related procedures	Mandatory	1
-	Group sessions—mental health	Mandatory	1
-	Group sessions—other medical/surgical/diagnostic	Mandatory	1
-	Group sessions—other outreach services	Mandatory	1
-	Group sessions—pathology	Mandatory	1
-	Group sessions—pharmacy	Mandatory	1
-	Group sessions—radiology and organ imaging	Mandatory	1
-	Individual sessions (public psychiatric, alcohol and drug hospital) - emergency and outpatient	Mandatory	1
-	Individual sessions (public psychiatric, alcohol and drug hospital)—outreach and community	Mandatory	1
-	Individual sessions—alcohol and drug	Mandatory	1
-	Individual sessions—allied health services	Mandatory	1
-	Individual sessions—community health services	Mandatory	1
-	Individual sessions—dental	Mandatory	1
-	Individual sessions—dialysis	Mandatory	1
-	Individual sessions—district nursing services	Mandatory	1
-	Individual sessions—emergency services	Mandatory	1
-	Individual sessions—endoscopy and related procedures	Mandatory	1
-	Individual sessions—mental health	Mandatory	1
-	Individual sessions—other medical/surgical/diagnostic	Mandatory	1
-	Individual sessions—other outreach services	Mandatory	1
-	Individual sessions—pathology	Mandatory	1
-	Individual sessions—pharmacy	Mandatory	1
-	Individual sessions—radiology and organ imaging	Mandatory	1
-	Net capital expenditure (accrual accounting)—buildings and building services	Mandatory	1
-	Net capital expenditure (accrual accounting)—constructions	Mandatory	1

-	Net capital expenditure (accrual accounting)—equipment	Mandatory	1
-	Net capital expenditure (accrual accounting)—information technology	Mandatory	1
-	Net capital expenditure (accrual accounting)—intangible assets	Mandatory	1
-	Net capital expenditure (accrual accounting)—land	Mandatory	1
-	Net capital expenditure (accrual accounting)—major medical equipment	Mandatory	1
-	Net capital expenditure (accrual accounting)—other equipment	Mandatory	1
-	Net capital expenditure (accrual accounting)—transport	Mandatory	1
-	Recurrent expenditure (indirect health care)— public health and monitoring services	Mandatory	1
-	Recurrent expenditure (indirect health care)—central administrations	Mandatory	1
-	Recurrent expenditure (indirect health care)—central and statewide support services	Mandatory	1
-	Recurrent expenditure (indirect health care)—other	Mandatory	1
-	Recurrent expenditure (indirect health care)—patient transport services	Mandatory	1
-	Recurrent expenditure (salaries and wages)—administrative and clerical staff	Mandatory	1
-	Recurrent expenditure (salaries and wages)—diagnostic and health professionals	Mandatory	1
-	Recurrent expenditure (salaries and wages)—domestic and other staff	Mandatory	1
-	Recurrent expenditure (salaries and wages)—enrolled nurses	Mandatory	1
-	Recurrent expenditure (salaries and wages)—other personal care staff	Mandatory	1
-	Recurrent expenditure (salaries and wages)—registered nurses	Mandatory	1
-	Recurrent expenditure (salaries and wages)—salaried medical officers	Mandatory	1
-	Recurrent expenditure (salaries and wages)—student nurses	Mandatory	1

-	Recurrent expenditure (salaries and wages)—total	Mandatory	1
-	Recurrent expenditure (salaries and wages)—trainee/pupil nurses	Mandatory	1
-	Recurrent expenditure—administrative expenses	Mandatory	1
-	Recurrent expenditure—depreciation	Mandatory	1
-	Recurrent expenditure—domestic services	Mandatory	1
-	Recurrent expenditure—drug supplies	Mandatory	1
-	Recurrent expenditure—food supplies	Mandatory	1
-	Recurrent expenditure—interest payments	Mandatory	1
-	Recurrent expenditure—medical and surgical supplies	Mandatory	1
-	Recurrent expenditure—other recurrent expenditure	Mandatory	1
-	Recurrent expenditure—patient transport	Mandatory	1
-	Recurrent expenditure—payments to visiting medical officers	Mandatory	1
-	Recurrent expenditure—repairs and maintenance	Mandatory	1
-	Recurrent expenditure—superannuation employer contributions	Mandatory	1
-	Revenue—other	Mandatory	1
-	Revenue—patient	Mandatory	1
-	Revenue—recoveries	Mandatory	1
-	Specialised service indicators—acquired immune deficiency syndrome unit	Mandatory	1
-	Specialised service indicators—acute renal dialysis unit	Mandatory	1
-	Specialised service indicators—acute spinal cord injury unit	Mandatory	1
-	Specialised service indicators—alcohol and drug unit	Mandatory	1
-	Specialised service indicators—bone marrow transplantation unit	Mandatory	1
-	Specialised service indicators—burns unit (level III)	Mandatory	1
-	Specialised service indicators—cardiac surgery unit	Mandatory	1
-	Specialised service indicators—clinical genetics unit	Mandatory	1
-	Specialised service indicators—comprehensive epilepsy centre	Mandatory	1

-	Specialised service indicators—coronary care unit	Mandatory	1
-	Specialised service indicators—diabetes unit	Mandatory	1
-	Specialised service indicators—domiciliary care service	Mandatory	1
-	Specialised service indicators—geriatric assessment unit	Mandatory	1
-	Specialised service indicators—heart, lung transplantation unit	Mandatory	1
-	Specialised service indicators—hospice care unit	Mandatory	1
-	Specialised service indicators—in-vitro fertilisation unit	Mandatory	1
-	Specialised service indicators—infectious diseases unit	Mandatory	1
-	Specialised service indicators—intensive care unit (level III)	Mandatory	1
-	Specialised service indicators—liver transplantation unit	Mandatory	1
-	Specialised service indicators—maintenance renal dialysis centre	Mandatory	1
-	Specialised service indicators—major plastic/reconstructive surgery unit	Mandatory	1
-	Specialised service indicators—neonatal intensive care unit (level III)	Mandatory	1
-	Specialised service indicators—neurosurgical unit	Mandatory	1
-	Specialised service indicators—nursing home care unit	Mandatory	1
-	Specialised service indicators—obstetric/maternity	Mandatory	1
-	Specialised service indicators—oncology unit, cancer treatment	Mandatory	1
-	Specialised service indicators—pancreas transplantation unit	Mandatory	1
-	Specialised service indicators—psychiatric unit/ward	Mandatory	1
-	Specialised service indicators—rehabilitation unit	Mandatory	1
-	Specialised service indicators—renal transplantation unit	Mandatory	1
-	Specialised service indicators—sleep centre	Mandatory	1
-	Specialised service indicators—specialist paediatric	Mandatory	1
-	Statistical area level 2 (SA2)	Mandatory	1
-	Teaching status	Mandatory	1

Residential mental health care NMDS 2012-2013

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	468206
Registration status:	Health, Standard 07/03/2012
DSS type:	National Minimum Data Set (NMDS)
Scope:	Episodes of residential care for residents in all government-funded residential mental health care services in Australia, except those residential care services that are in receipt of funding under the Aged Care Act and subject to Commonwealth reporting requirements (i.e. report to the System for the payment of Aged Residential Care (SPARC) collection).

Collection and usage attributes

Statistical unit:

Episodes of residential care.

Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.

Collection methods:

Data are collected at each service from resident administrative and care related record systems. Services forward data to the relevant state or territory health authority on a regular basis (e.g. monthly).

National reporting arrangements

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collection, on an annual basis.

Government-operated services that employ mental health trained staff on-site 24 hours per day are to be included from 1 July 2004.

Government-funded, non-government operated services and non 24-hour staffed services can be included from 1 July 2004, optionally.

For non 24-hour staffed services to be included they must employ mental health-trained staff on-site at least 50 hours per week with at least 6 hours staffing on any single day.

Periods for which data are collected and nationally collated

	Financial years ending 30 June each year. The reference period starts on 1 July and ends on 30 June each year.
Implementation start date:	01/07/2012
Implementation end date:	30/06/2013
Comments:	Some admitted patient care services may meet the definition of a residential mental health service. However, as they are admitted patient care services, relevant data on their patients are reported to the National Minimum Data Set for Admitted Patient Care. *Glossary items* **Episode of residential care end** **Episode of residential care start** **Resident** **Residential mental health care service**

Relational attributes

Related metadata references:	Supersedes Residential mental health care NMDS 2011-2012 Health, Superseded 07/03/2012

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Additional diagnosis	Mandatory	1
-	Area of usual residence (SA2)	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Episode of residential care end date	Mandatory	1
-	Episode of residential care end mode	Mandatory	1
-	Episode of residential care start date	Mandatory	1
-	Episode of residential care start mode	Mandatory	1
-	Establishment sector	Mandatory	1
-	Indigenous status	Mandatory	1
-	Leave days from residential care	Mandatory	1

-	Marital status	Mandatory	1
-	Mental health legal status	Mandatory	1
-	Organisation identifier	Mandatory	1
-	Organisation name	Mandatory	1
-	Person identifier	Mandatory	1
-	Principal diagnosis	Mandatory	1
-	Referral destination to further care (from specialised mental health residential care)	Mandatory	1
-	Region code	Mandatory	1
-	Region name	Mandatory	1
-	Residential service unit identifier	Mandatory	1
-	Residential service unit name	Mandatory	1
-	Residential stay start date	Mandatory	1
-	Service unit cluster identifier	Mandatory	1
-	Service unit cluster name	Mandatory	1
-	Sex	Mandatory	1

DSS

Acute coronary syndrome (clinical) DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 372930

Registration status: Health, Standard 01/10/2008

DSS type: Data Set Specification (DSS)

Scope: This Acute Coronary Syndrome (ACS) data set specification is not mandated for collection but is recommended as best practice if ACS data are to be collected. This data set specification enables individual hospitals or health service areas to develop collection methods and policies appropriate for their service.

The scope for the ACS data set specification is to collect data on the period between when a person with ACS symptoms was first referred to a hospital or directly presented at a hospital, and when a person leaves the hospital, either from the emergency department or is discharged from the hospital. Some of the data relevant to the management of patients attending hospital with ACS symptoms is specified for collection at follow-up visits with a specialist or as a non-admitted patient.

Acute coronary syndromes reflect the spectrum of coronary artery disease resulting in acute myocardial ischaemia, and span unstable angina, non-ST segment elevation myocardial infarction (NSTEMI) and ST-segment elevation myocardial infarction (STEMI). Clinically these diagnoses encompass a wide variation in risk, require complex and time urgent risk stratification and represent a large social and economic burden.

The definitions used in this data set specification are designed to underpin the data collected by health professionals in their day-to-day acute care practice. They relate to the realities of an acute clinical consultation for patients presenting with chest pain/ discomfort and the need to correctly identify, evaluate and manage patients at increased risk of a coronary event.

The data elements specified in this metadata set provide a framework for:

- promoting the delivery of evidenced-based acute coronary syndrome management care to patients;
- facilitating the ongoing improvement in the quality and safety of acute coronary syndrome management in acute care settings in Australia and New Zealand;
- improving the epidemiological and public health understanding of this syndrome; and
- supporting acute care services as they develop information systems to complement the above.

This is particularly important as the scientific evidence supporting the development of the data elements within the ACS data set specification indicate that accurate identification of the evolving myocardial infarction patient or the high/intermediate risk patient leading to the implementation of the appropriate management pathway impacts on the patient's outcome. Having a nationally recognised set of definitions in relation to defining a patient's diagnosis, risk status and outcomes is a prerequisite to achieving the above aims.

The ACS data set specification is based on the American College of Cardiology (ACC) Data Set for Acute Coronary Syndrome as published in the Journal of the American College of Cardiology in December 2001 (38:2114-30) as well as more recent scientific evidence around the diagnosis of myocardial infarction presented in the National Heart Foundation of Australia/Cardiac Society of Australia and New Zealand Guidelines for the management of acute coronary syndromes (MJA 2006;184;S1-S32). The data elements are alphabetically listed and grouped in a similar manner to the American College of Cardiology's data set format. These features of the Australian ACS data set should ensure that the data is internationally comparable.

Many of the data elements in this data set specification may also be used in the collection of other cardiovascular clinical information.

Where appropriate, it may be useful if the data definitions in this data set specification were also used to address data definition needs in non-clinical environments such as public health surveys etc. This could allow for qualitative comparisons between data collected in, and aggregated from, clinical settings (i.e. using application of the ACS data set specification), with that collected through other means (e.g. public health surveys, reports).

A set of ACS data elements and standardised definitions can inform the development and conduct of future registries at both the national and local level.

The working group formed under the National Heart Foundation of Australia (Heart Foundation) and the Cardiac Society of Australia and New Zealand (CSANZ) initiative was diverse and included representation from the following organisations: the Heart Foundation, the CSANZ, the Australasian College of Emergency Medicine, the Australian Institute of Health and Welfare, the Australasian Society of Cardiac & Thoracic Surgeons, Royal Australian College of Physicians (RACP), RACP - Towards a Safer Culture, National Centre for Classification in Health (Brisbane), the NSW Aboriginal Health & Medical Research Council, the George Institute for International Health, the School of Population Health at the University of Western Australia and the National Cardiovascular Monitoring System Advisory Committee.

To ensure the broad acceptance of the data set specification, the working group also sought consultation from the heads of cardiology departments, other specialist professional bodies and regional key opinion leaders in the field of acute coronary syndromes.

Collection and usage attributes

Guide for use:

There are six data clusters in the Acute Coronary Syndrome (Clinical) DSS. To ensure a complete description of the clinical management of acute coronary syndromes (ACS) it is recommended that all clusters be collected along with the individual data elements during the current ACS event by the individual hospital or health service area.

The six data clusters in this DSS include:

1. Acute coronary syndrome clinical event cluster
2.
3. Functional stress test cluster
4.

5. Electrocardiogram cluster
6.
7. Ventricular ejection fraction cluster
8.
9. Acute coronary syndrome pharmacotherapy cluster
10.
11. Coronary artery cluster

Collection methods: This data set specification is primarily concerned with the clinical use of ACS-Data. Acute care environments such as hospital emergency departments, coronary care units or similar acute care areas are the settings in which implementation of the core ACS data set specification should be considered. A wider range of health and health related establishments that create, use or maintain, records on health care clients, could also use it.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Acute coronary syndrome clinical event cluster	Conditional	1
-	Acute coronary syndrome pharmacotherapy data cluster	Optional	1
-	Coronary artery cluster	Optional	1
-	Electrocardiogram cluster	Optional	1
-	Functional stress test cluster	Optional	1
-	Ventricular ejection fraction cluster	Conditional	1
-	Acute coronary syndrome procedure type	Optional	1
-	Acute coronary syndrome related medical history	Optional	1
-	Acute coronary syndrome stratum	Optional	1
-	Admission date	Optional	1
-	Admission time	Optional	1
-	Angina status	Optional	1
-	Bleeding episode using TIMI criteria (status)	Optional	1
-	C-reactive protein level (measured)	Optional	1
-	Chest pain pattern category	Optional	1
-	Cholesterol—HDL (measured)	Optional	1
-	Cholesterol—LDL (calculated)	Conditional	1

-	Cholesterol—total (measured)	Optional	1
-	Clinical evidence of acute coronary syndrome related medical history	Optional	1
-	Clinical procedure timing (status)	Optional	1
-	Country of birth	Optional	1
-	Creatine kinase isoenzyme—upper limit of normal range (U/L)	Optional	1
-	Creatine kinase level (U/L)	Conditional	1
-	Creatine kinase MB isoenzyme level (micrograms per litre)	Conditional	1
-	Creatine kinase MB isoenzyme level (units per litre)	Conditional	1
-	Creatine kinase MB isoenzyme—upper limit of normal range (units per litre)	Conditional	1
-	Creatine kinase MB isoenzyme—upper limit of normal range (micrograms per litre)	Conditional	1
-	Creatinine serum level (measured)	Conditional	1
-	Date C-reactive protein level measured	Optional	1
-	Date creatine kinase MB isoenzyme measured	Conditional	1
-	Date creatinine serum level measured	Conditional	1
-	Date of birth	Optional	1
-	Date of death	Optional	1
-	Date of diagnostic cardiac catheterisation	Conditional	1
-	Date of implantable cardiac defibrillator procedure	Optional	1
-	Date of intra-aortic balloon pump procedure	Conditional	1
-	Date of most recent stroke	Conditional	1
-	Date of non-invasive ventilation administration	Conditional	1
-	Date of onset of acute coronary syndrome symptoms	Optional	1
-	Date of pacemaker insertion	Optional	1
-	Date of referral to rehabilitation	Optional	1
-	Date of triage	Optional	1
-	Date patient presents	Optional	1

-	Date troponin measured	Optional	1
-	Diabetes status	Conditional	1
-	Diabetes therapy type	Conditional	1
-	Dyslipidaemia treatment indicator	Conditional	1
-	Emergency department arrival mode - transport	Optional	1
-	Establishment identifier	Optional	1
-	Funding source for hospital patient	Optional	1
-	Glycosylated haemoglobin level (measured)	Optional	1
-	Glycosylated Haemoglobin—upper limit of normal range (percentage)	Conditional	1
-	Height (measured)	Conditional	1
-	Hypertension - treatment	Optional	1
-	Indigenous status	Optional	1
-	Instrumented bleeding location	Optional	1
-	Killip classification code	Optional	1
-	Lifestyle counselling type	Optional	1
-	Mode of separation	Optional	1
-	Non-instrumented bleeding location	Optional	1
-	Number of episodes of angina in last 24 hours	Conditional	1
-	Other/Underlying cause of acute coronary syndrome	Optional	1
-	Person identifier	Optional	1
-	Premature cardiovascular disease family history (status)	Optional	1
-	Principal diagnosis	Optional	1
-	Reason for readmission—acute coronary syndrome	Optional	1
-	Separation date	Optional	1
-	Sex	Optional	1
-	Time C-reactive protein level measured	Optional	1
-	Time creatine kinase MB isoenzyme measured	Conditional	1
-	Time of diagnostic cardiac catheterisation	Conditional	1
-	Time of implantable cardiac defibrillator procedure	Optional	1

-	Time of intra-aortic balloon pump procedure	Conditional	1
-	Time of non-invasive ventilation administration	Optional	1
-	Time of onset of acute coronary syndrome symptoms	Optional	1
-	Time of pacemaker insertion	Conditional	1
-	Time of triage	Optional	1
-	Time patient presents	Optional	1
-	Time troponin measured	Optional	1
-	Tobacco smoking status	Optional	1
-	Total blood units transfused	Conditional	1
-	Triage category	Conditional	1
-	Triglyceride level (measured)	Optional	1
-	Troponin assay type	Optional	1
-	Troponin assay—upper limit of normal range (micrograms per litre)	Conditional	1
-	Troponin level (measured)	Optional	1
-	Type of visit to emergency department	Optional	1
-	Underlying cause of death	Optional	1
-	Vascular history	Conditional	1
-	Weight in kilograms (measured)	Conditional	1

Breast cancer (Cancer registries) DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 370008

Registration status: Health, Standard 06/03/2009

DSS type: Data Set Specification (DSS)

Scope: This breast cancer data set is not mandated for collection but is recommended as best practice if breast cancer data are to be collected.

The data set would allow common, consistent and high quality breast cancer data to be collected by State and Territory cancer registries and collated nationally.

This data will help inform research, policy, planning and guideline development work in the breast cancer area.

Breast cancer may be used as a forerunner for other cancers in terms of establishing common data collections across cancer registries.

This data set includes 20 items, with the inclusion of five new standards and the addition of further detail to several existing standards.

Collection and usage attributes

Guide for use: Report each of the data elements in this data set once, and in no particular order.

Collection methods: State and Territory cancer registries collect data on incidence and annually report data to the Australian Institute of Health and Welfare.

Source and reference attributes

Submitting organisation: National Breast and Ovarian Cancer centre (NBOCC)

Australasian Association of Cancer Registries (AACR)

Australian Institute of Health and Welfare (AIHW)

Steward: Australasian Association of Cancer Registries (AACR)

Origin: National Breast and Ovarian Cancer centre (NBOCC)

Australasian Association of Cancer Registries (AACR)

Australian Institute of Health and Welfare (AIHW)

Reference documents:	Johnson CH, Adamo M (eds.), SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Cancer staging—M stage code	Mandatory	1
-	Cancer staging—N stage code	Mandatory	1
-	Cancer staging—T stage code	Mandatory	1
-	Cancer staging—TNM stage grouping code	Mandatory	1
-	Date of diagnosis of cancer	Mandatory	1
-	Histopathological grade	Mandatory	1
-	Human epidermal growth factor receptor-2 test result	Mandatory	1
-	Human epidermal growth factor receptor-2 test type	Mandatory	1
-	Laterality of primary cancer	Mandatory	1
-	Lymphovascular invasion	Mandatory	1
-	Morphology of cancer	Mandatory	1
-	Most valid basis of diagnosis of cancer	Mandatory	1
-	Neo-adjuvant therapy	Mandatory	1
-	Number of positive sentinel lymph nodes	Mandatory	1
-	Number of regional lymph nodes examined	Mandatory	1
-	Number of sentinel lymph nodes examined	Mandatory	1
-	Oestrogen receptor assay result	Mandatory	1
-	Primary site of cancer (ICDO-3 code)	Mandatory	1
-	Regional lymph nodes positive	Mandatory	1
-	Tumour size at diagnosis (solid tumours)	Mandatory	1

Cancer (clinical) DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 394731

Registration status: Health, Standard 07/12/2011

DSS type: Data Set Specification (DSS)

Scope: The purpose of the Cancer (clinical) data set specification (C(C)DSS) is to define data standards for the national collection of clinical cancer data so that data collected is consistent and reliable. Collection of this data set specification is not mandated but it is recommended as best practice if clinical cancer data are to be collected. It will facilitate more consistent data collection while enabling individual treatment centres or health service areas to develop data extraction and collection processes and policies that are appropriate for their service settings.

Mandatory reporting regulations have enabled population-based cancer registries in Australia to collect standard information on all incident cases of cancer apart from non-melanoma skin cancers, from which incidence, mortality and overall survival have been determined and trends monitored. The Cancer (clinical) data set specification provides a framework for the collection of more detailed and comprehensive clinical data such as stage of cancer at diagnosis, other prognostic characteristics, cancer treatment and patient outcomes.

The Cancer (clinical) data set specification will support prospective data collection from the time a person with cancer symptoms is referred or first presents to a hospital or specialist through the entire duration of their illness.

The majority of data items in the Cancer (clinical) data set specification are applicable to most solid tumours while many are also relevant to the haematopoietic malignancies such as leukaemia and lymphoma. Data set specifications for specialist tumour streams are also under development and these will contain supplementary data elements that will capture the special features of specific cancer types.

The definitions used in this data set specification are designed to capture the provision of cancer care on a day-to-day level. They relate to the cancer care pathway and the need to optimise care by correctly diagnosing, evaluating and managing patients with cancer. In addition, end-points and patterns of care can be monitored to understand both the appropriateness and effectiveness of cancer care.

The data elements specified provide a framework for:

- promoting the delivery of evidence-based care to patients with cancer
- facilitating the ongoing improvement in the quality and safety of cancer management in treatment settings
- improving the epidemiological and public health understanding of cancer
- informing treatment guidelines and professional education
- guiding resource planning and the evaluation of cancer control activities

They will facilitate the aggregation of data across different treatment centres.

The underlying long-term goal is to provide data support to improve outcomes for patients by increasing the quality and length of life. For example, a comparison of the actual management of patients with best practice guidelines may identify shortfalls in treatment and limitations in access to treatment modalities for some patients.

The working group formed under the stewardship of Cancer Australia was diverse and included representation from the following organisations: Cancer Australia, University of Sydney-Department of Gynaecological Oncology, Westmead Institute for Cancer Research, Cancer Council Victoria, Royal Brisbane & Women’s Hospital, National Breast and Ovarian Cancer Centre, The Royal Women’s Hospital, Queensland Health, Ministry of Health, NSW Health, TROG Cancer Research, and the Cancer Institute NSW.

To ensure the broad acceptance of the data set specification, the proposed list of data items was circulated to members of Cancer Australia’s National Cancer Data Strategy Advisory Group, a multidisciplinary group with a broad spectrum of epidemiological knowledge and expertise, and the inter-governmental Strategic Forum, comprising clinicians and senior health department officials from the Australian Government and from each state and territory government, and with strong community representation. The working group also sought consultation from cancer registry data managers, clinical leaders, pathologists, medical oncologists and radiation oncologists to achieve consensus when required.

Collection and usage attributes

Guide for use: The Cancer (clinical) data set specification contains six data clusters relating to cancer treatment. To ensure a complete description of the clinical management of cancer, it is recommended that if the patient has had the specific treatment modality the cluster refers to, each data item within the cluster should be completed.

The data clusters are as follows:

- Chemotherapy for cancer cluster
- Hormone therapy for cancer cluster
- Immunotherapy for cancer cluster
- Radiotherapy for cancer cluster
- Surgery for cancer cluster
- Systemic therapy procedure for cancer cluster

Collection methods: This data set is primarily directed at the clinical and clinical epidemiological use of cancer data. Treatment centres such as hospitals, radiotherapy centres and cancer specialist practices are the settings in which implementation of the core Cancer (clinical) data set specification should be considered. The data set specification can also be used by a wider range of health and health-related establishments that create, use, or maintain records on health-care clients.

Source and reference attributes

Submitting organisation: Cancer Australia

Relational attributes

Related metadata references: Supersedes Cancer (clinical) DSS Health, Superseded 07/12/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Chemotherapy for cancer cluster	Conditional	1
-	Hormone therapy for cancer cluster	Conditional	1
-	Immunotherapy for cancer cluster	Conditional	1
-	Radiotherapy for cancer cluster	Conditional	1
-	Surgery for cancer cluster	Conditional	1
-	Systemic therapy procedure for cancer cluster	Conditional	1
-	Address line (person)	Mandatory	1

-	Cancer staging scheme source edition number	Mandatory	1
-	Cancer staging—M stage code	Mandatory	1
-	Cancer staging—N stage code	Mandatory	1
-	Cancer staging—stage grouping other	Mandatory	1
-	Cancer staging—T stage code	Mandatory	1
-	Cancer staging—TNM stage grouping code	Mandatory	1
-	Cancer status	Mandatory	1
-	Cancer treatment type	Mandatory	1
-	Date accuracy indicator	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of death	Conditional	1
-	Date of diagnosis of cancer	Mandatory	1
-	Date of diagnosis of first recurrence as distant metastasis	Conditional	1
-	Date of diagnosis of first recurrence as locoregional cancer	Conditional	1
-	Date of last contact	Mandatory	1
-	Establishment number	Mandatory	1
-	Family name	Mandatory	1
-	Given name(s)	Mandatory	1
-	Histopathological grade	Mandatory	1
-	HPI-O	Mandatory	1
-	Indigenous status	Mandatory	1
-	Laterality of primary cancer	Mandatory	1
-	Medicare card number	Mandatory	1
-	Morphology of cancer	Mandatory	1
-	Most valid basis of diagnosis of cancer	Mandatory	1
-	Most valid basis of diagnosis of recurrence	Conditional	1
-	Number of regional lymph nodes examined	Conditional	1
-	Other cancer treatment	Conditional	99

-	Outcome of treatment	Mandatory	1
-	Person identifier	Mandatory	1
-	Primary site of cancer (ICD-O-3 code)	Mandatory	1
-	Region of first recurrence as distant metastasis	Conditional	99
-	Region of first recurrence as locoregional cancer	Conditional	99
-	Regional lymph nodes positive	Conditional	1
-	Sex	Mandatory	1
-	Staging basis of cancer	Mandatory	1
-	Staging scheme source	Mandatory	1
-	Tumour size at diagnosis (solid tumours)	Conditional	1
-	Underlying cause of death	Conditional	1

Cardiovascular disease (clinical) DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	374213
Registration status:	Health, Standard 22/12/2009
DSS type:	Data Set Specification (DSS)

Scope:

The collection of cardiovascular data (CV-Data) in this metadata set is voluntary.

The definitions used in CV-Data are designed to underpin the data collected by health professionals in their day-to-day practice. They relate to the realities of a clinical consultation and the ongoing nature of care and relationships that are formed between doctors and patients in clinical practice.

The data elements specified in this metadata set provide a framework for:

- promoting the delivery of high quality cardiovascular disease preventive and management care to patients,
- facilitating ongoing improvement in the quality of cardiovascular and chronic disease care predominantly in primary care and other community settings in Australia, and
- supporting general practice and other primary care services as they develop information systems to complement the above.

This is particularly important as general practice is the setting in which chronic disease prevention and management predominantly takes place. Having a nationally recognised set of definitions in relation to defining a patient's cardiovascular behavioural, social and biological risk factors, and their prevention and management status for use in these clinical settings, is a prerequisite to achieving these aims.

Many of the data elements in this metadata set are also used in the collection of diabetes clinical information.

Where appropriate, it may be useful if the data definitions in this metadata set were used to address data definition needs for use in non-clinical environments such as public health surveys etc. This could allow for qualitative comparisons between data collected in, and aggregated from clinical settings (i.e. using application of CV-Data), with that collected through other means (e.g. public health surveys).

Collection and usage attributes

Collection methods: This metadata set is primarily concerned with the clinical use of CV-data. It could also be used by a wider range of health and health related establishments that create, use or maintain records on health care clients.

Relational attributes

Related metadata references: Supersedes Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Alcohol consumption frequency (self reported)	Mandatory	1
-	Alcohol consumption in standard drinks per day (self reported)	Mandatory	1
-	Behaviour-related risk factor intervention	Mandatory	8
-	Behaviour-related risk factor intervention - purpose	Mandatory	5
-	Blood pressure—diastolic (measured)	Mandatory	1
-	Blood pressure—systolic (measured)	Mandatory	1
-	Cholesterol—HDL (measured)	Mandatory	1
-	Cholesterol—LDL (calculated)	Mandatory	1
-	Cholesterol—total (measured)	Mandatory	1
-	Country of birth	Mandatory	1
-	Creatinine serum level (measured)	Mandatory	1
-	CVD drug therapy—condition	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of diagnosis	Mandatory	1
-	Date of referral to rehabilitation	Conditional	1
-	Diabetes status	Mandatory	1
-	Diabetes therapy type	Mandatory	1
-	Division of General Practice number	Mandatory	1

-	Fasting status	Mandatory	1
-	Formal community support access status	Mandatory	1
-	Height (measured)	Mandatory	1
-	Indigenous status	Mandatory	1
-	Informal carer existence indicator	Mandatory	1
-	Labour force status	Mandatory	1
-	Living arrangement	Mandatory	1
-	Person identifier	Mandatory	1
-	Physical activity sufficiency status	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Preferred language	Mandatory	1
-	Premature cardiovascular disease family history (status)	Mandatory	1
-	Proteinuria status	Mandatory	1
-	Renal disease therapy	Mandatory	1
-	Service contact date	Mandatory	1
-	Sex	Mandatory	1
-	Tobacco smoking status	Mandatory	1
-	Tobacco smoking—consumption/quantity (cigarettes)	Mandatory	1
-	Triglyceride level (measured)	Mandatory	1
-	Vascular history	Mandatory	1
-	Vascular procedures	Mandatory	1
-	Waist circumference (measured)	Mandatory	1
-	Weight in kilograms (measured)	Mandatory	1

Computer Assisted Telephone Interview demographic module DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	374218
Registration status:	Health, Standard 03/12/2008
DSS type:	Data Set Specification (DSS)
Scope:	Key demographic set for use in Computer Assisted Telephone Interviewing (CATI) health surveys. It is intended to be used by anyone conducting population health surveys using the CATI mode, such as State/Territory government health agencies. This data set is to standardise demographic collection in all CATI surveys of health topics, such as CATI asthma and CATI diabetes surveys. The standardisation of the collection of health survey data is a major focus of the National Public Health Partnership (NPHP) work plan. The CATI demographic module DSS is not mandated for collection but recommended as best practice.

Collection and usage attributes

Collection methods:	Population health surveys conducted by CATI

Source and reference attributes

Submitting organisation:	National Public Health Information Working Group.

Relational attributes

Related metadata references:	Supersedes Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Age	Optional	1
-	Age range	Optional	1
-	Country of birth	Optional	1

-	Date of birth	Optional	1
-	Household annual gross income range	Optional	1
-	Household annual gross income range ($ 10,000 range)	Optional	1
-	Indigenous status	Optional	1
-	Marital status	Optional	1
-	Postcode—Australian (person)	Optional	1
-	Sex	Optional	1
-	Suburb/town/locality name (person)	Optional	1
-	Year of arrival in Australia	Conditional	1

Diabetes (clinical) DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 304865

Registration status: Health, Standard 21/09/2005

DSS type: Data Set Specification (DSS)

Scope: The use of this standard is voluntary.

However, if data is to be collected the Diabetes (clinical) Data Set Specification (DSS) aims to ensure national consistency in relation to defining, monitoring and recording information on patients diagnosed with diabetes.

The Diabetes (clinical) DSS relates to the clinical status of, the provision of services for, and the quality of care delivered to individuals with diabetes, across all health care settings including:

- General Practitioners;
- Divisions of General Practice;
- Diabetes Centres
- Specialists in private practice; and
- Community Health Nurses and Diabetes Educators.

The Diabetes (clinical) DSS:

- provides concise, unambiguous definitions for items/conditions related to diabetes quality care, and
- aims to ensure standardised methodology of data collection in Australia.

The expectation is that collection of this data set facilitates good quality of care, contributes to preventive care and has the potential to enhance self-management by patients with diabetes.

The underlying goal is improvement of the length and quality of life of patients with diabetes, and prevention or delay in the development of diabetes related complications.

Collection and usage attributes

Collection methods: This metadata set is primarily concerned with the clinical use of Diabetes data. It could/should be used by health and health related establishments that create, use or maintain records on health care clients.

One methodology is for data to be collected over a 1-month

	period of all diabetes patients presenting at sites participating in the collection. The information is de-identified to protect the privacy of individuals. The participation is voluntary. An individual benchmarking report is provided. The results provide a snapshot of care of people with diabetes.
Comments:	Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published. **Scope links with other Metadata sets** Cardiovascular disease (clinical) DSS.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group

Relational attributes

Related metadata references:	Supersedes Diabetes (clinical) DSS Health, Superseded 21/09/2005

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Blindness (diabetes complication)	Mandatory	1
-	Blood pressure—diastolic (measured)	Mandatory	1
-	Blood pressure—systolic (measured)	Mandatory	1
-	Cardiovascular medication (current)	Mandatory	1
-	Cataract - history	Mandatory	4
-	Cerebral stroke due to vascular disease (history)	Mandatory	1
-	Cholesterol—HDL (measured)	Mandatory	1
-	Cholesterol—total (measured)	Mandatory	1
-	Coronary artery disease—history of intervention or procedure	Mandatory	1
-	Creatinine serum level (measured)	Mandatory	1
-	Date of birth	Mandatory	1
-	Diabetes status	Mandatory	1
-	Diabetes therapy type	Mandatory	1

-	Dyslipidaemia treatment indicator	Mandatory	1
-	Erectile dysfunction	Mandatory	1
-	Fasting status	Mandatory	1
-	Foot deformity	Mandatory	1
-	Foot lesion (active)	Mandatory	1
-	Foot ulcer (history)	Mandatory	1
-	Foot ulcer (current)	Mandatory	1
-	Glycosylated haemoglobin level (measured)	Mandatory	1
-	Glycosylated Haemoglobin—upper limit of normal range (percentage)	Mandatory	1
-	Health professionals attended (diabetes mellitus)	Mandatory	1
-	Height (measured)	Mandatory	1
-	Hypertension - treatment	Mandatory	1
-	Hypoglycaemia - severe	Mandatory	1
-	Indigenous status	Mandatory	1
-	Initial visit indicator—diabetes mellitus	Mandatory	1
-	Lower limb amputation due to vascular disease	Mandatory	1
-	Microalbumin level—albumin/creatinine ratio (measured)	Conditional	1
-	Microalbumin level—micrograms per minute (measured)	Conditional	1
-	Microalbumin level—milligrams per 24 hour (measured)	Conditional	1
-	Microalbumin level—milligrams per litre (measured)	Conditional	1
-	Microalbumin level—upper limit of normal range (albumin/creatinine ratio)	Conditional	1
-	Microalbumin level—upper limit of normal range (micrograms per minute)	Conditional	1
-	Microalbumin level—upper limit of normal range (milligrams per 24 hour)	Conditional	1
-	Microalbumin level—upper limit of normal range (milligrams per litre)	Conditional	1
-	Myocardial infarction (history)	Mandatory	1
-	Ophthalmological assessment—outcome (left retina)	Mandatory	1

-	Ophthalmological assessment—outcome (right retina)	Mandatory	1
-	Ophthalmoscopy performed indicator	Mandatory	1
-	Peripheral neuropathy (status)	Mandatory	1
-	Peripheral vascular disease in feet (status)	Mandatory	1
-	Pregnancy—current status	Mandatory	1
-	Referred to ophthalmologist (diabetes mellitus)	Mandatory	1
-	Renal disease—end-stage (diabetes complication)	Mandatory	1
-	Service contact date	Mandatory	1
-	Sex	Mandatory	1
-	Tobacco smoking status (diabetes mellitus)	Mandatory	1
-	Triglyceride level (measured)	Mandatory	1
-	Visual acuity (left eye)	Mandatory	1
-	Visual acuity (right eye)	Mandatory	1
-	Weight in kilograms (measured)	Mandatory	1
-	Year insulin started	Mandatory	1
-	Year of diagnosis of diabetes mellitus	Mandatory	1

Functioning and Disability DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 320319

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

DSS type: Data Set Specification (DSS)

Scope: The Functioning and Disability DSS aims to ensure national consistency in relation to defining and measuring human functioning and disability. This DSS has been developed to be consistent with the International Classification of Functioning, Disability and Health (ICF).

Functioning and disability are dual concepts in a broad framework.

Functioning is the umbrella term for any or all of: body functions, body structures, activities and participation. Functioning is a multidimensional concept denoting the neutral aspects of the interaction between an individual (with a health condition) and that individual's environmental and personal factors.

Disability is the umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation. Disability is a multi-dimensional and complex concept and is conceived as a dynamic interaction between health conditions and environmental and personal factors (WHO 2001:6).

A health condition may be a disease (acute or chronic), disorder, injury or trauma. Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives. Personal factors relate to the individual, such as age, sex and Indigenous status.

The components of functioning and disability are classified and defined in the ICF as **body structures** and **body functions**, **activities** and **participation** and **environmental factors**. Each component is composed of various domains; these are sets of related physiological functions, anatomical structures, actions, tasks, areas of life, and external influences. Qualifiers, the numeric measures coded after the relevant domain, are usually essential to the meaningful use of the classification because of the neutral terms of the domains.

Many different 'definitions' of disability are used in Australia, both in administrative data collections and in Acts of Parliament. The consistent identification of disability in national data collections has been recommended in a number of reports, for instance to enable:

- the monitoring of access to generic services by people with disability;
- the collection of more consistent data on disability support and related services, including data on service use by different groups;
- population data and service data to be related, thereby improving the nation's analytical capacity in relation to the need for and supply of services; and
- improved understanding of the relationship between disability, health conditions and other health outcomes.

Defining disability makes it possible to determine the number of people in the population with disability, those who are accessing services, both disability specific and generic, and those with a disability in the general population with unmet need. Better definition of disability will aid better targeting of resources to those in need.

The concept 'Disability' can be operationalised in a wide variety of settings and for various purposes, using a combination of related metadata items as building blocks.

The metadata items selected for a particular application may vary depending on the approach to functioning and disability. For example, in hospital rehabilitation, the focus may be on the impairment and activity dimensions, and in community-based care the focus may be primarily on participation. Some applications may require a broad scope for inclusion (e.g. discrimination legislation). Data collections relating to services will select combinations of the data elements, which best reflect the eligibility criteria for the service.

The Functioning and Disability DSS comprises the following four clusters to describe level of human functioning:

12. Body functioning, qualified by extent of impairment
13. Body structure, qualified by extent, nature and location of impairment
14. Activities and participation, qualified by level of difficulty and need for assistance with undertaking activities and extent of and satisfaction with participation
15. Environmental factors, qualified by extent of influence of the environment

Data collected using this DSS can be related to national data collections which use ICF concepts such as the Commonwealth

State Territory Disability Agreement (CSTDA) NMDS collection and the ABS Survey of Ageing, Disability and Carers and, from 2006, the Census.

Collection and usage attributes

Collection methods:

Each of the four clusters that make up the Functioning and Disability DSS should be recorded for a complete description of human functioning. This information can be gathered over time by a range of health and community care providers.

Completion of the DSS will record a person-centred description of the experience of functioning of the individual who is the subject of the data. The experience of functioning is in relation to a health condition, and does not consider decrements in functioning that may be associated with social factors such as ethnic background or economic status. For example, the level of communication is recorded in relation to the heath condition, not to the fact that a person does not speak English at home.

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an umbrella term for 'disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N]}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}.

This DSS may be used in data collections in the community services, housing and health sectors.

Comments:

The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002). The ICF is grounded in a human rights philosophy, and its relationship to the UN Standard Rules on Equalization of Opportunities for Persons with Disabilities endorsed by the United Nations in 1994 is acknowledged. The purpose of the Rules is to ensure that people with disabilities, as members of their societies, may exercise the same rights and obligations as others.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Steward:	Advisory Committee on Australian and International Disability Data (ACAIDD)
Origin:	WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW
Reference documents:	Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites: • WHO ICF website http://www.who.int/classifications/icf/en/ • Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Activities and Participation cluster	Optional	1
-	Body functions cluster	Optional	1
-	Body structures cluster	Optional	1
-	Environmental factors cluster	Optional	1

Health care client identification DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 374201

Registration status: Health, Standard 03/12/2008

DSS type: Data Set Specification (DSS)

Scope: The data elements specified in this metadata set provide a framework for improving the positive identification of persons in health care organisations. This metadata set applies in respect of all potential or actual clients of the Australian health care system. It defines demographic and other identifying data elements suited to capture and use for person identification in health care settings.

The objectives in collecting the data elements in this metadata set are to promote uniformly good practice in:

- identifying individuals
- recording identifying data so as to ensure that each individual's health records will be associated with that individual and no other.

The process of positively identifying people within a health care service delivery context entails matching data supplied by those individuals against data the service provider holds about them. The positive and unique identification of health care clients is a critical event in health service delivery, with direct implications for the safety and quality of health care.

There are many barriers to successfully identifying individuals in health care settings, including variable data quality; differing data capture requirements and mechanisms; and varying data matching methods. These definitions provide a base for improving the confidence of health service providers and clients alike that the data being associated with any given individual, and upon which clinical decisions are made, is appropriately associated.

Collection and usage attributes

Collection methods: This metadata set is primarily concerned with the clinical use of Health care client identification data. It should be used by health and health-related establishments that create, use or maintain records on health care clients.

Establishments should use this metadata set, where appropriate, for collecting data when registering health care clients or potential health care clients.

The collection of data based on this metadata set is voluntary.

National reporting arrangements

Collectors of this metadata set should refer to relevant privacy legislation, codes of fair information practice and other guidelines so as not to breach personal privacy in their collection, use, storage and disclosure of health care client information. There is no comprehensive privacy legislation covering both the public and private sectors across Australia so users need to consider their particular set of circumstances (i.e. location and sector) and whether privacy legislation covers those circumstances.

A Commonwealth legislative scheme applies to the private sector. Users may refer to the Federal Privacy Commissioner's web site for assistance in complying with their privacy obligations. In the public sector, in instances where no legislation, code of fair information practice or other guidelines covers the particular circumstances, users should refer to AS 4400 Personal privacy protection in health care information systems.

Relational attributes

Related metadata references: Supersedes Health care client identification DSS Health, Superseded 03/12/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Address line (person)	Mandatory	1
-	Address type (person)	Mandatory	1
-	Address—country identifier (person)	Mandatory	1
-	Australian state/territory identifier	Mandatory	1
-	Birth order	Mandatory	1
-	Birth plurality	Mandatory	1
-	Building/complex sub-unit number (person)	Mandatory	1
-	Building/complex sub-unit type—abbreviation (person)	Mandatory	1

-	Building/property name (person)	Mandatory	1
-	Centrelink customer reference number	Mandatory	1
-	Country of birth	Mandatory	1
-	Date accuracy indicator	Mandatory	1
-	Date of birth	Mandatory	1
-	Electronic communication address (person)	Mandatory	1
-	Electronic communication medium (person)	Mandatory	1
-	Electronic communication usage code (person)	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Establishment number	Mandatory	1
-	Establishment sector	Mandatory	1
-	Family name	Mandatory	1
-	Floor/level number (person)	Mandatory	1
-	Floor/level type (person)	Mandatory	1
-	Given name sequence number	Mandatory	1
-	Given name(s)	Mandatory	1
-	House/property number (person)	Mandatory	1
-	Indigenous status	Mandatory	1
-	Lot/section number (person)	Mandatory	1
-	Medicare card number	Mandatory	1
-	Mother's original family name	Mandatory	1
-	Name context flag	Mandatory	1
-	Name suffix	Mandatory	1
-	Name suffix sequence number	Mandatory	1
-	Name title	Mandatory	1
-	Name title sequence number	Mandatory	1
-	Name type	Mandatory	1
-	Non-Australian state/province (person)	Mandatory	1
-	Person identifier	Mandatory	1

-	Person identifier type—health care (person)	Mandatory	1
-	Postal delivery point identifier (person)	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Postcode—international (person)	Mandatory	1
-	Region code	Mandatory	1
-	Sex	Mandatory	1
-	State/Territory of birth	Mandatory	1
-	Street name (person)	Mandatory	1
-	Street suffix code (person)	Mandatory	1
-	Street type code (person)	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1

Health care provider identification DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	374199
Registration status:	Health, Standard 03/12/2008
DSS type:	Data Set Specification (DSS)

Scope:

The scope of these data elements includes identification of individual and organisation health care providers. The data elements also allow for identification of an individual in a health care organisation. The definition of health care provider is:

'any person or organisation who is involved in or associated with the delivery of healthcare to a client, or caring for client wellbeing'.

The data elements have been defined to enable a common, best practice approach to the way data are captured and stored, to ensure that records relating to a provider will be associated with that individual and/or organisation and no other. The definitions are proposed for clinical and administrative data management purposes.

The ability to positively identify health care providers and locate their relevant details is an important support to the provision of speedy, safe, high quality, comprehensive and efficient health care. Unambiguous identification of individual health care providers is necessary for:

- Requesting and reporting of orders, tests and results (e.g. pathology, diagnostic imaging)
- Other communications and referrals between health care providers regarding ongoing care of patients (e.g. a referral from a GP to a specialist, a hospital discharge plan)
- Reporting on health care provision to statutory authorities (e.g. reporting of hospital patient administration systems data to State/Territory government health agencies)
- Payments to providers
- Registration of providers
- Directories or lists of providers and their service locations for consumer information.

Collection and usage attributes

Collection methods: Collected at point of entry to health care for the purposes of the identification of the provider of that health care.

Comments: There are many barriers to successfully identifying individuals in health care settings, including variable data quality; differing data capture requirements and mechanisms; and varying data matching methods. This data set specification provides a framework for improving the confidence that the data being associated with any given individual or organisation, is appropriately associated.

Source and reference attributes

Submitting organisation: Standards Australia Inc Health Informatics Committee (IT-014)

Reference documents: Health care client identification DSS

The Australian Standard AS4846 Health Care Provider Identification identifies other data that should be collected. These data are collections of free text information and as such are not capable of standardisation as a national health data standard. Within AS4846 however they form part of the data collection necessary for the complete identification of a heath care provider.

These data elements are identified in the section Standardised elsewhere section below.

If these data elements are collected in conjunction with those of the Data set specification they form a collection equivalent to that of the Australian Standard AS4846.

Relational attributes

Related metadata references: Supersedes Health care provider identification DSS Health, Superseded 03/12/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Address line (person)	Mandatory	1
-	Address line (service provider organisation)	Mandatory	1
-	Address type (person)	Mandatory	1
-	Address type (service provider organisation)	Mandatory	1
-	Address—country identifier (person)	Mandatory	1

-	Australian state/territory identifier	Mandatory	1
-	Australian state/territory identifier (service provider organisation)	Mandatory	1
-	Building/complex sub-unit number (person)	Mandatory	1
-	Building/complex sub-unit number (service provider organisation)	Mandatory	1
-	Building/complex sub-unit type—abbreviation (person)	Mandatory	1
-	Building/complex sub-unit type—abbreviation (service provider organisation)	Mandatory	1
-	Building/property name (person)	Mandatory	1
-	Building/property name (service provider organisation)	Mandatory	1
-	Date accuracy indicator	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of death	Mandatory	1
-	Electronic communication address (person)	Mandatory	1
-	Electronic communication address (service provider organisation)	Mandatory	1
-	Electronic communication medium (person)	Mandatory	1
-	Electronic communication medium (service provider organisation)	Mandatory	1
-	Electronic communication usage code (person)	Mandatory	1
-	Family name	Mandatory	1
-	Floor/level number (person)	Mandatory	1
-	Floor/level number (service provider organisation)	Mandatory	1
-	Floor/level type (person)	Mandatory	1
-	Floor/level type (service provider organisation)	Mandatory	1
-	Given name sequence number	Mandatory	1
-	Given name(s)	Mandatory	1
-	House/property number (person)	Mandatory	1
-	House/property number (service provider organisation)	Mandatory	1
-	Lot/section number (person)	Mandatory	1

-	Lot/section number (service provider organisation)	Mandatory	1
-	Name context flag	Mandatory	1
-	Name suffix	Mandatory	1
-	Name suffix sequence number	Mandatory	1
-	Name title	Mandatory	1
-	Name title sequence number	Mandatory	1
-	Name type	Mandatory	1
-	Name type (service provider organisation)	Mandatory	1
-	Non-Australian state/province (person)	Mandatory	1
-	Non-Australian state/province (service provider organisation)	Mandatory	1
-	Organisation end date	Mandatory	1
-	Organisation name	Mandatory	1
-	Organisation start date	Mandatory	1
-	Person identifier	Mandatory	1
-	Postal delivery point identifier (person)	Mandatory	1
-	Postal delivery point identifier (service provider organisation)	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Postcode—Australian (service provider organisation)	Mandatory	1
-	Postcode—international (person)	Mandatory	1
-	Postcode—international (service provider organisation)	Mandatory	1
-	Provider occupation category (self-identified) (ANZSCO 1st edition)	Mandatory	1
-	Provider occupation end date	Mandatory	1
-	Provider occupation start date	Mandatory	1
-	Sex	Mandatory	1
-	Street name (person)	Mandatory	1
-	Street name (service provider organisation)	Mandatory	1
-	Street suffix code (person)	Mandatory	1
-	Street suffix code (service provider organisation)	Mandatory	1

-	Street type code (person)	Mandatory	1
-	Street type code (service provider organisation)	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Suburb/town/locality name (service provider organisation)	Mandatory	1

Indigenous primary health care DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 430629

Registration status: Health, Standard 07/12/2011

DSS type: Data Set Specification (DSS)

Scope: The Indigenous primary health care data set specification (IPHC DSS) is primarily designed to support the collection of aggregate information from Indigenous-specific primary health care services. The IPHC DSS describes the aggregate data to be reported by those Indigenous-specific primary health care services. Only the data, which services aggregate using cohort definitions and specialised software, will be supplied through the OATSIH Community Health Reporting Environment (OCHRE), a web-based reporting tool. No individual level client data will be supplied to either the Australian Institute of Health and Welfare (AIHW) or the Department of Health and Ageing (DoHA).

For the purposes of the IPHC DSS, Aboriginal and Torres Strait Islander primary health care is defined as:

"…socially and culturally appropriate, universally accessible, scientifically sound, first level care. It is provided by health services and systems with a suitably trained workforce comprised of multidisciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control and; involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment, and care of the sick, community development, advocacy, and rehabilitation services."

This definition has been endorsed by the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), the Australian General Practice Network (AGPN), the Australian Primary Health Care Research Institute (APHCRI), and the Australian Medical Association (AMA).

Aboriginal and Torres Strait Islander primary health care services include:

1. Aboriginal Community Controlled Health Service (ACCHS): primary health care services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it (through a locally elected Board of Management); and

2. Other Aboriginal and Torres Strait Islander primary health care services: health services funded principally to provide services to Aboriginal and Torres Strait Islander individuals with funding provided by the federal and/or state or territory governments. These non community-controlled services mainly exist in the Northern Territory and northern part of Queensland.

Services use a clinical audit tool program for extracting and aggregating data from their patient information and recall systems. The IPHC DSS has been written to inform this program. Once aggregated, the data will be sent to the AIHW via the OATSIH Community Health Reporting Environment (OCHRE), a web-based reporting tool with an ‘in-confidence’ security classification.

The IPHC DSS includes aggregate data only; it does not include data elements describing any details relating to or arising from individual client visits, at the client visit level, e.g. blood pressure measurements, body mass index (BMI) values and so on.

Aggregate data will initially be collected from a limited number of primary health care services, i.e. those funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) via the Healthy for Life program. From mid-2012, data collection will be extended to the remainder of services funded by OATSIH to deliver primary health care. From mid-2013, data collection will be expanded to also include state- and territory-funded Indigenous-specific primary health care services not funded by OATSIH.

Collection and usage attributes

Statistical unit:

Each unit represents aggregated data from an individual Indigenous-specific primary health care service.

Collection methods:

The IPHC DSS describes only the aggregated data. Patient Information Referral Systems (PIRS) contain many variables related to individual clients. The Clinical Audit Tool (CAT) is programmed to extract variables determined in data elements and counting how many clients have these variables. Services will then authorise transmission of these de-individualised data extracted by CAT to AIHW through the OCHRE web-based tool.

The regular client status of a client will be determined by the service on the PIRS and will need to be reviewed on a twice-yearly basis.

National reporting arrangements

Each service funded to provide Indigenous-specific primary health care should record service provision in clinical information management systems that allow the electronic transmission of data for reporting.

Periods for which data are collected and nationally collated

Data collections and data reporting will be on a 6-monthly basis.

Source and reference attributes

Submitting organisation: Department of Health and Ageing (DoHA)

Australian Institute of Health and Welfare (AIHW)

Reference documents: Pen Computer Systems 2009. Clinical Audit Tool - User Guide, Pen Computer Systems Pty Ltd, Sydney, viewed 7 November 2011, http://help.pencs.com.au/cat.htm

Relational attributes

Related metadata references: See also Indigenous primary health care key performance indicators (2012) Health, Superseded 23/02/2012

See also Indigenous primary health care key performance indicators (2013) Health, Standard 07/12/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Address line (service provider organisation)	Mandatory	1
-	Age	Mandatory	1
-	Alcohol consumption status recorded indicator	Conditional	1
-	Australian state/territory identifier (service provider organisation)	Mandatory	1
-	Birth weight	Mandatory	1
-	Birth weight recorded indicator	Conditional	1
-	Blood pressure measurement result less than or equal to 130/80 mmHg indicator	Conditional	1
-	Blood pressure measurement result recorded indicator	Conditional	1

-	Body mass index recorded indicator	Conditional	1
-	Body mass index—classification	Conditional	1
-	Building/complex sub-unit number (service provider organisation)	Mandatory	1
-	Building/property name (service provider organisation)	Mandatory	1
-	Cardiovascular disease recorded indicator	Mandatory	1
-	Cervical screening indicator	Mandatory	3
-	Chronic obstructive pulmonary disease recorded indicator	Mandatory	1
-	Day of operation	Mandatory	7
-	Diabetes status	Mandatory	1
-	Electronic communication address (service provider organisation)	Mandatory	7
-	Electronic communication medium (service provider organisation)	Mandatory	7
-	Estimated glomerular filtration rate (eGFR) recorded indicator	Mandatory	1
-	Full-time equivalent paid staff	Mandatory	1
-	Fully immunised recorded indicator	Mandatory	1
-	Glycosylated haemoglobin level	Conditional	2
-	Glycosylated haemoglobin measurement result recorded indicator	Conditional	2
-	GP Management Plan indicator	Conditional	1
-	Hysterectomy indicator	Mandatory	1
-	Indigenous status	Mandatory	1
-	Influenza immunisation indicator	Conditional	1
-	MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) indicator	Conditional	2
-	Microalbumin urine test result	Mandatory	1
-	Name type (service provider organisation)	Mandatory	1
-	Organisation name	Mandatory	1
-	Postcode—Australian (service provider organisation)	Mandatory	1
-	Regular client indicator	Mandatory	1

-	Service operation days	Mandatory	1
-	Service operation hours	Mandatory	1
-	Service operation weeks	Mandatory	1
-	Sex	Mandatory	1
-	Smoking status recorded indicator	Conditional	1
-	Standards assessment indicator	Mandatory	1
-	Standards assessment level	Mandatory	1
-	Street name (service provider organisation)	Mandatory	1
-	Street type code (service provider organisation)	Mandatory	1
-	Suburb/town/locality name (service provider organisation)	Mandatory	1
-	Team Care Arrangement (MBS Item 723) indicator	Conditional	1

Injury surveillance DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	393268
Registration status:	Health, Standard 14/12/2009
DSS type:	Data Set Specification (DSS)
Scope:	The scope of this minimum data set is patient level data from selected emergency departments of hospitals and other settings.

Collection and usage attributes

Collection methods:

National reporting arrangements

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated

Financial years ending 30 June each year.

Source and reference attributes

Submitting organisation: National Health Information Group

Relational attributes

Related metadata references: Supersedes Injury surveillance DSS Health, Superseded 14/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Activity when injured	Mandatory	1
-	Activity when injured (non-admitted patient)	Mandatory	1
-	Bodily location of main injury	Mandatory	1
-	External cause	Mandatory	99
-	External cause—human intent	Mandatory	1
-	Narrative description of injury event	Mandatory	1
-	Nature of main injury (non-admitted patient)	Mandatory	1

-	Place of occurrence of external cause of injury (ICD-10-AM)	Mandatory	1
-	Place of occurrence of external cause of injury (non-admitted patient)	Mandatory	1

Medical indemnity DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	329638
Registration status:	Health, Standard 07/12/2011
DSS type:	Data Set Specification (DSS)

Scope:

The Medical indemnity data set specification (DSS) describes the data items and standardised data outputs for medical indemnity claims for the Medical Indemnity National Collection (MINC).

The MINC contains information on medical indemnity claims against health providers. These are claims for compensation for harm or other loss allegedly due to the delivery of health care. This health care may occur in settings such as hospitals, outpatient clinics, general practitioner surgeries, community health centres, residential aged care or mental health care establishments or during the delivery of ambulatory care. Adverse events or harm due to medical treatment, which do not result in a medical indemnity claim, are not included in the MINC.

In 2002, Australia's Health Ministers decided that a 'national database for medical negligence claims' should be established. In 2003 the Medical Indemnity Data Working Group (MIDWG) came into existence with its membership drawn from health authorities, the Department of Health and Ageing and the Australian Institute of Health and Welfare (AIHW). The MIDWG collaborated on establishing a Medical Indemnity National Collection (Public Sector), comprising data from the jurisdictions. In 2006 private medical indemnity insurers agreed to have their data on medical indemnity claims included in the MINC. In 2008 the Australian Health Ministers' Advisory Council approved funding for data development work. The data items and recording specifications proposed for DSS development are based on those endorsed by the MIDWG for the 2009-10 data transmission period.

Medical indemnity claims fit into two categories, i.e. actual claims (on which legal activity has commenced via a letter of demand, the issue of a writ or a court proceeding) and potential claims (where the health authority or private medical indemnity insurer has placed a reserve against a health-care incident in the expectation that it may eventuate to an actual medical indemnity claim). Information in the MINC relates to actual and potential medical indemnity claims and the alleged or reported health-care incidents leading to medical indemnity claims.

The MINC includes basic demographic information on the patient at the centre of the alleged health-care incident; related information such as the type of incident or allegation and the clinical specialties involved; the reserve amount set against the likely cost of settling the medical indemnity claim; the time between setting the reserve and closing the medical indemnity claim; and the cost of closing the medical indemnity claim and the nature of any compensatory payments.

Compensatory payments may be made to the patient and/or to an other party claiming collateral loss as a result of the loss or harm experienced by the patient.

As a general guide, the main steps in the management of public sector medical indemnity claims are:

1. An incident that could lead to a medical indemnity claim is notified to the relevant claims management body. In some jurisdictions medical indemnity claims are managed by the relevant state or territory health authority; however, in others, most of the claims management process is handled by a body external to the health authority. Occasionally, some of the legal work may be outsourced to private law firms.

2. If the likelihood of a medical indemnity claim eventuating is considered sufficiently high, a reserve is placed, based on an estimate of the likely cost of the claim when closed.

3. Various events can signal the start of a medical indemnity claim, for example, a writ or letter of demand may be issued by the claimant's solicitor (this can occur before an incident has been notified) or the defendant may make an offer to the claimant to settle the matter before a writ or letter has been issued. In some cases no action is taken by the claimant or the defendant.

4. The medical indemnity claim is investigated. This can involve liaising with clinical risk management staff within the health facility concerned and seeking expert medical advice.

5. As the medical indemnity claim progresses the reserve is monitored and adjusted if necessary.

6. A medical indemnity claim is closed when, in the opinion of the health authority, there will be no future unforeseen costs associated with the claim's investigation, litigation or a payment to a claimant. If a claim is closed and the possibility of future costs arises, the claim may be reopened.

7. A medical indemnity claim may be finalised through several processes—through state/territory-based complaints processes, court-based alternative dispute resolution processes, or in

court. In some jurisdictions settlement via statutorily mandated conference processes must be attempted before a medical indemnity claim can go to court. In some cases settlement is agreed between claimant and defendant, independent of any formal process. A medical indemnity claim file that has remained inactive for a long time may be finalised through discontinuation.

The detail of this process varies between jurisdictions, and in some jurisdictions there are different processes for small and large medical indemnity claims. Private medical indemnity insurers follow a similar process in managing claims reported to them that are covered by the insurance they provide to private medical practitioners.

Collection and usage attributes

Guide for use: The following terminology is used in the Medical indemnity DSS:

- Claim refers to a medical indemnity claim
- Claimant could be another party/parties alleging loss due to the incident, rather than or in addition to the patient.

Collection methods: State and territory health authorities provide data on medical indemnity claims to the AIHW for national collation, annually. Data is for the financial year ending 30 June. Private medical indemnity insurers provide data on the same annual basis for a subset of the data items provided by public sector health authorities.

Comments: The Medical indemnity DSS has been developed by the AIHW in conjunction with the MIDWG.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Date accuracy indicator	Mandatory	5
1	Medical indemnity claim state/territory identifier	Mandatory	1
2	Medical indemnity claim identifier	Mandatory	1
3	Type of compensatory payment to patient	Mandatory	1

4	Type of compensatory payment to other party	Mandatory	1
5	Date of birth	Mandatory	1
6	Sex	Mandatory	1
7	Indigenous status	Mandatory	1
8	Primary incident or allegation type	Mandatory	1
9	Additional incident or allegation type	Conditional	3
10	Clinical service context	Mandatory	1
11	Clinical service context text	Conditional	1
12	Primary body function or structure of patient affected	Mandatory	1
13	Additional body function or structure of patient affected	Conditional	3
14	Extent of harm from a health-care incident	Mandatory	1
15	Date health-care incident occurred	Mandatory	1
16	Geographic remoteness	Mandatory	1
17	Health service setting	Mandatory	1
18	Patient relationship to health-care service provider	Mandatory	1
19	Principal clinician specialty involved in health-care incident	Mandatory	1
20	Additional clinician specialty involved in health-care incident	Conditional	3
21	Reserve placement date	Mandatory	1
22	Medical indemnity claim reserve size	Mandatory	1
23	Medical indemnity claim commencement date	Conditional	1
24	Medical indemnity claim finalisation date	Conditional	1
25	Mode of medical indemnity claim finalisation	Mandatory	1
26	Medical indemnity claim size	Mandatory	1
27	Medical indemnity claim status	Mandatory	1
28	Medical indemnity payment recipient	Mandatory	1
29	Class action indicator	Mandatory	1

Non-admitted patient DSS 2012-13

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 471846

Registration status: Health, Standard 07/12/2011

DSS type: Data Set Specification (DSS)

Scope: The scope of this data set specification (DSS)(Phase 1) is outpatient clinic service events involving non-admitted patients at public hospitals classified as either principal referral, and specialist women's and children's hospitals or large hospitals (Peer Group A or B) as reported in the Australian Institute of Health and Welfare's Australian Hospital Statistics publication of 2008-09.

The Non-admitted patient (NAP) DSS is intended to capture instances of service provision from the point of view of the patient.

For the purpose of this DSS, an outpatient clinic is a specialty unit or organisational arrangement under which a hospital provides outpatient clinic services. The nature of the service provided by the clinic is classified by 'clinic type'. All outpatient clinic types are included in the DSS, except specialised mental health and alcohol and other drug treatment services which are included in separate NMDSs noted below.

The scope includes:

- **All arrangements made to deliver outpatient clinic service events** (not covered by the NMDSs listed below) to non-admitted patients:

  whose treatment has been funded through the hospital, regardless of the source from which the hospital derives these funds. In particular, Department of Veterans' Affairs, compensable and other patients funded through the hospital (including Medicare ineligible patients) are included; and

  regardless of setting or mode

Excluded from scope in Phase 1 are:

- **All services covered by NMDS for:**

  Admitted patient care,

  Admitted patient mental health care,

  Alcohol and other drug treatment services,

  Community mental health care,

Non-admitted patient emergency department care, e.g. all outpatient clinic services provided to admitted patients are excluded;

- **All outpatient service events delivered by private specialist services** under private practice arrangements;
- **Service events** funded by the hospital but **delivered by another entity** (including community health service, NGOs and private hospitals);
- **Service events which deliver non-clinical care** (activities such as home cleaning, meals on wheels, home maintenance);
- **Diagnostic imaging, pathology, pharmacy and other ancillary services** whether they are **associated with an outpatient clinic service event** or **provided independently** of an outpatient clinic service event.

Collection and usage attributes

Statistical unit: Non-admitted patient service event

Collection methods: All characteristics are reported for each service event as at the time of the service event.

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Source and reference attributes

Submitting organisation: NAP NMDS (Phase 1) working group

Relational attributes

Related metadata references: Supersedes Non-admitted patient DSS 2011-12 Health, Superseded 07/12/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of usual residence	Mandatory	1
-	Area of usual residence (SA2)	Mandatory	1
-	Care type, derived subacute	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Establishment identifier	Mandatory	1

-	Group session indicator	Mandatory	1
-	Indigenous status	Mandatory	1
-	Outpatient clinic type	Mandatory	1
-	Person identifier	Mandatory	1
-	Principal source of funding	Mandatory	1
-	Service delivery mode	Mandatory	1
-	Service delivery setting	Mandatory	1
-	Service event date	Mandatory	1
-	Service request received date	Mandatory	1
-	Service request source	Mandatory	1
-	Sex	Mandatory	1

Palliative care performance indicators DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	295806
Registration status:	Health, Standard 05/12/2007
DSS type:	Data Set Specification (DSS)

Scope:

This data set specification specifies information for collection about all administrative health regions, and whether they have developed strategic plans which incorporate specified palliative care elements. It also specifies information for collection about all government-funded **palliative care agencies** (service provider organisations), their approach to some aspects of service delivery, and their efforts in specific areas of quality improvement.

This information enables reporting of nationally-agreed palliative care performance indicators. Currently, there are four national performance indicators that have been agreed for reporting by the Palliative Care Intergovernmental Forum. These are:

1. The proportion of administrative health regions that have a written plan for palliative care that incorporates palliative care elements,

2. The proportion of palliative care agencies, within their setting of care, that routinely undertake or undergo formal assessment against the Palliative Care Australia standards,

3. The proportion of palliative care agencies, within their setting of care, that actively collect feedback from clients and staff (within the workforce) relating to services and service delivery,

4. The proportion of palliative care agencies, within their setting of care, that have formal working partnerships with other services provider(s) or organisation(s).

Collection and usage attributes

Collection methods:

The data for this DSS are obtained from two sources: a survey of administrative health regions and a survey of all government-funded palliative care agencies (service provider organisations) that provide care in community and/or admitted patient settings.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Administrative health region name	Mandatory	1
-	Administrative health region palliative care strategic plan indicator	Mandatory	1
-	Coordinator of volunteers indicator	Mandatory	1
-	Feedback collection indicator	Mandatory	1
-	Feedback collection method	Conditional	8
-	Level of palliative care service	Mandatory	1
-	Most common service delivery setting	Mandatory	1
-	Palliative care agency service delivery setting	Mandatory	7
-	Partner organisation type	Conditional	8
-	Standards assessment indicator	Mandatory	1
-	Standards assessment level	Conditional	1
-	Standards assessment method	Conditional	2
-	Working partnership indicator	Mandatory	1

Perinatal DSS 2012-2013

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 473035

Registration status: Health, Standard 07/03/2012

DSS type: Data Set Specification (DSS)

Scope: The scope of the Perinatal data set specification (DSS) is all births in Australia in hospitals, birth centres and the community. The data set includes information on all births, both live and stillborn, of at least 20 weeks gestation or 400 grams birth weight.

These data have two dimensions, which are the baby and the mother. All data relevant to the birth are conveyed in relation to one of these.

Collection and usage attributes

Guide for use: This data set specification is intended as an interim standard only, in that it should only be used for as long as:

16. the optional data element Female—number of antenatal care visits, total N[N] is not able to be reported by all jurisdictions, and
17. the optional data element Person—area of usual residence, geographical location code (ASGC 2011) NNNNN is reported by those jurisdictions that wish to do so.

If jurisdictions are capable of reporting the Number of antenatal care visits data element in their perinatal data from 1 July 2012 then they should do so. It is expected that this data element will become reportable for all jurisdictions from 1 July 2013, in which case it will be included as a mandatory data element in the Perinatal national minimum data set (NMDS) for 2013-2014.

Jurisdictions should only report the ASGC-based geographical location data element if they have a legitimate need to geocode their perinatal data in accordance with both ASGC 2011 and ASGS 2011. It is expected that this data element will be reported by a small number of jurisdictions for the 2012-2013 year only. From 2013-2014 onwards, geographical reporting should be based solely on the ASGS.

Collection methods: *National reporting arrangements*

State and territory health authorities provide the data to the Australian Institute of Health and Welfare's National Perinatal

Epidemiology and Statistics Unit for national collation, on an annual basis.

Periods for which data are collected and nationally collated

Financial years ending 30 June each year.

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Perinatal NMDS 2012-2013	Mandatory	1
-	Antenatal care visits	Optional	1
-	Area of usual residence	Optional	1

Prison clinic contact DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 396072

Registration status: Health, Standard 25/08/2011

DSS type: Data Set Specification (DSS)

Scope: The Prison clinic contact DSS describes data on the visits by prisoners to the prison clinic during the National Prisoner Health Census reporting period.

Collection and usage attributes

Statistical unit: The two statistical units in this data set specification are the Health Service Event and the Person.

In this data set specification person refers to the prisoner attending the prison clinic.

Guide for use: This DSS is a component of the Prisoner health DSS. The Prisoner health DSS describes data about public and private prisons operating in Australia. It includes data on prison entrants, prisoners who visit a prison clinic or take repeat medication while in custody, prison clinic services and prison clinic staffing levels.

In this DSS, a 'visit' is defined as a face-to-face consultation for which an entry is made in the health service record (other than for routine household-type treatments such as band-aids or paracetemol).

Collection methods: Information on clinic visits is provided by the treating health professional at the clinic using the Prisoners in Custody—Clinic Visits form. One form is to be completed for each clinic contact.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Prisoner health DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Person identifier	Mandatory	1
2	Date of birth	Mandatory	1
3	Sex	Mandatory	1
4	Transgender	Mandatory	1
5	Indigenous status	Mandatory	1
6	Initiator of prison clinic visit	Mandatory	1
7	Reason for health clinic attendance	Mandatory	23
8	Type of service provider consulted	Mandatory	1

Prison entrants DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	395955
Registration status:	Health, Standard 25/08/2011
DSS type:	Data Set Specification (DSS)
Scope:	The Prison entrants DSS describes data about all persons aged 18 years and over entering prison system during the National Prisoner Health Census reporting period.

Collection and usage attributes

Guide for use:

This DSS is a component of the Prisoner health DSS. The Prison entrants DSS describes data about people entering the prison system during the National Prisoner Health Census reporting period. This includes demographic data and data about a prison entrant's mental health, chronic disease status, their use of alcohol and other drugs, their use of health services and pregnancy.

Collection methods:

Information about the prison entrant is collected by a health professional at the prison reception health assessment (alternatively known as the intake or induction assessment) using the Prison Entrants form.

One Prison Entrants form should be completed for each person who enters the prison system during the National Prisoner Health Census reporting period.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	Australian Institute of Health and Welfare 2009. From corrections to community: a set of indicators of the health of Australia's prisoners. Bulletin no. 75. Cat. no. AUS 120. Canberra: AIHW

Relational attributes

Implementation in Data Set Specification:	Prisoner health DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Prison establishment identifier	Mandatory	1
2	Australian State/Territory identifier (establishment)	Mandatory	1
3	Person identifier	Mandatory	1
4	Date of birth	Mandatory	1
5	Age	Conditional	1
6	Country of birth	Mandatory	1
7	Main language other than English spoken at home	Mandatory	1
8	Sex	Mandatory	1
9	Transgender	Mandatory	1
10	Indigenous status	Mandatory	1
11	Highest year of school completed	Mandatory	1
12	Non-school qualification cluster	Mandatory	1
13	Education attendance status 30 days prior to imprisonment	Mandatory	1
14	Labour force status 30 days prior to imprisonment	Mandatory	1
15	First time in prison or juvenile detention indicator	Mandatory	1
16	Incarceration history cluster	Conditional	1
17	Prison entrant age at first detention	Conditional	1
18	Legal status of prison entrant	Mandatory	1
19	Imprisonment in the last 12 months indicator	Mandatory	1
20	Mental health disorder indicator	Mandatory	1
21	Medication for mental health disorder indicator	Conditional	1
22	Distress related to current imprisonment indicator	Mandatory	1
23	Chronic condition cluster	Mandatory	1
24	Health service utilisation cluster	Mandatory	1
25	Health service non-utilisation cluster	Mandatory	1
26	Reason for non-utilisation of health service	Conditional	10

27	Blow to the head indicator	Mandatory	1
28	Self-harm indicator	Mandatory	1
29	Self-harm ideation in the last 12 months	Mandatory	1
30	AUDIT score of risky alcohol consumption cluster	Mandatory	1
31	Smoking status cluster	Mandatory	1
32	Substances used illicitly cluster	Mandatory	1
33	Opioid pharmacotherapy treatment cluster	Mandatory	1
34	Cervical screening indicator	Conditional	1
35	Pregnancy status cluster	Conditional	1
36	Mental health service referral	Mandatory	1
37	At risk of suicide or self-harm indicator	Mandatory	1

Prison establishments DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	398457
Registration status:	Health, Standard 25/08/2011
DSS type:	Data Set Specification (DSS)
Scope:	The Prison establishments DSS describes data on services provided in prison health clinics.

Collection and usage attributes

Guide for use:	This DSS is a component of the Prisoner health DSS, which describes data collected from public and private prisons throughout Australia on prison entrants, prisoners who visit a prison clinic, prisoners who are taking repeat medication, prison clinic services and staffing levels.
Collection methods:	Information on the prison's services is provided by the manager of the prison's health services using the National Prisoner Health Census Prison Establishment Form.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification:	Prisoner health DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Prison establishment identifier	Mandatory	1
2	Organisation name	Mandatory	1
3	Australian State/Territory identifier (establishment)	Mandatory	1
4	ACCHO/AMS visitation frequency	Mandatory	1
5	ACCHO/AMS service provider type	Conditional	9
6	Prisoner health discharge summary cluster	Mandatory	1

7	Vaccines administered cluster	Conditional	1
8	Full-time equivalent prison staff cluster	Mandatory	1
9	Number of pregnant prisoners	Conditional	1
10	Hospital transfer cluster	Mandatory	1
11	Sex of prison entrants cluster	Mandatory	1

Prisoner health DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 375978

Registration status: Health, Standard 25/08/2011

DSS type: Data Set Specification (DSS)

Scope: The Prisoner health data set specification (DSS) describes data collected from all public and private prisons throughout Australia on prison entrants, prisoners who visit a prison clinic, prisoners who are taking repeat medication while in custody, prison clinic services and staffing levels. The data are used to report against the National Prisoner Health Indicators, assist in monitoring the health of prisoners and inform prisoner health service planning and delivery.

In this collection, public and private prisons include those administered by Corrective Services departments, including correctional facilities and remand centres. Excluded from the collection are periodic detention centres, court and police cells, juvenile detention centres, immigration detention centres, secure psychiatric facilities, military prisons, and home detention programs.

The Prisoner health DSS contains four component data set specifications:

Prison entrants DSS: describes data on all prisoners entering prison in the National Prisoner Health Census period. This includes demographics, mental health, chronic diseases, alcohol and other drug use, use of health services and pregnancy.

Prison clinic contact DSS: describes data from all visits by prisoners to the prison clinic during the National Prisoner Health Census period regarding the number of clinic contacts each prisoner made and the reason for clinic attendance.

Prisoners in custody repeat medications DSS: describes data on the category of repeat medications administered to prisoners on one day during the National Prisoner Health Census period.

Prison establishments DSS: describes data provided by prison clinic management regarding the services provided by prison clinics.

Collection and usage attributes

Statistical unit: Prisoner and Prison Entrant

Collection methods: The National Prisoner Health Census consists of the following four questionnaires which are used to obtain data on prison entrants, prisoners who visit the prison clinic, use of repeat medications and prison establishments:

- Prison Entrants form
- Prisoners in Custody—Clinic Visits form
- Prisoners in Custody—Repeat Medications form
- Prison Establishment form.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents: AIHW (Australian Institute of Health and Welfare) 2009. From corrections to community: a set of indicators of the health of Australia's prisoners. Bulletin no. 75. Cat. no. AUS 120. Canberra: AIHW

AIHW 2010. The health of Australia's prisoners 2009. Cat. no. PHE 123. Canberra: AIHW

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Prison clinic contact DSS	Mandatory	99
-	Prison entrants DSS	Mandatory	1
-	Prison establishments DSS	Mandatory	1
-	Prisoners in custody repeat medications DSS	Mandatory	1

Prisoners in custody repeat medications DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 396074

Registration status: Health, Standard 25/08/2011

DSS type: Data Set Specification (DSS)

Scope: The Prisoners in custody repeat medications DSS describes data regarding all instances of prisoners in custody taking repeat medication.

Collection and usage attributes

Guide for use: This DSS is a component of the Prisoner health DSS. The Prisoner health DSS describes data about public and private prisons operating in Australia. It includes data on prison entrants, prisoners who visit a prison clinic or take repeat medication while in custody, prison clinic services and prison clinic staffing levels.

This DSS includes all prescribed medications administered on one day during the National Prisoner Health Census period and depot medications i.e. medications injected so absorption occurs over a prolonged period, whether or not they were administered on the census day. Routine household-type medications, such as paracetamol, taken on an as-needed basis are not included.

Collection methods: Information on all repeat medications administered to prisoners on a designated day in the National Prisoner Health Census reporting period is recorded on the Prisoners in Custody—Repeat Medications form by the treating health professional at the clinic visit. More than one medication category may be recorded.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Prisoner health DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Person identifier	Mandatory	1
2	Date of birth	Mandatory	1
3	Sex	Mandatory	1
4	Transgender	Mandatory	1
5	Indigenous status	Mandatory	1
6	Medication type	Mandatory	23

Public hospital establishment address details DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 471194

Registration status: Health, Standard 07/12/2011

DSS type: Data Set Specification (DSS)

Scope: The Public hospital establishment address details data set specification (DSS) is used to collect information pertaining to the address of the hospital establishments reported in the Public hospital establishments NMDS.

The mandatory fields to be reported for address are:

- Establishment—organisation identifier (Australian), NNX[X]NNNNN
- Address—road number 1, road number X[6]
- Address—road name, text X[45]
- Address—road type, code AA[AA]
- Address—suburb/town/locality name, text X[46]
- Address—Australian postcode, code (Postcode datafile) {NNNN}
- Address—Australian state/territory identifier, code AA[A]

All other data elements are to be reported if that data element is a component of the address of the Public hospital establishment.

Relational attributes

Related metadata references: See also Public hospital establishments NMDS 2012-2013 Health, Standard 07/12/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Address site name	Conditional	1
-	Australian postcode (address)	Mandatory	1
-	Australian state/territory identifier of address	Mandatory	1
-	Complex road name	Conditional	1
-	Complex road number 1	Conditional	1
-	Complex road number 2	Conditional	1
-	Complex road type	Conditional	1
-	Establishment identifier	Mandatory	1
-	Level number identifier	Conditional	1
-	Road name	Mandatory	1
-	Road number 1	Mandatory	1
-	Road number 2	Conditional	1
-	Road type	Mandatory	1
-	Secondary complex name	Conditional	1
-	Sub-dwelling unit number	Conditional	1
-	Suburb/town/locality name within address	Mandatory	1

Radiotherapy waiting times DSS 2012-

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 447921

Registration status: Health, Standard 07/12/2011

DSS type: Data Set Specification (DSS)

Scope: The main purpose of the Radiotherapy waiting times data set specification (RWT DSS) is to describe the information that must be collected to calculate the waiting times for two time periods in the treatment pathway for radiotherapy services in Australia:

18.
19. The time between the date a patient's first referral is received at a particular establishment by a radiation oncologist to the date of that patient's first consultation at that establishment with a radiation oncologist; and
20.
21. The time between the patient's ready-for-care date and the date of the first megavoltage external beam radiotherapy treatment.

Establishments in scope are only those healthcare establishments that provide megavoltage external beam radiotherapy treatment (in-scope radiotherapy treatment). Both public and private establishments are in scope. It is desirable for both public establishments and private establishments to report data to the DDS.

The scope is not limited by diagnosis: it includes people with cancer (notifiable and non-notifiable) and people who do not have cancer.

People in scope are those who, within the reference period:

- had a first consultation at a particular establishment with a radiation oncologist, but did not start a course of radiotherapy treatment (regardless of whether treatment was prescribed) (consult only—related to wait time period 1 above); or
- had a first consultation at a particular establishment with a radiation oncologist and started a course of radiotherapy treatment (consult + treatment—related to wait time periods 1 and 2 above); or
- started a course of radiotherapy treatment but whose first consultation at that establishment with a radiation

oncologist was in a previous reference period (treatment only—related to wait time 2 above).

For public establishments, all in-scope activity should be reported, including services provided by specialists operating under right of private practice arrangements.

Collection and usage attributes

Statistical unit:

22. First consultations at an establishment with a radiation oncologist;
23. Courses of radiotherapy treatment started.

Guide for use:

The table below defines some key concepts used in the Radiotherapy waiting times DSS. It is assumed that data submitted to the Radiotherapy waiting times DSS adhere to these definitions. These definitions do not necessarily apply to other data sets.

Key concept	Definition
Course of radiotherapy treatment	A course of radiotherapy treatment is a series of one or more radiotherapy treatments prescribed by a radiation oncologist. A course of radiotherapy treatment should have an associated ready-for-care date and, when treatment starts, a radiotherapy start date. A patient can receive more than one course of radiotherapy treatment at the same time (i.e. courses which are simultaneous or which overlap). These courses may have the same or different ready-for-care dates and the same or different radiotherapy start dates. Only a radiation oncologist can prescribe a course of radiotherapy treatment. A prescription is not equal to a course of radiotherapy treatment. A prescription may be for one or more courses of radiotherapy treatment. A prescription outlines the anatomical region/sites to be treated and is for a prescribed dose at a defined volume (fractionation) over a defined period of time. One course of radiotherapy treatment may cover multiple phases and multiple

	treatment plans. The completion of a course of radiotherapy treatment is not relevant to the definition of a course of radiotherapy treatment.
Diagnosis	Diagnosis may be described either by the principal diagnosis and primary site of cancer (where radiotherapy is intended as treatment for cancer), or by the prinicipal diagnosis of the disease being treated (where radiotherapy is intended as treatment for a disease other than cancer).
Treatment start	Treatment starts with the first fraction delivered and does not include the planning or simulation stages of radiotherapy.

The statistical unit will be calculated by the AIHW for time periods 1 and 2 (see Scope above) using the following data elements:

For waiting period 1, AIHW will calculate the time in days between 'Health service event—service request received date, DDMMYYYY' and 'Health service event—first service contact date, DDMMYYYY'.

For waiting period 2, AIHW will calculate the time in days between 'Patient—ready-for-care date, DDMMYYYY' and 'Patient—radiotherapy start date, DDMMYYYY'.

Implementation start date: 01/07/2012

Source and reference attributes

Submitting organisation: NHISSC Radiotherapy Waiting Times Working Group

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of usual residence (SA2)	Mandatory	1
-	Clinical emergency indicator	Conditional	1
-	Date of birth	Mandatory	1
-	Establishment identifier	Mandatory	1
-	First health service contact date	Conditional	1
-	Health service request received date	Conditional	1

-	Indigenous status	Mandatory	1
-	Intention of treatment	Conditional	1
-	Person identifier	Mandatory	1
-	Primary site of cancer (ICD-10-AM code)	Conditional	1
-	Principal diagnosis	Mandatory	1
-	Radiotherapy start date	Conditional	1
-	Ready-for-care date	Conditional	1
-	Sex	Mandatory	1
-	Statistical area level 2 (SA2)	Mandatory	1

Registered chiropractic labour force DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384097

Registration status: Health, Standard 10/12/2009

DSS type: Data Set Specification (DSS)

Scope: All chiropractors listed with the Australian Health Practitioner Regulation Agency during the reference period. Chiropractors included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered chiropractor.

A Registered chiropractor refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a chiropractor at any time during the reference period.

Guide for use: This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency

Note that a health professional may be qualified and registered in more than one profession.

Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.

Collection methods: *National reporting arrangements*

Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.

The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.

Periods for which data are collected and collated

Data are collated annually. The period is determined by the national registration renewal period for chiropractors.

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at http://www.ahpra.gov.au

Relational attributes

Implementation in Data Set Specification: Registered health labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Labour force status cluster	Optional	1
-	Main job of registered chiropractor cluster	Optional	1
-	Second job of registered chiropractor cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered dental and allied dental health professional labour force DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	384102
Registration status:	Health, Standard 10/12/2009
DSS type:	Data Set Specification (DSS)
Scope:	All dental and allied dental health professionals listed with the Australian Health Practitioner Regulation Agency during the reference period. Dental and allied dental health professionals included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

Statistical unit:

The statistical unit for this data set is the Registered dental and allied dental health professional.

A Registered dental and allied dental health professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Registration Agency as a dental or allied dental health professional at any time during the reference period.

Guide for use:

This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency

Note that a health professional may be qualified and registered in more than one profession.

Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.

Collection methods:

National reporting arrangements

Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.

The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.

Periods for which data are collected and collated

Data are collated annually. The period is determined by the national registration renewal period for dental and allied dental health professionals.

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at http://www.ahpra.gov.au

Relational attributes

Implementation in Data Set Specification: Registered health labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Labour force status cluster	Optional	1
-	Main job of registered dental and allied dental health professional cluster	Optional	1
-	Second job of registered dental and allied dental health professional cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Conditional	0
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered health labour force DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 380533

Registration status: Health, Standard 10/12/2009

DSS type: Data Set Specification (DSS)

Scope: All health professionals listed with the Australian Health Practitioner Regulation Agency (AHPRA) during the reference period. This encompasses health professions that require registration under the National Registration and Accreditation Scheme and includes, but is not limited to:

- chiropractic
- dentistry
- dental hygiene
- dental prosthetics
- dental therapy
- medicine
- midwifery
- nursing (enrolled, registered, practitioner)
- optometry
- osteopathy
- pharmacy
- physiotherapy
- podiatry
- psychology

This DSS includes health professionals who are currently registered with AHPRA and health professionals who are no longer registered but remain listed with AHPRA.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered health professional.

A Registered health professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency at any time during the reference period.

Guide for use:

This DSS comprises a set of DSS for health professions covered by the Australian Health Practitioner Regulation Agency. It includes:

- Registered chiropractic labour force DSS
- Registered dental and allied dental labour force DSS
- Registered medical labour force DSS
- Registered midwifery labour force DSS
- Registered nursing labour force DSS
- Registered optometry labour force DSS
- Registered osteopathy labour force DSS
- Registered pharmacy labour force DSS
- Registered physiotherapy labour force DSS
- Registered podiatry labour force DSS
- Registered psychology labour force DSS

Note that a health professional may be qualified and registered in more than one profession.

The Registered health labour force DSS provides comprehensive data on Australia's registered health labour force. It assists governments, educators, health care providers and the community to understand the current health labour force and with workforce planning.

Collection methods:

National reporting arrangements

Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.

The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS primarily comprises workforce data.

Periods for which data are collected and collated

Data are collated annually for each profession. The period is determined by the national registration renewal period for health professionals and may differ between health professions.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Health labour force NMDS Health, Superseded 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Registered chiropractic labour force DSS	Optional	1
-	Registered dental and allied dental health professional labour force DSS	Optional	1
-	Registered medical professional labour force DSS	Optional	1
-	Registered midwifery labour force DSS	Optional	1
-	Registered nursing professional labour force DSS	Optional	1
-	Registered optometry labour force DSS	Optional	1
-	Registered osteopathy labour force DSS	Optional	1
-	Registered pharmacy labour force DSS	Optional	1
-	Registered physiotherapy labour force DSS	Optional	1
-	Registered podiatry labour force DSS	Optional	1
-	Registered psychology labour force DSS	Optional	1

Registered medical professional labour force DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 375422

Registration status: Health, Standard 10/12/2009

DSS type: Data Set Specification (DSS)

Scope: All medical professionals listed with the Australian Health Practitioner Regulation Agency during the reference period, including:

- medical practitioners;
- medical specialists; and
- medical specialists-in-training.

Medical professionals included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered medical professional.

A Registered medical professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a medical practitioner, medical specialist or medical specialist-in-training at any time during the reference period.

Guide for use: This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.

Note that a health professional may be qualified and registered in more than one profession.

Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.

Collection methods:

National reporting arrangements

Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.

The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.

Periods for which data are collected and collated

Data are collated annually. The period is determined by the national registration renewal period for medical professionals.

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: For further information regarding the national registration scheme for health professionals, please

	see the Australian Health Practitioner Regulation Agency website at http://www.ahpra.gov.au

Relational attributes

Implementation in Data Set Specification:	Registered health labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Labour force status cluster	Optional	1
-	Main job of registered medical professional cluster	Optional	1
-	Second job of registered medical professional cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Field of medicine - medical practitioner	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered midwifery labour force DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	384118
Registration status:	Health, Standard 10/12/2009
DSS type:	Data Set Specification (DSS)
Scope:	All midwives listed with the Australian Health Practitioner Regulation Agency during the reference period. Midwives included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

Statistical unit:

The statistical unit for this data set is the Registered midwife.

A Registered midwife refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a midwife at any time during the reference period.

Guide for use:

This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency

Note that a health professional may be qualified and registered in more than one profession.

Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.

Collection methods:

National reporting arrangements

Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.

The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.

Periods for which data are collected and collated

Data are collated annually. The period is determined by the national registration renewal period for midwives.

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at http://www.ahpra.gov.au

Relational attributes

Implementation in Data Set Specification: Registered health labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Labour force status cluster	Optional	1
-	Main job of registered midwife cluster	Optional	1
-	Second job of registered midwife cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1

-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered nursing professional labour force DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384109

Registration status: Health, Standard 10/12/2009

DSS type: Data Set Specification (DSS)

Scope: All nursing professionals listed with the Australian Health Practitioner Regulation Agency during the reference period, including:

- enrolled nurses;
- registered nurses; and
- nurse practitioners.

Nursing professionals included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered nursing professional.

A Registered nursing professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as an enrolled nurse, registered nurse, or nurse practitioner at any time during the reference period.

Guide for use:

This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.

Note that a health professional may be qualified and registered in more than one profession.

Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.

Collection methods:

National reporting arrangements

Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.

The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.

Periods for which data are collected and collated

Data are collated annually. The period is determined by the national registration renewal period for nursing professionals.

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at http://www.ahpra.gov.au

Relational attributes

Implementation in Data Set Specification: Registered health labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Labour force status cluster	Optional	1
-	Main job of registered nursing professional cluster	Optional	1
-	Second job of registered nursing professional cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered optometry labour force DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	384124
Registration status:	Health, Standard 10/12/2009
DSS type:	Data Set Specification (DSS)
Scope:	All optometrists listed with the Australian Health Practitioner Regulation Agency during the reference period. Optometrists included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

Statistical unit:	The statistical unit for this data set is the Registered optometrist. A Registered optometrist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as an optometrist at any time during the reference period.
Guide for use:	This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency. Note that a health professional may be qualified and registered in more than one profession. Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.
Collection methods:	*National reporting arrangements*

Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.

The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.

Periods for which data are collected and collated

Data are collated annually. The period is determined by the national registration renewal period for optometrists.

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at http://www.ahpra.gov.au

Relational attributes

Implementation in Data Set Specification: Registered health labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Labour force status cluster	Optional	1
-	Main job of registered optometrist cluster	Optional	1
-	Second job of registered optometrist cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered osteopathy labour force DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	384128
Registration status:	Health, Standard 10/12/2009
DSS type:	Data Set Specification (DSS)
Scope:	All osteopaths listed with the Australian Health Practitioner Regulation Agency during the reference period. Osteopaths included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

Statistical unit:

The statistical unit for this data set is the Registered osteopath.

A Registered osteopath refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as an osteopath at any time during the reference period.

Guide for use:

This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.

Note that a health professional may be qualified and registered in more than one profession.

Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.

Collection methods:

National reporting arrangements

Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.

The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.

Periods for which data are collected and collated

Data are collated annually. The period is determined by the national registration renewal period for osteopaths.

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at http://www.ahpra.gov.au

Relational attributes

Implementation in Data Set Specification: Registered health labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Labour force status cluster	Optional	1
-	Main job of registered osteopath cluster	Optional	1
-	Second job of registered osteopath cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1

-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered pharmacy labour force DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384152

Registration status: Health, Standard 10/12/2009

DSS type: Data Set Specification (DSS)

Scope: All pharmacists listed with the Australian Health Practitioner Regulation Agency during the reference period. Pharmacists included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered pharmacist.

A Registered pharmacist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a pharmacist at any time during the reference period.

Guide for use: This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.

Note that a health professional may be qualified and registered in more than one profession.

Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.

Collection methods: *National reporting arrangements*

Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.

The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.

Periods for which data are collected and collated

Data are collated annually. The period is determined by the national registration renewal period for pharmacists.

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at http://www.ahpra.gov.au

Relational attributes

Implementation in Data Set Specification: Registered health labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Labour force status cluster	Optional	1
-	Main job of registered pharmacist cluster	Optional	1
-	Second job of registered pharmacist cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered physiotherapy labour force DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384162

Registration status: Health, Standard 10/12/2009

DSS type: Data Set Specification (DSS)

Scope: All physiotherapists listed with the Australian Health Practitioner Regulation Agency during the reference period. Physiotherapists included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered physiotherapist.

A Registered physiotherapist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a physiotherapist at any time during the reference period.

Guide for use: This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.

Note that a health professional may be qualified and registered in more than one profession.

Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.

Collection methods:

National reporting arrangements

Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.

The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.

Periods for which data are collected and collated

Data are collated annually. The period is determined by the national registration renewal period for pharmacists.

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at http://www.ahpra.gov.au

Relational attributes

Implementation in Data Set Specification: Registered health labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Labour force status cluster	Optional	1
-	Main job of registered physiotherapist cluster	Optional	1
-	Second job of registered physiotherapist cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered podiatry labour force DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384166

Registration status: Health, Standard 10/12/2009

DSS type: Data Set Specification (DSS)

Scope: All podiatrists listed with the Australian Health Practitioner Regulation Agency during the reference period. Podiatrists included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered podiatrist.

A Registered podiatrist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a podiatrist at any time during the reference period.

Guide for use: This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.

Note that a health professional may be qualified and registered in more than one profession.

Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.

Collection methods: *National reporting arrangements*

Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.

The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.

Periods for which data are collected and collated

Data are collated annually. The period is determined by the national registration renewal period for podiatrists.

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at http://www.ahpra.gov.au

Relational attributes

Implementation in Data Set Specification: Registered health labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Labour force status cluster	Optional	1
-	Main job of registered podiatrist cluster	Optional	1
-	Second job of registered podiatrist cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered psychology labour force DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384170

Registration status: Health, Standard 10/12/2009

DSS type: Data Set Specification (DSS)

Scope: All psychologists listed with the Australian Health Practitioner Regulation Agency during the reference period. Psychologists included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered psychologist.

A Registered psychologist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a psychologist at any time during the reference period.

Guide for use: This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.

Note that a health professional may be qualified and registered in more than one profession.

Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.

Collection methods: *National reporting arrangements*

Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.

The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.

Periods for which data are collected and collated

Data are collated annually. The period is determined by the national registration renewal period for psychologists.

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at http://www.ahpra.gov.au

Relational attributes

Implementation in Data Set Specification: Registered health labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Labour force status cluster	Optional	1
-	Main job of registered psychologist cluster	Optional	1
-	Second job of registered psychologist cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode—Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Cluster

Activities and Participation cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 320111

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

DSS type: Data Element Cluster

Scope: This data cluster is one of four clusters that make up the Functioning and Disability DSS. To ensure a complete description of human functioning it is recommended that this cluster be collected along with the following three clusters over time and by a range of health and community care providers:

24. Body functions cluster
25. Body structures cluster
26. Environmental factors cluster

In the context of health, activity refers to the execution of a task or action by an individual, and participation refers to involvement in a life situation.

The Activities and Participation cluster collects information on a person's level of difficulty with activities, assistance needed to perform activities, extent of participation, and satisfaction with participation in the following life areas:

27. Learning and applying knowledge
28. General tasks and demands
29. Communication
30. Mobility
31. Self-care
32. Domestic life
33. Interpersonal interactions and relationships
34. Major life areas
35. Community, social and civic life

The use of this cluster to collect information on activity limitations and participation restrictions should enhance data quality for medical purposes as well as for a range of purposes related to understanding human functioning. This data cluster should be complementary to information on diseases.

The information collected in the Activities and Participation cluster may also indicate the sorts of interventions that could result in improved functioning. This could be in the form of rehabilitation, health-related interventions, equipment, or support for example.

Collection and usage attributes

Guide for use:

The following four measures are used to describe activities and participation in life areas:

36. **Difficulty** with activities may include pain involved, time taken, effort, number of errors, clumsiness, and modification of the manner in which the activity is performed. Difficulty is the combination of the frequency with which the problem exists, the duration of the problem and the intensity of the problem.
37. **Need for assistance** with activities includes personal assistance and/or supervision.
38. **Extent of participation** indicates the level of participation restriction. This corresponds to an externally observable measure of participation.
39. **Satisfaction with participation** corresponds to the person's own perspective on their participation, and reflects their attitude to their participation in the various life areas. It is essentially a summary measure in which are embedded the concepts of choice, opportunity and importance.

For each life area code recorded there can be one response for each of the measures. The choice of measure will depend on the user and their information requirements.

There are numerous possible methods for collecting activity, activity limitation, participation and participation restriction. A decision could be made to collect information:

- about every domain;
- on domains of particular relevance; or
- on a number of domains which are prioritised according to specified criteria.

See also the *ICF Australian User Guide* for further guidelines.

Collection methods:

The Person—activities/participation life area, code (ICF 2001) AN[NNN] data element is supported by a value domain - Activities and participation code (ICF 2001) AN[NNN] - representing a single list of activity and participation domains that are grouped together.

The World Health Organization suggests the list be used in one of four operational ways.

a) To designate some domains as activities and others as participation, not allowing any overlap.

b) Same as (a) above, but allowing partial overlap.

c) To designate all detailed domains as activities and the broad category headings as participation.

d) To use all domains as both activities and participation.

The ICF Australian User Guide proposes the use of either option (b) or (d) with the use of additional qualifiers to delineate between activity and participation.

The Person—activities and participation life area, code (ICF 2001) AN[NNN] data element can be used on its own as a neutral list of tasks, actions and life situations, or together with the four additional data elements in this cluster to record positive or neutral performance as well as activity limitations and participation restrictions. (It is important to note that the Person—activities and participation life area, code (ICF 2001) AN[NNN] data element must always be used when recording any of the other four data elements.)

Comments:

This cluster is based on the International Classification of Functioning, Disability and Health (ICF). The ICF is a reference member of the WHO Family of International Classifications (endorsed by the World Health Assembly in 2001) and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an ‘umbrella term for disease (acute or chronic), disorder, injury or trauma’ (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}.

The ICF recognises two constructs that can be used with 'Activities and Participation': performance and capacity. 'Performance' is what the person does in their usual environment. 'Capacity' describes 'an individual's ability to execute a task or an action in a standardised environment, where a standardised environment may be:

- an actual environment commonly used for assessment in test settings; or
- in cases where this is not possible, an assumed environment which can be thought to have a uniform impact' (WHO 2001).

The standardised environment has not been generally operationalised. However, the recognition of these two constructs in the ICF underscores the importance of recording the environment in which activities are being performed.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specification: Functioning and Disability DSS Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Activity and participation life area	Mandatory	1
-	Assistance with activities	Optional	1
-	Difficulty with activities	Optional	1
-	Extent of participation	Optional	1
-	Satisfaction with participation	Optional	1

Acute coronary syndrome clinical event cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	352671
Registration status:	Health, Standard 01/10/2008
DSS type:	Data Element Cluster
Scope:	The acute coronary syndrome (ACS) related clinical events are those which can negatively impact on the outcomes of a person with ACS. Information on the occurrence of these events in people with ACS is required due to an emerging appreciation of their relationship with late mortality. The clinical event cluster collects information on the timing and type of clinical events experienced during the current hospitalisation.

Relational attributes

Implementation in Data Set Specification:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Acute coronary syndrome related clinical event type	Conditional	15
-	Date of acute coronary syndrome related clinical event	Conditional	15
-	Time of acute coronary syndrome related clinical event	Conditional	1

Acute coronary syndrome pharmacotherapy data cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	351876
Registration status:	Health, Standard 01/10/2008
DSS type:	Data Element Cluster

Scope:

The pharmacotherapies collected in this data cluster are recommended for the management of acute coronary syndromes (ACS) in the national guidelines. The following pharmacotherapies are collected as part of this data cluster:

- Aspirin
- Angiotensin converting enzyme (ACE) inhibitor
- Angiotensin II receptor blocker
- Antithrombin
- Beta-blocker
- Clopidogrel
- Fibrinolytic
- Glycoprotein IIb/IIIa receptor antagonist
- Statin

The pharmacotherapy cluster collects information on the type of pharmacotherapies prescribed and the timing of each prescription.

Source and reference attributes

Steward:

The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Reference documents:

National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specification:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Date of intravenous fibrinolytic therapy	Conditional	1
-	Fibrinolytic drug used	Conditional	1
-	Pharmacotherapy type prescribed for acute coronary syndrome in hospital	Mandatory	10
-	Pharmacotherapy type taken for acute coronary syndrome post discharge	Mandatory	7
-	Reason for non prescription of pharmacotherapy	Conditional	9
-	Time of intravenous fibrinolytic therapy	Conditional	1
-	Timing of ACE-inhibitor prescription	Conditional	5
-	Timing of angiotensin II receptor blocker prescription	Conditional	5
-	Timing of antithrombin therapy prescription	Conditional	4
-	Timing of aspirin prescription	Conditional	5
-	Timing of beta-blocker prescription	Conditional	5
-	Timing of clopidogrel prescription	Conditional	5
-	Timing of glycoprotein IIb/IIIa inhibitor prescription	Conditional	4
-	Timing of statin prescription	Conditional	5

AUDIT score of risky alcohol consumption cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 403067

Registration status: Health, Standard 25/08/2011

DSS type: Data Element Cluster

Scope: This data cluster is used to provide a score on the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT) screening instrument. The data elements in this cluster relate to alcohol use in the last 12 months only. The AUDIT is a reliable and simple screening tool which is sensitive to the early detection of risky and high-risk (or hazardous and harmful) drinking.

Collection and usage attributes

Guide for use: The AUDIT score of risky alcohol consumption cluster comprises three data elements which record the frequency of alcohol consumption, the number of standard drinks consumed on a typical day when drinking and the frequency of consuming six or more standard drinks on one occasion.

The combination of codes for the three data elements: *Person—alcohol consumption amount (self-reported), total standard drinks NN*; *Person—alcohol consumption frequency, AUDIT alcohol consumption frequency code N*; and *Person—consumption of 6 or more standard drinks on one occasion, AUDIT consumption of 6 or more standard drinks code N* are used to provide a score on the AUDIT.

Responses to each question on the AUDIT are scored from 0 to 4, with a maximum possible score over the three questions being 12. A score of 6 or more on the AUDIT may indicate a risk of alcohol-related harm.

The formula for calculating a standard drink is:

Volume of container in litres x % alcohol by volume (ml/100ml) X 0.789*= The number of standard drinks. For example:

285ml full strength beer (4.9% alcohol)   1 standard drink

425ml light beer (2.9% alcohol)	1 standard drink
375ml stubby or can (4.9% alcohol)	1.4 standard drinks
425ml full strength beer (4.9% alcohol)	1.6 standard drinks
30 ml spirits (40% alcohol)	1 standard drink
150ml wine (12% alcohol)	1.5 standard drinks

* The specific gravity of ethyl alcohol is 0.789.

Collection methods:

The AUDIT contains the following questions:

Over the last 12 months:

a) How often did you have a drink containing alcohol?

0 Never

1 Monthly or less

2 2-4 times a month

3 2-3 times a week

4 4 or more times a week

b) How many standard drinks would you have on a typical day when you were drinking?

0 1 or 2

1 3 or 4

2 5 or 6

3 7 to 9

4 10 or more

c) How often did you have six or more standard drinks on one occasion?

0 Never

1 Less than monthly

	2 Monthly
	3 Weekly
	4 Daily or almost daily
	If the person's response to '(a) How often did you have a drink containing alcohol' is Never, do not ask questions (b) and (c). The person should only record one answer to each question.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	Department of Health and Ageing 2009. The Australian Standard Drink. Canberra: Department of Health and Ageing. Babor T, Higgins-Biddle JC, Saunders JB, Monteiro MG 2001. The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care. 2nd edn. Switzerland: World Health Organization.

Relational attributes

Implementation in Data Set Specification:	Prison entrants DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Alcohol consumption frequency	Mandatory	1
2	Alcohol consumption in standard drinks per day (self reported)	Conditional	1
3	Frequency consumed 6 or more standard drinks on one occasion	Conditional	1

Body functions cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 320117

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

DSS type: Data Element Cluster

Scope: This data cluster is one of four clusters that make up the Functioning and Disability DSS. To ensure a complete description of human functioning it is recommended that it be collected along with the following three clusters over time and by a range of health and community care providers:

40. Body Structures cluster
41. Activities and Participation cluster
42. Environmental factors cluster

Body functions are the physiological functions of body systems (including psychological functions). The term ‘body’ refers to the human organism as a whole; hence it includes the brain and its functions, that is, the mind.

The Body functions cluster collects information on the presence and extent of impairment of the eight body function domains listed below:

43. Mental functions
44. Sensory functions and pain
45. Voice and speech functions
46. Functions of the cardiovascular, haematological, immunological and respiratory systems
47. Functions of the digestive, metabolic and the endocrine system
48. Genitourinary and reproductive functions
49. Neuromusculoskeletal and movement-related functions
50. Functions of the skin and related structures

Impairments of body functions, as defined in the ICF, are problems in body functions such as a loss or significant departure from population standards or averages. The ICD uses impairment as ‘signs and symptoms’, a ‘component of disease’ or sometimes ‘reason for contact with health services’.

Impairments are recorded in terms of their extent or magnitude, nature and/or location. Determination of impairment is undertaken primarily by those qualified to evaluate physical and mental functioning or structure according to these standards.

Impairments should be detectable or noticeable by others or the person by direct observation or by inference from indirect observation. Impairments are not the same as the underlying pathology, but are manifestations of that pathology.

Impairments can be temporary or permanent; progressive, regressive or static; intermittent or continuous. The deviation from the population norm may be slight or severe and may fluctuate over time. Impairments may result in other impairments.

Impairments may be part, or an expression of a health condition, but do not necessarily indicate that a disease is present or that the individual should be regarded as sick.

The use of this cluster to collect information on impairments of body functions should enhance data quality for medical purposes as well as for a range of purposes related to human functioning. This data cluster should be complementary to information on diseases.

The information collected in the Body functions cluster may also indicate the sorts of interventions that could result in improved functioning. This could be in the form of rehabilitation, health-related interventions, equipment, or support for example.

Collection and usage attributes

Collection methods:

The Person—body function, code (ICF 2001) AN[NNNN] data element is a neutral list of functions that can be used to record positive or neutral body function, as well as impairment of a specified body function when used in conjunction with Person—extent of impairment of body function, code (ICF 2001)N. For each body function code recorded there should be a code for impairment of body functions.

There are numerous possible methods for collecting body functions and impairments. A decision could be made to collect information:

- about every domain;
- on domains of particular relevance; or
- on a number of domains which are prioritised according to specified criteria.

See also the *ICF Australian User Guide* for further guidelines.

Comments: This cluster is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specification: Functioning and Disability DSS Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Body function	Mandatory	1

-	Impairment of body function	Mandatory	1

Body structures cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 320151

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

DSS type: Data Element Cluster

Scope: This data cluster is one of four clusters that make up the Functioning and Disability DSS. To ensure a complete description of human functioning it is recommended that this cluster be collected along with the following three clusters over time and by a range of health and community care providers:

51. Body functions cluster
52. Activities and participation cluster
53. Environmental factors cluster

Body structures are anatomical parts of the body such as organs, limbs and their components.

The Body structures cluster collects information on the presence and extent of impairment, the nature of the change and the location of the impairment for the eight body structure domains listed below:

54. Structures of the nervous system
55. The eye, ear and related structures
56. Structures involved in voice and speech
57. Structures of the cardiovascular, immunological and respiratory systems
58. Structures related to the digestive, metabolism and endocrine systems
59. Structures related to genitourinary and reproductive systems
60. Structures related to movement
61. Skin and related structures

Impairments of body structures, as defined in the ICF, are problems in body structure such as a loss or significant departure from population standards or averages. The ICD uses impairment as ‘signs and symptoms’, a ‘component of disease’ or sometimes ‘reason for contact with health services’.

Impairments are recorded in terms of their extent or magnitude, nature and/or location. Determination of impairment is undertaken primarily by those qualified to evaluate physical and mental functioning or structure according to population standards or averages.

Impairments should be detectable or noticeable by others or the person by direct observation or by inference from indirect observation. Impairments are not the same as the underlying pathology, but are manifestations of that pathology.

Impairments can be temporary or permanent; progressive, regressive or static; intermittent or continuous. The deviation from the population norm may be slight or severe and may fluctuate over time. Impairments may result in other impairments.

Impairments may be part, or an expression of a health condition, but do not necessarily indicate that a disease is present or that the individual should be regarded as sick.

The use of this cluster to collect information on impairments should enhance data quality for medical purposes as well as for a range of purposes related to understanding human functioning. This data cluster should be complementary to information on diseases.

The information collected in the Body structures cluster may also indicate the sorts of interventions that could result in improved functioning. This could be in the form of rehabilitation, health-related interventions, equipment, or support for example.

Collection and usage attributes

Guide for use:

The Person—body structure, code (ICF 2001) AN[NNNN] is a data element supported by the value domain Body structure code (ICF 2001) AN(NNNN) that represents a neutral list of structures from the ICF. This data element can be used to record positive or neutral body structure, as well as impairment of a specified body structure when used in conjunction with Person—extent of impairment of body structure, code (ICF 2001) N.

It is optional to record the location and nature of the impairment using Person—nature of impairment of body structure, code (ICF 2001) X and Person—location of impairment of body structure, code (ICF

2001) X respectively.

There are numerous possible methods for collecting body structures and impairments. A decision could be made to collect information:

- about every domain;
- on domains of particular relevance; or
- on a number of domains which are prioritised according to specified criteria.

Comments:

This cluster is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N]}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N]}

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specification:

Functioning and Disability DSS Community
Services, Standard 16/10/2006
Health, Standard 29/11/2006

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Body structure	Mandatory	1
-	Change to body structure	Optional	1

-	Impairment of body structure	Mandatory	1
-	Location of impairment	Optional	1

Chemotherapy for cancer cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	418323
Registration status:	Health, Standard 07/12/2011
DSS type:	Data Element Cluster

Scope:

Chemotherapy is cancer treatment that achieves its antitumour effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

The chemotherapy cluster consists of those data elements recommended for collection as best practice when the patient is administered chemotherapy as part of the initial course of treatment for cancer. The chemotherapy cluster collects information on the chemotherapy agent or protocol, the number of cycles administered and the start and finish dates of treatment.

Information on the agent and number of cycles of chemotherapy treatment is required to evaluate patterns of care, the effectiveness of different treatment modalities and treatment by patient outcome. Collecting the start and finish dates will enable an estimate of the duration of chemotherapy and the time interval from diagnosis to treatment.

The use of standard definitions and formats supports the consistent collection and management of data and enables the integration of data from different sources. It provides a common language facilitating the interpretation and analysis of results, data linkage for statistical purposes, longitudinal studies and patient patterns of care and outcome studies. These results may then inform professional guidelines and training, quality assurance and the planning and evaluation of cancer control activities, potentially improving outcomes for patients.

Collection and usage attributes

Guide for use:

Capturing chemotherapy agents and cycles can be problematic. Chemotherapy agents are administered in treatment cycles, either singly or in a combination regimen or protocol of two or more chemotherapy drugs. Treatment may be administered prior to surgery or radiotherapy to reduce the tumour burden (neoadjuvant), concurrent with radiotherapy, following surgery or radiotherapy (adjuvant) or on its own. Regimens may be complex involving many drugs given at different times during the initial course of treatment. In addition, if a patient has an adverse reaction, one of the agents in a combination regimen may be changed.

Furthermore, chemotherapy regimens are often expressed as acronyms identifying the agents used in combination. However, the letters used are not consistent across regimens, and in some cases (for example, "BEACOPP") the same letter is used to represent two different treatments. Finally, treatment protocols may be specific to the treatment centre.

Standard protocols are available online at eviQ Cancer Treatments Online (www.eviQ.org.au). This website is powered by the Cancer Institute NSW and endorsed by Cancer Australia, and provides current, evidence based, best practice cancer treatment protocols and information. It is recommended that only regimen or protocol names listed in eviQ be used to record chemotherapy agents; in all other cases, record the full generic name of each individual chemotherapy agent for each course of treatment.

Collection methods: Chemotherapy agents and cycles are recorded for each course of chemotherapy administered during the initial course of treatment regardless of treatment intent or timing.

The data element *Healthcare provider—organisation identifier, N(16)* may be recorded for each treatment/cycle. It is recommended that, wherever possible, the database be configured to allow entry of different healthcare provider identifiers for each therapeutic mode/course of treatment/cycle.

The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The start date and completion date of chemotherapy are recorded once only for chemotherapy administered during the initial course of treatment.

This information should be collected from the patient's medical record.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Australian Institute of Health and Welfare (AIHW) 2010. National health data dictionary. Version 15. National health data dictionary series. Cat. no. HWI 107. Canberra: AIHW

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Standard Cancer Treatment and Management Pathways Program, Cancer Services and Education Division, eviQ Cancer Treatments Online. Cancer Institute NSW

Relational attributes

Related metadata references: See also Cancer treatment—cancer treatment type, code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specification: Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on patient receiving chemotherapy.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Chemotherapy completion date	Mandatory	1
-	Chemotherapy cycles administered	Mandatory	99
-	Chemotherapy start date	Mandatory	1
-	Systemic therapy agent or protocol	Mandatory	99
-	Systemic therapy agent or protocol, eviQ	Conditional	3

Chronic condition cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 399234

Registration status: Health, Standard 25/08/2011

DSS type: Data Element Cluster

Scope: These data elements are used in conjunction to determine:

- the number of prison entrants who have ever been told that they have either arthritis, asthma, cancer, cardiovascular disease or diabetes; and
- the number of prison entrants who currently have at least one of the above listed chronic conditions.

Collection and usage attributes

Guide for use: The Chronic condition cluster comprises three data elements which allow:

1. Data on the type of chronic condition to be combined with an indicator of whether the prison entrant has ever been told by a doctor or nurse that he or she has the condition. This is achieved by the combination of the two data elements: *Person—type of chronic condition, code N* and *Person—specific chronic condition indicator, yes/no code N*.

2. Data on the type of chronic condition to be matched with an indicator of whether the person reports that they currently have the condition. This is achieved by the combination of the two data elements: *Person—type of chronic condition, code N* and *Person—chronic condition indicator, yes/no code N.*

This combination of the three data elements as shown above allows the following two items to be recorded:

- the type of chronic condition the prison entrant reports ever having been told they have, and
- whether the prison entrant reports that they currently have the chronic condition.

The Chronic condition cluster describes the following information:

Type of chronic condition	Specific chronic condition indicator	Chronic condition indicator
Arthritis	Yes	Yes/No
	No	N/A
Asthma	Yes	Yes/No
	No	N/A
Cancer	Yes	Yes/No
	No	N/A
Cardiovascular disease	Yes	Yes/No
	No	N/A
Diabetes	Yes	Yes/No
	No	N/A

N/A is not applicable

Collection methods: Information on chronic conditions is collected at the reception assessment on the National Prisoner Health Census Prison Entrants form.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Prison entrants DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Specific chronic condition indicator	Mandatory	1
2	Type of chronic condition	Conditional	5
3	Chronic condition indicator	Conditional	1

Coronary artery cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 352651

Registration status: Health, Standard 01/10/2008

DSS type: Data Element Cluster

Scope: This cluster collects information on the characteristics of and interventions performed for the coronary arteries during the current hospitalisation. The coronary arteries included in this cluster are:

- Left anterior descending coronary artery
- Inferior surface artery
- Left circumflex coronary artery
- Diagonal coronary artery
- Left main coronary artery
- Posterior descending artery
- Right coronary artery

Collection and usage attributes

Collection methods: When reporting the maximum stenosis in the coronary arteries, reporting of all the following coronary vessels is mandatory:

- Diagonal coronary artery
- Left anterior descending coronary artery
- Inferior surface artery
- Left circumflex coronary artery
- Left main coronary artery
- Posterior descending artery
- Right coronary artery

Source and reference attributes

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specification: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Coronary artery bypass graft location	Conditional	7
-	Coronary artery stenosis location	Mandatory	7
-	Date of coronary artery bypass graft	Conditional	99
-	Date of primary percutaneous coronary intervention	Conditional	1
-	Date of rescue percutaneous coronary intervention	Conditional	1
-	Date of revascularisation percutaneous coronary intervention	Conditional	1
-	Maximum stenosis coronary artery	Mandatory	1
-	Number of coronary artery lesions attempted	Conditional	99
-	Number of coronary artery lesions successfully dilated	Conditional	99
-	Number of coronary artery stents	Conditional	99
-	Percutaneous coronary intervention procedure type	Conditional	1
-	Time of primary percutaneous coronary intervention	Conditional	1
-	Time of rescue percutaneous coronary intervention	Conditional	1
-	Time of revascularisation percutaneous coronary intervention	Conditional	1

Elective surgery waiting times cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 464669

Registration status: Health, Standard 07/12/2011

DSS type: Data Element Cluster

Scope: The scope of the Elective surgery waiting times data element cluster is patients on elective surgery waiting lists managed by public acute hospitals, in either category 1 or 2 of the 'Reason for removals from elective surgery waiting list' data element.

This will include private patients treated in public hospitals, and may include public patients treated in private hospitals.

Hospitals may also collect information for other care (as defined in the 'Waiting list category' data element), but this is not part of the national minimum data set (NMDS) for Elective surgery waiting times.

Patients on waiting lists managed by hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included.

Collection and usage attributes

Guide for use: Outsourced or contracted patients

Public hospitals managing elective surgery waiting lists may either outsource elective surgery work to another hospital (public or private) or contract another hospital (public or private) to provide elective surgery on their behalf.

In such cases, the hospital where the outsourced or contracted elective surgery occurs is required to include the *'Establishment—organisation identifier (Australian), NNX[X]NNNNN'* data element for the hospital managing the elective surgery waiting list as part of the Elective surgery waiting times data cluster.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:
This data element cluster is to be reported for patients on waiting lists for elective surgery, which are managed by public acute hospitals and have a category 1 or 2 assigned for the reason for removal from the elective surgery waiting list.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Clinical urgency	Mandatory	1
-	Establishment identifier	Conditional	1
-	Extended wait patient	Mandatory	1
-	Indicator procedure	Mandatory	1
-	Listing date for care	Mandatory	1
-	Overdue patient	Mandatory	1
-	Reason for removal from elective surgery waiting list	Mandatory	1
-	Surgical specialty	Mandatory	1
-	Waiting time at removal from elective surgery waiting list	Mandatory	1

Electrocardiogram cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	351884
Registration status:	Health, Standard 01/10/2008
DSS type:	Data Element Cluster
Scope:	An electrocardiogram (ECG) measures the electrical activity of the heart over time. The evaluation of an ECG provides important diagnostic information relevant to the risk stratification, diagnosis and management of acute coronary syndromes. The electrocardiogram cluster collects information on the timing of each ECG and specific diagnostic characteristics determined from the ECG: • ECG change type and location • Bundle-branch block status • Q waves status • ST-segment elevation in lead V4R

Relational attributes

Implementation in Data Set Specification:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Bundle-branch block status	Conditional	1
-	Date of electrocardiogram	Mandatory	99
-	ECG - Q waves indicator	Mandatory	99
-	Electrocardiogram - new Q waves indicator	Conditional	99
-	Electrocardiogram - lead V4R presence indicator	Mandatory	99
-	Electrocardiogram - ST-segment-elevation in lead V4R	Conditional	99
-	Electrocardiogram change location	Conditional	1
-	Electrocardiogram change type	Conditional	99
-	Heart rhythm type	Mandatory	99
-	Time of electrocardiogram	Mandatory	99

Environmental factors cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 320195

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

DSS type: Data Element Cluster

Scope: This data cluster is one of four clusters that make up the Functioning and Disability DSS. To ensure a complete description of human functioning it is recommended that this cluster be collected along with the following three clusters over time and by a range of health and community care providers:

62. Body functions cluster
63. Body structures cluster
64. Activities and participation cluster

Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives. These factors can have a positive or negative influence on a person's participation as a member of society, on performance of activities, or on a person's body function or structure.

The Environmental Factors cluster collects information on the extent to which each of the domains in the five chapters listed below influence the body function or structure, activity or participation of a person:

65. Products and technology
66. Natural environment and human-made changes to environment
67. Support and relationships
68. Attitudes
69. Services, systems and policies

Each chapter contains categories at different levels ordered from general to detailed. For detailed information the user should follow the structure of the ICF; the codes should be drawn from the same hierarchical level within any particular chapter.

Codes at the ICF chapter headings may be recorded. If further detail is required the Environmental

Factors classification includes 3 and 4 digit codes:

e5 Services, systems and policies

e580 Health services, systems and policies

e5800 Health services

Where multiple environmental factors and the extent of influence are recorded, the following prioritising system may be useful:

- The first recorded environmental factor is the one having the greatest impact on the individual.
- Second and subsequent environmental factors are also of relevance to the individual.

The Environmental factors cluster may be used in health, community services and other disability-related data collections to record the environmental factors that facilitate or inhibit optimum functioning at the body, person or societal level. Identifying whether, and by how much, these environmental factors are influencing an individual’s level of functioning, and whether the influence is a facilitator or barrier, may indicate the sorts of interventions that will optimise the individual’s functioning. This information may be useful for policy development, service provision, or advocacy purposes. Preventative strategies could also be indicated by this information.

Collection and usage attributes

Guide for use:

For each environmental factor code recorded there should be one response for the influence of the environmental factor.

There are numerous possible methods for collecting environmental factors. Information can be collected on:

- all environmental factors;
- environmental factors of particular relevance;
- a number of environmental factors, prioritised according to specified criteria;
- one environmental factor per person; or
- record environmental factors for each recorded body function, body structure, and activities and participation.

See also the *ICF Australian User Guide* for further guidelines.

Comments: This cluster is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N}.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specification: Functioning and Disability DSS Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Environmental factor	Mandatory	1
-	Influence of environmental factor	Mandatory	1

Full-time equivalent prison staff cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	413709
Registration status:	Health, Standard 25/08/2011
DSS type:	Data Element Cluster
Scope:	These data elements are used in conjunction with each other to determine the number of full-time equivalent health staff working within a prison.

Collection and usage attributes

Guide for use:

The Full-time equivalent prison staff cluster comprises two data elements: *Establishment (prison)—number of full-time equivalent staff, total number N[N]* and *Establishment (prison)—health worker type, occupation code (ANZSCO 1st edition) N[NNN]{NN}* that describe the number of full-time equivalent health staff working within a prison.

The Full-time equivalent prison staff cluster describes the following information:

Type of health staff	Number
Medical practitioner	N[N]
Psychologists	N[N]
Dental practitioner	N[N]
Psychiatrist	N[N]
Registered nurse	N[N]
Enrolled nurse	N[N]
Aboriginal and Torres Strait Islander health worker	N[N]
Nurse practitioner	N[N]
Other	N[N]
Total number	N[NN]

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Prison establishments DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Number of full-time equivalent prison staff	Mandatory	1
-	Prison health worker type	Mandatory	9

Functional stress test cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	351878
Registration status:	Health, Standard 01/10/2008
DSS type:	Data Element Cluster
Scope:	A functional stress test evaluates arterial blood flow to the heart muscle during increased cardiac work through physical exercise or pharmacological methods. The functional stress test cluster collects information on the timing, characteristics and results of a functional stress test performed during the current hospital presentation.

Relational attributes

Implementation in Data Set Specification:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Date of functional stress test	Conditional	1
-	Functional stress ischaemic and perfusion outcome result	Conditional	1
-	Functional stress test assessment of cardiac perfusion	Conditional	1
-	Functional stress test element	Conditional	1
-	Functional stress test intensity	Conditional	1
-	Functional stress test performed indicator	Mandatory	1

Government health expenditure function revenue data element cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	372219
Registration status:	Health, Standard 03/12/2008
DSS type:	Data Element Cluster
Scope:	The scope of this data cluster is revenue relating to direct government and government-funded expenditure on health and health–related goods and services or non-health care goods and services to support these activities.

Collection and usage attributes

Guide for use:	Revenues are to be reported in millions to the nearest 100,000 e.g. $4.1 million.
Collection methods:	This data is collected according to the organisation's source of revenue and type of health or health related function relevant to each State and Territory. This is supplied by the GHE and specified in the reporting guidelines as provided by the AIHW.

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Relational attributes

Related metadata references:	Supersedes Government health expenditure function revenue data cluster Health, Superseded 03/12/2008
Implementation in Data Set Specification:	Government health expenditure NMDS 2009-2010 Health, Standard 01/04/2009 *Implementation start date:* 01/07/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Organisation revenues	Mandatory	99
-	Source of public and private revenue	Mandatory	1
-	Type of health or health related function	Mandatory	1

Government health expenditure organisation expenditure capital consumption data element cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	376401
Registration status:	Health, Standard 01/04/2009
DSS type:	Data Element Cluster
Scope:	The scope of this data cluster is direct government and government-funded expenditure by a health industry relevant organisation consisting of consumption of fixed capital (depreciation). These are all either health and health–related goods and services or non-health care goods and services to support the health industry relevant organisation's activities.

Collection and usage attributes

Guide for use:	Expenses are to be reported in millions to the nearest 100,000 e.g. $4.1 million.
Collection methods:	This data is collected according to the organisation's main activity types and type of health or health related function relevant to each State and Territory. This is supplied by the GHE and specified in the reporting guidelines as provided by the AIHW.

Relational attributes

Related metadata references:	Supersedes Government health expenditure organisation expenditure capital consumption data element cluster Health, Superseded 01/04/2009
Implementation in Data Set Specification:	Government health expenditure NMDS 2009-2010 Health, Standard 01/04/2009 *Implementation start date:* 01/07/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Capital consumption expenses	Conditional	1
-	Health industry relevant organisation type	Conditional	1

-	Type of health or health related function	Conditional	1

Government health expenditure organisation expenditure data element cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	376888
Registration status:	Health, Standard 01/04/2009
DSS type:	Data Element Cluster
Scope:	The scope of this data cluster is direct government and government-funded expenditure by a health industry relevant organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, workers compensation premiums and payouts, purchases of goods and services and consumption of fixed capital (depreciation). These are all either health and health–related goods and services or non-health care goods and services to support the health industry relevant organisation's activities.

Collection and usage attributes

Guide for use:	Expenses are to be reported in millions to the nearest 100,000 e.g. $4.1 million.
Collection methods:	This data is collected according to the organisation's main activity types and type of health or health related function relevant to each State and Territory. This is supplied by the GHE and specified in the reporting guidelines as provided by the AIHW.

Relational attributes

Related metadata references:	Supersedes Government health expenditure organisation expenditure data cluster Health, Superseded 01/04/2009
Implementation in Data Set Specification:	Government health expenditure NMDS 2009-2010 Health, Standard 01/04/2009 *Implementation start date:* 01/07/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Capital consumption expenses	Mandatory	1
-	Employee expenses	Mandatory	1

-	Health industry relevant organisation type	Mandatory	1
-	Organisation expenses, total Australian currency	Mandatory	1
-	Purchase of goods and services	Mandatory	1
-	Type of health or health related function	Mandatory	1

Government health expenditure organisation expenditure employee related data element cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	376897
Registration status:	Health, Standard 01/04/2009
DSS type:	Data Element Cluster
Scope:	The scope of this data cluster is direct government and government-funded expenditure by a health industry relevant organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, and workers compensation premiums and payouts. These are all either health and health–related goods and services or non-health care goods and services to support the health industry relevant organisation's activities.

Collection and usage attributes

Guide for use:	Expenses are to be reported in millions to the nearest 100,000 e.g. $4.1 million.
Collection methods:	This data is collected according to the organisation's main activity types and type of health or health related function relevant to each State and Territory. This is supplied by the GHE and specified in the reporting guidelines as provided by the AIHW.

Relational attributes

Related metadata references:	Supersedes Government health expenditure organisation expenditure employee related data element cluster Health, Superseded 01/04/2009
Implementation in Data Set Specification:	Government health expenditure NMDS 2009-2010 Health, Standard 01/04/2009 *Implementation start date:* 01/07/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Employee expenses	Mandatory	1
-	Health industry relevant organisation type	Conditional	1

-	Type of health or health related function	Conditional	1

Government health expenditure organisation expenditure purchase of goods and services data element cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	376891
Registration status:	Health, Standard 01/04/2009
DSS type:	Data Element Cluster
Scope:	The scope of this data cluster is direct government and government-funded expenditure by a health industry relevant organisation consisting mainly of purchases of goods and services. These are all either health and health–related goods and services or non-health care goods and services to support the health industry relevant organisation's activities.

Collection and usage attributes

Guide for use:	Expenses are to be reported in millions to the nearest 100,000 e.g. $4.1 million.
Collection methods:	This data is collected according to the organisation's main activity types and type of health or health related function relevant to each State and Territory. This is supplied by the GHE and specified in the reporting guidelines as provided by the AIHW.

Relational attributes

Related metadata references:	Supersedes Government health expenditure organisation expenditure purchase of goods and services data element cluster Health, Superseded 01/04/2009
Implementation in Data Set Specification:	Government health expenditure NMDS 2009-2010 Health, Standard 01/04/2009 *Implementation start date:* 01/07/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Health industry relevant organisation type	Conditional	1
-	Purchase of goods and services	Mandatory	1

-	Type of health or health related function	Conditional	1

Government health expenditure organisation revenue data element cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	376884
Registration status:	Health, Standard 01/04/2009
DSS type:	Data Element Cluster
Scope:	The scope of this data cluster is revenue relating to direct government and government-funded expenditure by a health industry relevant organisation.

Collection and usage attributes

Guide for use:	Revenues are to be reported in millions to the nearest 100,000 e.g. $4.1 million.
Collection methods:	This data is collected according to the organisation's source of revenue and main activity types relevant to each State and Territory. This is supplied by the GHE and specified in the reporting guidelines as provided by the AIHW.

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Relational attributes

Related metadata references:	Supersedes Government health expenditure organisation revenue data element cluster Health, Superseded 01/04/2009
Implementation in Data Set Specification:	Government health expenditure NMDS 2009-2010 Health, Standard 01/04/2009 *Implementation start date:* 01/07/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Health industry relevant organisation type	Mandatory	1
-	Organisation revenues	Conditional	99
-	Source of public and private revenue	Mandatory	1

Health service non-utilisation cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 412707

Registration status: Health, Standard 25/08/2011

DSS type: Data Element Cluster

Scope: These data elements are used in conjunction with each other to describe the non-utilisation of health services in the community and in prison by prison entrants in the last 12 months; and to gain a greater understanding of the health seeking behaviours of prison entrants.

Collection and usage attributes

Guide for use: The Health service non-utilisation cluster comprises three data elements that provide information on a prison entrant's health seeking behaviours in the community and prison. This is achieved by the combination of the three data elements: *Prison entrant—service provider needed but not utilised indicator, yes/no code N*; *Prison entrant—type of service provider needed but not utilised, occupation code (ANZSCO 1st edition) N[NNN]{NN}* and *Health service event—prisoner location when service provider was needed, but not utilised, prisoner location code N*.

The Health service non-utilisation cluster describes the following information:

Health service provider not consulted	Location of prisoner: Community	Location of prisoner: Prison
Medical practitioner (Doctor/GP)	Y/N	Y/N
Nurse	Y/N	Y/N
Psychologist	Y/N	Y/N
Psychiatrist	Y/N	Y/N
Aboriginal and Torres Strait Islander health	Y/N	Y/N

worker		
Drug and alcohol counsellor	Y/N	Y/N
Dentist	Y/N	Y/N
Social worker/welfare officer	Y/N	Y/N

Collection methods: Information on health service non-utilisation is provided at the reception assessment on the National Prisoner Health Census Prison Entrants form. Only prison entrants who have been in prison in the last 12 months may provide responses to the 'Prison' category.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Prison entrant—imprisonment in the last 12 months indicator, yes/no code N Health, Standard 25/08/2011

Implementation in Data Set Specification: Prison entrants DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Service provider needed but not utilised indicator	Mandatory	1
2	Type of service provider needed but not utilised	Conditional	8
3	Prisoner location when service provider was needed, but not utilised	Conditional	16

Health service utilisation cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	402411
Registration status:	Health, Standard 25/08/2011
DSS type:	Data Element Cluster
Scope:	These data elements are used in conjunction with each other to describe the utilisation of health services in the community and in prison by prison entrants in the last 12 months; and to gain a greater understanding of the health seeking behaviours of prison entrants.

Collection and usage attributes

Guide for use:

The Health service utilisation cluster comprises three data elements that provide information on a prison entrant's health seeking behaviours in the community and prison. This is achieved by the combination of the three data elements: *Prison entrant—individual service provider consulted indicator, yes/no code N*, *Prison entrant—type of service provider consulted, occupation code (ANZSCO 1st edition) N[NNN]{NN}* and *Health service event—prisoner location, code N.*

The Health service utilisation cluster describes the following information:

Health service provider consulted	Location of prisoner: Community	Location of prisoner: Prison
Medical practitioner (Doctor/GP)	Y/N	Y/N
Nurse	Y/N	Y/N
Drug and alcohol counsellor	Y/N	Y/N
Aboriginal and Torres Strait Islander Health Worker	Y/N	Y/N
Dental practitioner	Y/N	Y/N

Psychologist	Y/N	Y/N
Psychiatrist	Y/N	Y/N
Social worker/welfare officer	Y/N	Y/N

Collection methods: Information on health service utilisation is provided at the reception assessment on the National Prisoner Health Census Prison Entrants form. Only prison entrants who have been in prison in the last 12 months may provide responses to the ‘Prison’ category.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Prison entrant—imprisonment in the last 12 months indicator, yes/no code N Health, Standard 25/08/2011

Implementation in Data Set Specification: Prison entrants DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Service provider consulted indicator	Mandatory	1
2	Type of service provider consulted (prison entrant)	Conditional	8
3	Prisoner location when service provider utilised	Conditional	16

Hormone therapy for cancer cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 418349

Registration status: Health, Standard 07/12/2011

DSS type: Data Element Cluster

Scope: Hormone therapy is cancer treatment that achieves its antitumour effect through changes in hormonal balance. It includes the administration of hormones, agents acting via hormonal mechanisms, antihormones and steroids.

The hormone therapy cluster consists of those data elements recommended for collection as best practice when the patient is administered hormone therapy as part of the initial course of treatment for cancer. The hormone therapy cluster collects information on the hormone therapy agent or protocol and the start and finish dates of treatment.

Information on the hormone therapy agent is required to evaluate patterns of care, the effectiveness of different treatment modalities and treatment by patient outcome. Collecting the start and finish dates will enable an estimate of the duration of hormone therapy and the time interval from diagnosis to treatment.

The use of standard definitions and formats supports the consistent collection and management of data and enables the integration of data from different sources. It provides a common language facilitating the interpretation and analysis of results, data linkage for statistical purposes, longitudinal studies and patient patterns of care and outcome studies. These results may then inform professional guidelines and training, quality assurance and the planning and evaluation of cancer control activities, potentially improving outcomes for patients.

Collection and usage attributes

Guide for use: Standard protocols are available online at eviQ Cancer Treatments Online (www.eviQ.org.au). This website is powered by the Cancer Institute NSW and endorsed by Cancer Australia, and provides current, evidence based, best practice cancer treatment protocols and information. It is recommended that only regimen or protocol names listed in eviQ be used to record hormone therapy agents; in all other cases, record the full generic name of each individual hormone therapy agent for each course of treatment.

Collection methods:

Hormone therapy agents are recorded for each course of hormone therapy administered during the initial course of treatment regardless of treatment intent or timing.

The data element *Healthcare provider—organisation identifier, N(16)* may be recorded for each treatment/cycle. It is recommended that, wherever possible, the database be configured to allow entry of different healthcare provider identifiers for each therapeutic mode/course of treatment/cycle.

The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The start date and completion date of hormone therapy are recorded once only for hormone therapy administered during the initial course of treatment.

This information should be collected from the patient's medical record.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents:

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Australian Institute of Health and Welfare 2010. National health data dictionary. Version 15. National health data dictionary series. Cat. no. HWI 107. Canberra: AIHW

Standard Cancer Treatment and Management Pathways Program, Cancer Services and Education Division, eviQ Cancer Treatments Online. Cancer Institute NSW

Relational attributes

Related metadata references: See also Cancer treatment—cancer treatment type, code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specification: Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on patient receiving hormone therapy.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*

-	Hormone therapy completion date	Mandatory	1
-	Hormone therapy start date	Mandatory	1
-	Systemic therapy agent or protocol	Mandatory	99
-	Systemic therapy agent or protocol, eviQ	Conditional	3

Hospital transfer cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	412990
Registration status:	Health, Standard 25/08/2011
DSS type:	Data Element Cluster
Scope:	These data elements are used in conjunction with each other to describe the number of planned and unplanned transfers between prison and a community-based hospital during the National Prisoner Health Census period.

Collection and usage attributes

Guide for use:

The Hospital transfer cluster comprises two data elements that allow data on the number and type (planned/unplanned) of transfers between prison and a community-based hospital during the National Prisoner Health Census period to be determined.

This is achieved by the combination of the two data elements: *Establishment (prison)—planned hospital transfer indicator, yes/no code N* and *Establishment (prison)—number of hospital transfers, number N[NN].*

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification:	Prison establishments DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Number of hospital transfers	Mandatory	1
-	Planned hospital transfer indicator	Mandatory	2

Immunotherapy for cancer cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 418352

Registration status: Health, Standard 07/12/2011

DSS type: Data Element Cluster

Scope: Immunotherapy, also known as biological therapy, biotherapy or biological response modifier therapy, is cancer treatment that achieves its antitumour effect by altering the immune system or changing the host's response to the tumour cells.

The immunotherapy cluster consists of those data elements recommended for collection as best practice when the patient is administered immunotherapy as part of the initial course of treatment for cancer. The immunotherapy cluster collects information on the immunotherapy agent or protocol and the start and finish dates of treatment.

Information on the immunotherapy agent is required to evaluate patterns of care, the effectiveness of different treatment modalities and treatment by patient outcome. Collecting the start and finish dates will enable an estimate of the duration of immunotherapy and the time interval from diagnosis to treatment.

The use of standard definitions and formats supports the consistent collection and management of data and enables the integration of data from different sources. It provides a common language facilitating the interpretation and analysis of results, data linkage for statistical purposes, longitudinal studies and patient patterns of care and outcome studies. These results may then inform professional guidelines and training, quality assurance and the planning and evaluation of cancer control activities; potentially improving outcomes for patients.

Collection and usage attributes

Guide for use: Standard protocols are available online at eviQ Cancer Treatments Online (www.eviQ.org.au). This website is powered by the Cancer Institute NSW and endorsed by Cancer Australia, and provides current, evidence based, best practice cancer treatment protocols and information. It is recommended that only regimen or protocol names listed in eviQ be used to record immunotherapy agents; in all other cases, record the full generic name of each individual immunotherapy agent for each course of treatment.

Collection methods:

Immunotherapy agents and cycles are recorded for each course of immunotherapy administered during the initial course of treatment regardless of treatment intent or timing.

The data element *Healthcare provider—organisation identifier, N(16)* may be recorded for each treatment/cycle. It is recommended that, wherever possible, the database be configured to allow entry of different healthcare provider identifiers for each therapeutic mode/course of treatment/cycle.

The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

The start date and completion date of immunotherapy are recorded once only for immunotherapy administered during the initial course of treatment.

This information should be collected from the patient's medical record.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents:

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Australian Institute of Health and Welfare 2010. National health data dictionary. Version 15. National health data dictionary series. Cat. no. HWI 107. Canberra: AIHW

Standard Cancer Treatment and Management Pathways Program, Cancer Services and Education Division, eviQ Cancer Treatments Online. Cancer Institute NSW

Relational attributes

Related metadata references: See also Cancer treatment—cancer treatment type, code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specification: Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on patient receiving immunotherapy.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*

-	Immunotherapy completion date	Mandatory	1
-	Immunotherapy start date	Mandatory	1
-	Systemic therapy agent or protocol	Mandatory	99
-	Systemic therapy agent or protocol, eviQ	Conditional	3

Incarceration history cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 398973

Registration status: Health, Standard 25/08/2011

DSS type: Data Element Cluster

Scope: These data elements are used in conjunction with each other to provide information on a prison entrant's incarceration history.

Collection and usage attributes

Guide for use: The Incarceration history cluster provides information on the total number of times a prison entrant has been in custody in a **juvenile detention centre** or a prison. This is achieved by the combination of the two data elements: *Prison entrant—type of corrective services facility, code N,* and *Prison entrant—number of times in prison or juvenile detention.*

The Incarceration history cluster describes data on:

	Juvenile detention centre	Adult prison
Number of times in custody	N[N]	N[N]

As this data cluster aims to collect the prison entrant's previous history of incarceration, both items may be applicable to the one prisoner. That is, a prisoner may have previously been detained in both a juvenile detention centre (as a juvenile offender) and then in a prison (as an adult offender).

Collection methods: Information on a person's incarceration history is collected during the reception assessment on the National Prisoner Health Census Prison Entrants form.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Prison entrant—age at first detention, total years NN Health, Standard 25/08/2011

See also Prison entrant—first time in prison or juvenile detention indicator, yes/no code N Health, Standard 25/08/2011

Implementation in Data Set Specification:

Prison entrants DSS Health, Standard 25/08/2011

Conditional obligation:
Conditional on having previously been in custody

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Prison entrant number of times in prison or juvenile detention	Mandatory	1
2	Type of corrective services facility	Mandatory	2

Labour force status cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 383452

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: All health professionals renewing their registration with the Australian Health Practitioner Regulation Agency.

Collection and usage attributes

Statistical unit: The statistical unit is the Registered health professional.

Guide for use: The data elements in this cluster, when used together, describe the labour force status of registered health professionals. The cluster assists to describe the size and availability of the health labour force.

The data can be output as sub-groups of the labour force using the following categories:

70. Employed
    1. Employed in Australia in registered profession
        1. Employed in the profession
        2. On extended leave
    2. Employed in Australia outside of registered profession
        1. Looking for work in registered profession
        2. Not looking for work in registered profession
    3. Employed overseas in registered profession
        1. Looking for work in Australia in registered profession
        2. Not looking for work in Australia in registered profession
71. Not employed in Australia
    1. Looking for work in Australia in registered profession
    2. Not looking for work in Australia in registered profession
72. Retired from registered profession in Australia

The employed category excludes those only engaged in unpaid and/or voluntary activities.

Not employed in Australia includes those who are not employed at all and those who are only employed outside Australia.

Collection methods: Data elements in this cluster comprise five key labour force concepts for the registered profession:

- Country of employment
- Extended leave status
- Jobseeker status
- Labour force status
- Retirement status

It is not necessary to collect these concepts as separate questions. Instead, they are best combined to form the response categories to a set of survey questions.

The following questions are an example of how the separate data elements from this cluster should be used together. They identify the labour force status of a health professional in the registered profession in the last week.

1. Last week, were you:

- Working in the registered profession in Australia? (continue with questionnaire)
- Employed in the registered profession but within a period of leave for 3 months or more? (thank you, nothing further)
- Working in the registered profession overseas? (go to question 2)
- Working, but not in the profession? (go to question 2)
- Not working in paid employment at all? (go to question 2)

2. Last week, did you take active steps to look for work in the registered profession in Australia?

Active steps include: applying for work in the profession, enquiring about a job, answering an advertisement, registering with an employment agency, advertising for work or contacting people in the profession about a job.

- No, I am retired from regular work
- No, not at all
- Yes, I looked for work (either full-time or part-time)

Thank you - no further questions

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Health professional-labour force status cluster Health, Superseded 10/12/2009

Implementation in Data Set Specification:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Country of employment in registered profession	Optional	1
-	Employment status - health professional	Optional	1
-	Extended leave status in registered profession	Optional	1
-	Jobseeker status in registered profession	Optional	1
-	Retirement status in registered profession	Optional	1

Main job of registered chiropractor cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	383989
Registration status:	Health, Standard 10/12/2009
DSS type:	Data Element Cluster

Scope:

The main job of registered chiropractors who were employed in the profession during the reference week.

The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit:

The statistical unit for this data set is the Registered chiropractor.

A Registered chiropractor refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a chiropractor at any time during the reference period.

Guide for use:

Data elements in this cluster assist in describing the type and distribution of services of registered chiropractors in their main job. This cluster forms part of the Registered chiropractic labour force DSS, along with *Second job of registered chiropractor* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected from all chiropractors employed in the profession. Data elements in the *Second job of registered chiropractor* cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered chiropractic labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.

The main job:

- includes time spent travelling to home visits or calls out;
- excludes other time travelling between work locations; and
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Second job of registered chiropractor cluster Health, Standard 10/12/2009

Implementation in Data Set Specification: Registered chiropractic labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - chiropractor	Optional	1

Main job of registered dental and allied dental health professional cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 383991

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: The main job of registered dental and allied dental health professionals who were employed in the profession during the reference week.

The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered dental and allied dental health professional.

A Registered dental and allied dental health professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a dental or allied dental health professional at any time during the reference period.

Guide for use: Data elements in this cluster assist in describing the type and distribution of services of registered dental and allied dental professionals in their main job. This cluster forms part of the Registered dental and allied dental labour force DSS, along with *Second job of registered dental and allied dental professionals* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected from all dental and allied dental professionals employed in the profession. Data elements in the *Second job of registered dental and allied dental professionals* cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered dental and allied dental labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.

The main job:

- includes time spent travelling to home visits or calls out;
- excludes other time travelling between work locations; and
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Second job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Implementation in Data Set Specification: Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of practice - dental	Conditional	0
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - dental	Optional	1

Main job of registered medical professional cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 375513

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: The main job of registered medical professionals who were employed in the profession during the reference week.

The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered medical professional.

A Registered medical professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a medical practitioner, medical specialist or medical specialist-in-training at any time during the reference period.

Guide for use: Data elements in this cluster assist in describing the type and distribution of services of registered medical professionals in their main job. This cluster forms part of the Registered medical professional labour force DSS, along with *Second job of registered medical professional* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected from all medical professionals employed in the profession. Data elements in the *Second job of registered medical professional* cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered medical professional labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.

The main job:

- includes time spent travelling to home visits or calls out;
- excludes other time travelling between work locations; and
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Second job of registered medical professional cluster Health, Standard 10/12/2009

Implementation in Data Set Specification: Registered medical professional labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons who are employed in the registered profession.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - medical practitioner	Optional	1

Main job of registered midwife cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	384011
Registration status:	Health, Standard 10/12/2009
DSS type:	Data Element Cluster

Scope:

The main job of registered midwives who were employed in the profession during the reference week.

The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit:

The statistical unit for this data set is the Registered midwife.

A Registered midwife refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a midwife at any time during the reference period.

Guide for use:

Data elements in this cluster assist in describing the type and distribution of services of registered midwives in their main job. This cluster forms part of the Registered midwifery labour force DSS, along with *Second job of registered midwife* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected from all midwives employed in the profession. Data elements in the *Second job of registered midwife* cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered midwifery labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.

The main job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Second job of registered midwife cluster Health, Standard 10/12/2009

Implementation in Data Set Specification: Registered midwifery labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of practice - midwifery	Conditional	0
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - midwife	Optional	1

Main job of registered nursing professional cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	383993
Registration status:	Health, Standard 10/12/2009
DSS type:	Data Element Cluster
Scope:	The main job of registered nursing professionals who were employed in the profession during the reference week. The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit:	The statistical unit for this data set is the Registered nursing professional. A Registered nursing professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a nurse at any time during the reference period.
Guide for use:	Data elements in this cluster assist in describing the type and distribution of services of registered nursing professionals in their main job. This cluster forms part of the Registered nursing labour force DSS, along with *Second job of registered nursing professional* cluster, *Work setting hours* cluster, and a range of other data elements. Data elements in this cluster are collected from all nursing health professionals employed in the profession. Data elements in the *Second job of registered nursing professional* cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered nursing labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.

The main job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Second job of registered nursing professional cluster Health, Standard 10/12/2009

Implementation in Data Set Specification: Registered nursing professional labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of practice - nursing	Conditional	0
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - nurse	Optional	1

Main job of registered optometrist cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 383998

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: The main job of registered optometrists who were employed in the profession during the reference week.

The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered optometrist.

A Registered optometrist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as an optometrist at any time during the reference period.

Guide for use: Data elements in this cluster assist in describing the type and distribution of services of registered optometrists in their main job. This cluster forms part of the Registered optometry labour force DSS, along with *Second job of registered optometrist* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected from all optometrists employed in the profession. Data elements in the *Second job of registered optometrist* cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered optometry labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.

The main job:

- includes time spent travelling to home visits or calls out;
- excludes other time travelling between work locations; and
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Second job of registered optometrist cluster Health, Standard 10/12/2009

Implementation in Data Set Specification: Registered optometry labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - optometrist	Optional	1

Main job of registered osteopath cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	384000
Registration status:	Health, Standard 10/12/2009
DSS type:	Data Element Cluster

Scope:

The main job of registered osteopaths who were employed in the profession during the reference week.

The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit:

The statistical unit for this data set is the Registered osteopath.

A Registered osteopath refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as an osteopath at any time during the reference period.

Guide for use:

Data elements in this cluster assist in describing the type and distribution of services of registered osteopaths in their main job. This cluster forms part of the Registered osteopathy labour force DSS, along with *Second job of registered osteopath* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected from all osteopaths employed in the profession. Data elements in the *Second job of registered osteopath* cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered osteopathy labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.

The main job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Second job of registered osteopath cluster Health, Standard 10/12/2009

Implementation in Data Set Specification: Registered osteopathy labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - osteopath	Optional	1

Main job of registered pharmacist cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	384002
Registration status:	Health, Standard 10/12/2009
DSS type:	Data Element Cluster

Scope:

The main job of registered pharmacists who were employed in the profession during the reference week.

The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit:

The statistical unit for this data set is the Registered pharmacist.

A Registered pharmacist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a pharmacist at any time during the reference period.

Guide for use:

Data elements in this cluster assist in describing the type and distribution of services of registered pharmacists in their main job. This cluster forms part of the Registered pharmacy labour force DSS, along with *Second job of registered pharmacist* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected from all pharmacists employed in the profession. Data elements in the *Second job of registered pharmacist* cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered pharmacy labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.

The main job:

- includes time spent travelling to home visits or calls out;

- excludes other time travelling between work locations; and
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Second job of registered pharmacist cluster Health, Standard 10/12/2009

Implementation in Data Set Specification: Registered pharmacy labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - pharmacist	Optional	1

Main job of registered physiotherapist cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 383995

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: The main job of registered physiotherapists who were employed in the profession during the reference week.

The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered physiotherapist.

A Registered physiotherapist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a physiotherapist at any time during the reference period.

Guide for use: Data elements in this cluster assist in describing the type and distribution of services of registered physiotherapists in their main job. This cluster forms part of the Registered physiotherapy labour force DSS, along with *Second job of registered physiotherapist* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected from all physiotherapists employed in the profession. Data elements in the *Second job of registered physiotherapist* cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered physiotherapy labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.

The main job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Second job of registered physiotherapist cluster Health, Standard 10/12/2009

Implementation in Data Set Specification: Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - physiotherapist	Optional	1

Main job of registered podiatrist cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384005

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: The main job of registered podiatrists who were employed in the profession during the reference week.

The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered podiatrist.

A Registered podiatrist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a podiatrist at any time during the reference period.

Guide for use: Data elements in this cluster assist in describing the type and distribution of services of registered podiatrists in their main job. This cluster forms part of the Registered podiatry labour force DSS, along with *Second job of registered podiatrist* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected from all podiatrists employed in the profession. Data elements in the *Second job of registered podiatrist* cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered podiatry labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.

The main job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Second job of registered podiatrist cluster Health, Standard 10/12/2009

Implementation in Data Set Specification: Registered podiatry labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - podiatrist	Optional	1

Main job of registered psychologist cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384009

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: The main job of registered psychologists who were employed in the profession during the reference week.

The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered psychologist.

A Registered psychologist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a psychologist at any time during the reference period.

Guide for use: Data elements in this cluster assist in describing the type and distribution of services of registered psychologists in their main job. This cluster forms part of the Registered psychology labour force DSS, along with *Second job of registered psychologist* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected from all psychologists employed in the profession. Data elements in the *Second job of registered psychologist* cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered psychology labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.

The main job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Second job of registered psychologist cluster Health, Standard 10/12/2009

Implementation in Data Set Specification: Registered psychology labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of practice - psychology	Conditional	0
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - psychologist	Optional	1

Non-school qualification cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 413211

Registration status: Health, Standard 25/08/2011

DSS type: Data Element Cluster

Scope: These data elements are used in conjunction with each other to determine whether a person has a non-school qualification and if so, the level of that qualification.

Collection and usage attributes

Guide for use: The Non-school qualification cluster comprises two data elements that determine a person's non-school-qualification.

This is achieved through the combination of the two data elements: *Person—non-school qualification indicator, yes/no/not stated/inadequately described code N* and *Person—level of highest non-school qualification, code N*.

The Non-school qualification cluster describes the following information:

Data element		
Non-school qualification indicator	Yes	No
Level of non-school qualification	Code N	N/A

N/A is not applicable.

Collection methods: Information on a prison entrant's non-school qualifications is collected as part of the reception assessment on the National Prisoner Health Census Prison Entrants form.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Prison entrants DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Non-school qualification indicator	Mandatory	1
2	Level of highest non-school qualification	Conditional	1

Opioid pharmacotherapy treatment cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 407265

Registration status: Health, Standard 25/08/2011

DSS type: Data Element Cluster

Scope: These data items are used in conjunction to determine:

- the number of prison entrants who have been on, or are currently on, an opioid pharmacotherapy treatment program; and
- the type of opioid pharmacotherapy treatment program a prison entrant has been on, or is on currently.

Collection and usage attributes

Guide for use: Opioid pharmacotherapy treatment (OPT) is a form of treatment for heroin or opiate dependence using prescribed opioid agonists, which have some properties similar or identical to those of heroin and morphine, including the effect on the brain, which alleviate withdrawal symptoms and block the craving for illicit opiates. The most common form of opioid pharmacotherapy treatment is methadone maintenance treatment. However, buprenorphine is also quite common in some countries (Kastelic et al. 2008).

The OPT program cluster comprises three data elements which provide information on a person's current and past OPT programs:
Person—previous opioid pharmacotherapy treatment program indicator, yes/no code N
Person—current opioid pharmacotherapy treatment program indicator, yes/no code N and
Person—type of opioid pharmacotherapy treatment, code N.

OPT program	Methadone	Methadone	Other	Other
	Current	Previous	Current	Previous
	Y/N	Y/N	Y/N	Y/N
	Y/N	Y/N	Y/N	Y/N

Never				

Collection methods: Data is collected at the reception assessment on the National Prisoner Health Census Prison Entrants form. Respondents may respond 'yes' to both 'on it now' and 'in the past'.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Kastelic A, Pont J & Stover H 2008. Opioid substitution treatment in custodial settings: a practical guide. Oldenburg: BIS-Verlag.

Relational attributes

Implementation in Data Set Specification: Prison entrants DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Previous opioid pharmacotherapy treatment program indicator	Mandatory	1
2	Current opioid pharmacotherapy treatment program indicator	Mandatory	1
3	Type of opioid pharmacotherapy treatment	Conditional	2

Pregnancy status cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	413204
Registration status:	Health, Standard 25/08/2011
DSS type:	Data Element Cluster
Scope:	These data elements are used in conjunction with each other to determine whether a female prison entrant has ever been pregnant and if so, the age of her first pregnancy.

Collection and usage attributes

Guide for use:

The Pregnancy status cluster comprises two data elements that allow a female's pregnancy history to be determined.

This is achieved by the combination of the two data elements: *Female—ever been pregnant indicator, yes/no/not stated/inadequately described code N* and *Female—age at first pregnancy, total years N[N]*.

The Pregnancy status cluster describes the following information:

Data element		
Ever been pregnant	Yes	No
Age at first pregnancy	N[N]	N/A

N/A is not applicable.

Collection methods:

Information on a prison entrant's pregnancy history is collected at the reception assessment on the National Prisoner Health Census Prison Entrants form.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification:	Prison entrants DSS Health, Standard 25/08/2011

Conditional obligation:
This cluster is conditional on the respondent being female.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Ever been pregnant indicator	Mandatory	1
2	Age at first pregnancy	Conditional	1

Prisoner health discharge summary cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 412281

Registration status: Health, Standard 25/08/2011

DSS type: Data Element Cluster

Scope: These data elements are used in conjunction with each other to determine:

- the number of sentenced and remand prisoners that were released from a prison during the National Prisoner Health Census period and
- the number of sentenced and remand prisoners who have a health-related discharge summary on file at the time of their release.

Collection and usage attributes

Guide for use: The Prisoner health discharge summary cluster combines the three data elements: *Person—prisoner health discharge summary indicator, yes/no code N, Person—legal status of prisoner, code N* and *Establishment (prison)—number of prisoners released, number N[NN]* to describe the number and type of prisoners who have a discharge summary on file when they are released from prison.

The Prisoner health discharge summary cluster describes the following information:

Detention status	Discharge summary indicator	Number
Remand[a]	Yes	N
Remand	No	N
Sentenced[b]	Yes	N
Sentenced	No	N

(a) Remand prisoners are persons who have been placed in custody while awaiting the outcome of a court hearing.

(b) Sentenced prisoners are those persons who have received a term of imprisonment from a court. This includes offenders who have been given an indeterminate sentence or custodial order, for example, forensic patients, or those who have received a life sentence.

Note: The number of prisoners who were released from a prison during the National Prisoner Health Census period does not include transfers to other prisons.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Prison establishments DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Legal status of prisoner	Mandatory	1
-	Number of prisoners released	Mandatory	1
-	Prisoner health discharge summary indicator	Mandatory	1

Radiotherapy for cancer cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	418354
Registration status:	Health, Standard 07/12/2011
DSS type:	Data Element Cluster

Scope:

The radiotherapy cluster consists of those data elements recommended for collection as best practice when the patient receives radiotherapy as part of the initial course of treatment for cancer. The radiotherapy cluster collects information on the radiotherapy type, dose, fractions, target site and the start and finish dates for each course of treatment.

Information on the type, dose, fractions and target site of radiotherapy is required to evaluate patterns of care, the effectiveness of different treatment modalities and treatment by patient outcome. Collecting the start and finish dates will enable an estimate of the duration of radiotherapy and the time interval from diagnosis to treatment.

The use of standard definitions and formats supports the consistent collection and management of data and enables the integration of data from different sources. It provides a common language facilitating the interpretation and analysis of results, data linkage for statistical purposes, longitudinal studies and patient patterns of care and outcome studies. These results may then inform professional guidelines and training, quality assurance and the planning and evaluation of cancer control activities, potentially improving outcomes for patients.

Collection and usage attributes

Guide for use:

Capturing the radiotherapy dose and fractions is problematic at some target sites, for example, head and neck cancers and breast cancers. In these cases, treatment is complex with the use of multiple treatment fields and the overall total dose may need to be determined manually by the radiation oncologist.

Collection methods:

The radiotherapy type, dose, fractions, target site and start and finish dates are recorded for each course of radiotherapy the patient received during the initial course of treatment for cancer regardless of treatment intent or timing.

The data element *Healthcare provider—organisation identifier, N(16)* may be recorded for each treatment. It is recommended that, wherever possible, the database be configured to allow entry of different healthcare provider identifiers for each therapeutic course of treatment.

The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

Information regarding radiotherapy will typically be found in the radiation oncologist's summary letter for the initial course of treatment

Determining the total dose, number of fractions and target site of radiotherapy may require assistance from the radiation oncologist for consistent coding.

Source and reference attributes

Submitting organisation: Cancer Australia

Relational attributes

Related metadata references: See also Cancer treatment—cancer treatment type, code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specification: Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on the patient receiving radiotherapy.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Radiation dose administered	Mandatory	99
-	Radiotherapy completion date	Mandatory	99
-	Radiotherapy fractions administered	Mandatory	99
-	Radiotherapy start date	Mandatory	99
-	Radiotherapy target site	Mandatory	99
-	Radiotherapy treatment type	Mandatory	99

Second job of registered chiropractor cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384019

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: The second job of registered chiropractors who were employed in more than one job in the profession during the reference week.

The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered chiropractor.

A Registered chiropractor refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a chiropractor at any time during the reference period.

Guide for use: Data elements in this cluster assist in describing the type and distribution of services of registered chiropractors in their second job. The cluster forms part of the Registered chiropractic labour force DSS, along with *Main job of registered chiropractor* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected only from those chiropractors employed in more than one job in the profession. Data elements in the *Main job of registered chiropractor* cluster are collected from all chiropractors employed in the profession. All other workforce data elements in the Registered chiropractic labour force DSS are collected from all chiropractors registered in the profession, and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.

The second job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Registered chiropractic labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - chiropractor	Optional	1

Second job of registered dental and allied dental health professional cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384016

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: The second job of registered dental and allied dental health professionals who were employed in more than one job in the profession during the reference week.

The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered dental and allied dental health professional.

A Registered dental and allied dental health professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a dental and allied dental health professional at any time during the reference period.

Guide for use: Data elements in this cluster assist in describing the type and distribution of services of registered dental and allied dental health professionals in their second job. The cluster forms part of the Registered dental and allied dental labour force DSS, along with *Main job of registered dental and allied dental health professional* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected only from those dental and allied dental health professionals employed in more than one job in the profession. Data elements in the *Main job of registered dental and allied dental health professional* cluster are collected from all dental and allied dental health professionals employed in the profession. All other workforce data elements in the Registered dental and allied dental labour force DSS are collected from all dental and allied dental health professionals registered in the profession, and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.

The second job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Implementation in Data Set Specification: Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of practice - dental	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - dental	Optional	1

Second job of registered medical professional cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 375561

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: The second job of registered medical professionals who were employed in more than one job in the profession during the reference week.

The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered medical professional.

A Registered medical professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a medical practitioner, medical specialist or medical specialist-in-training at any time during the reference period.

Guide for use: Data elements in this cluster assist in describing the type and distribution of services of registered medical professionals in their second job. The cluster forms part of the Registered medical labour force DSS, along with *Main job of registered medical professional* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected only from those medical professionals employed in more than one job in the profession. Data elements in the *Main* *job of registered medical professional* cluster are collected from all medical professionals employed in the profession. All other workforce data elements in the Registered medical labour force DSS are collected from all medical professionals registered in the profession, and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.

The second job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Registered medical professional labour force DSS
Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons who work in more than one job in the registered profession

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1

-	Work setting - medical practitioner	Optional	1

Second job of registered midwife cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384021

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: The second job of registered midwives who were employed in more than one job in the profession during the reference week.

The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered midwife.

A Registered midwife refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a midwife at any time during the reference period.

Guide for use: Data elements in this cluster assist in describing the type and distribution of services of registered midwives in their second job. The cluster forms part of the Registered midwifery labour force DSS, along with *Main job of registered midwife* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected only from those midwives employed in more than one job in the profession. Data elements in the *Main job of registered midwife* cluster are collected from all midwives employed in the profession. All other workforce data elements in the Registered midwifery labour force DSS are collected from all midwives registered in the profession, and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.

The second job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Registered midwifery labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of practice - midwifery	Conditional	0
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - midwife	Optional	1

Second job of registered nursing professional cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384013

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: The second job of registered nursing professionals who were employed in more than one job in the profession during the reference week.

The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered nursing professional.

A Registered nursing professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a nursing professional at any time during the reference period.

Guide for use: Data elements in this cluster assist in describing the type and distribution of services of registered nursing professionals in their second job. The cluster forms part of the Registered nursing labour force DSS, along with *Main job of registered nursing professional* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected only from those nursing professionals employed in more than one job in the profession. Data elements in the *Main job of registered nursing professional* cluster are collected from all nursing professionals employed in the profession. All other workforce data elements in the Registered nursing labour force DSS are collected from all nursing professionals registered in the profession, and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.

The second job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Registered nursing professional labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of practice - nursing	Conditional	0
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - nurse	Optional	1

Second job of registered optometrist cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	384024
Registration status:	Health, Standard 10/12/2009
DSS type:	Data Element Cluster

Scope:

The second job of registered optometrists who were employed in more than one job in the profession during the reference week.

The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit:

The statistical unit for this data set is the Registered optometrist.

A Registered optometrist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as an optometrist at any time during the reference period.

Guide for use:

Data elements in this cluster assist in describing the type and distribution of services of registered optometrists in their second job. The cluster forms part of the Registered optometry labour force DSS, along with *Main job of registered optometrist* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected only from those optometrists employed in more than one job in the profession. Data elements in the *Main job of registered optometrist* cluster are collected from all optometrists employed in the profession. All other workforce data elements in the Registered optometry labour force DSS are collected from all optometrists registered in the profession, and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.

The second job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Registered optometry labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - optometrist	Optional	1

Second job of registered osteopath cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	384026
Registration status:	Health, Standard 10/12/2009
DSS type:	Data Element Cluster

Scope:

The second job of registered osteopaths who were employed in more than one job in the profession during the reference week.

The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit:

The statistical unit for this data set is the Registered osteopath.

A Registered osteopath refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as an osteopath at any time during the reference period.

Guide for use:

Data elements in this cluster assist in describing the type and distribution of services of registered osteopaths in their second job. The cluster forms part of the Registered osteopathy labour force DSS, along with *Main job of registered osteopath* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected only from those osteopaths employed in more than one job in the profession. Data elements in the *Main job of registered osteopath* cluster are collected from all osteopaths employed in the profession. All other workforce data elements in the Registered osteopathy labour force DSS are collected from all osteopaths registered in the profession, and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.

The second job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Registered osteopathy labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - osteopath	Optional	1

Second job of registered pharmacist cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384028

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: The second job of registered pharmacists who were employed in more than one job in the profession during the reference week.

The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered pharmacist.

A Registered pharmacist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a pharmacist at any time during the reference period.

Guide for use: Data elements in this cluster assist in describing the type and distribution of services of registered pharmacists in their second job. The cluster forms part of the Registered pharmacy labour force DSS, along with *Main job of registered pharmacist* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected only from those pharmacists employed in more than one job in the profession. Data elements in the *Main job of registered pharmacist* cluster are collected from all pharmacists employed in the profession. All other workforce data elements in the Registered pharmacy labour force DSS are collected from all pharmacists registered in the profession, and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.

The second job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Registered pharmacy labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - pharmacist	Optional	1

Second job of registered physiotherapist cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	384030
Registration status:	Health, Standard 10/12/2009
DSS type:	Data Element Cluster
Scope:	The second job of registered physiotherapists who were employed in more than one job in the profession during the reference week. The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit:	The statistical unit for this data set is the Registered physiotherapist. A Registered physiotherapist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a physiotherapist at any time during the reference period.
Guide for use:	Data elements in this cluster assist in describing the type and distribution of services of registered physiotherapists in their second job. The cluster forms part of the Registered physiotherapy labour force DSS, along with *Main job of registered physiotherapist* cluster, *Work setting hours* cluster, and a range of other data elements. Data elements in this cluster are collected only from those physiotherapists employed in more than one job in the profession. Data elements in the *Main job of registered physiotherapist* cluster are collected from all physiotherapists employed in the profession. All other workforce data elements in the

Registered physiotherapy labour force DSS are collected from all physiotherapists registered in the profession, and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.

The second job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - physiotherapist	Optional	1

Second job of registered podiatrist cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384032

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: The second job of registered podiatrists who were employed in more than one job in the profession during the reference week.

The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered podiatrist.

A Registered podiatrist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a podiatrist at any time during the reference period.

Guide for use: Data elements in this cluster assist in describing the type and distribution of services of registered podiatrists in their second job. The cluster forms part of the Registered podiatry labour force DSS, along with *Main job of registered podiatrist* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected only from those podiatrists employed in more than one job in the profession. Data elements in the *Main job of registered podiatrist* cluster are collected from all podiatrists employed in the profession. All other workforce data elements in the Registered podiatry labour force DSS are collected from all podiatrists registered in the profession, and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.

The second job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Registered podiatry labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - podiatrist	Optional	1

Second job of registered psychologist cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 384034

Registration status: Health, Standard 10/12/2009

DSS type: Data Element Cluster

Scope: The second job of registered psychologists who were employed in more than one job in the profession during the reference week.

The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.

Collection and usage attributes

Statistical unit: The statistical unit for this data set is the Registered psychologist.

A Registered psychologist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulatory Agency as a psychologist at any time during the reference period.

Guide for use: Data elements in this cluster assist in describing the type and distribution of services of registered psychologists in their second job. The cluster forms part of the Registered psychology labour force DSS, along with *Main job of registered psychologist* cluster, *Work setting hours* cluster, and a range of other data elements.

Data elements in this cluster are collected only from those psychologists employed in more than one job in the profession. Data elements in the *Main job of registered psychologist* cluster are collected from all psychologists employed in the profession. All other workforce data elements in the Registered psychology labour force DSS are collected from all psychologists registered in the profession, and relate to all jobs held in the profession.

Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.

The second job:

- includes time spent travelling to home visits or calls out;
-
- excludes other time travelling between work locations; and
-
- excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Main job of registered psychologist cluster Health, Standard 10/12/2009

Implementation in Data Set Specification: Registered psychology labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of practice - psychology	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Postcode—Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - psychologist	Optional	1

Sex of prison entrants cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	412252
Registration status:	Health, Standard 25/08/2011
DSS type:	Data Element Cluster
Scope:	These data elements are used in conjunction with each other to describe the number of male and female prison entrants into a prison during the National Prisoner Health Census period.

Collection and usage attributes

Guide for use:

The Sex of prison entrants cluster comprises two data elements which allow data on the number of male and female prison entrants into a prison during the National Prisoner Health Census period to be determined.

This is achieved by the combination of the two data elements: *Establishment (prison)—number of prison entrants, number N[NN]* and *Person—sex, code N*.

The Sex of prison entrants cluster describes the following information:

Sex	Number of prison entrants
Male	N[NN]
Female	N[NN]

Comments:

The number and sex of prisoners entering Australia's prisons during the National Prisoner Health Census period will be used to derive statistics on the demographic characteristics of prison entrants.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Prison establishments DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Number of prison entrants	Mandatory	1
-	Sex	Mandatory	3

Smoking status cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 413060

Registration status: Health, Standard 25/08/2011

DSS type: Data Element Cluster

Scope: These data elements are used in conjunction with each other to determine the history and current smoking status of a person.

Collection and usage attributes

Guide for use: The Smoking status cluster comprises four data elements that, in combination, determine a person's current smoking status and history of tobacco use.

This is achieved by the combination of the four data elements: *Person—ever smoked a full cigarette indicator, yes/no/not stated/inadequately described code N*; *Person—tobacco smoking start age, total years N[NN]*; *Person—current smoking status indicator, yes/no/not stated/inadequately described code N* and *Person—tobacco smoking frequency, current tobacco smoking frequency code N*.

The Smoking status cluster describes the following information:

Data element		
Ever smoked a full cigarette	Yes	No
Tobacco smoking start age	N[NN]	N/A
Current smoking status	Yes/No	N/A
Tobacco smoking frequency	Code N	N/A

N/A is not applicable.

Collection methods: Information on a prison entrant's smoking status and history are collected at the reception assessment on the National Prisoner Health Census Prison Entrants form.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: Prison entrants DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Ever smoked a full cigarette indicator	Mandatory	1
2	Tobacco smoking start age	Conditional	1
3	Current smoking status	Conditional	1
4	Tobacco smoking frequency	Conditional	1

Statistical linkage key 581 cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 349510

Registration status:
Community Services, Standard 21/05/2010
Housing assistance, Standard 23/08/2010
Health, Standard 07/12/2011
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

DSS type: Data Element Cluster

Scope: Statistical data linkage refers to the bringing together of data from different sources to gain a greater understanding of a situation or individual from the combined (or linked) dataset. This facilitates a better understanding of the patterns of service use by groups of clients for research, statistical or policy analysis, planning and evaluation purposes.

Its form is: **XXXXXDDMMYYYYN**

The sequence in which the linkage key is completed is as follows:

Family name (the first 3 Xs)

Given name (the 4th and 5th X)

Date of birth by day, month and four-digit year

Sex

XXX 2nd, 3rd and 5th letters of the family name.

In the first three spaces the agency should record the 2nd, 3rd and 5th letters of the client's family name.

For example: If the client's family name is Smith the reported value should be MIH. If the client's family name is Jones the reported value should be ONS.

Regardless of the length of a person's name, the reported value should always be three characters long. If the legal family name is not long enough to supply the requested letters (i.e. a legal family name of less than five letters) then agencies should substitute the number '2' to reflect the missing letters. The placement of a number '2' should always correspond to the same space that the missing letter would have within the 3-digit field. A number (rather than a letter) is used for such a substitution in order to clearly indicate that an appropriate corresponding letter from the person's name is not available.

Cases where the family name has less than 5 letters:

If a person's family name is Farr, then value reported would be AR2 because the 2 is substituting for a missing 5th letter of the family name. Similarly, if the person's family name was Hua, then the value reported would be UA2 because the 2 is substituting for the missing 5th letter of the family name.

If a client's family name is missing altogether the agency should record the number 999 for all three spaces associated with the family name, (not the number 2). In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies should always ask the person to specify their legal first given name and their legal family name separately. These should then be recorded as first given name and family name as appropriate, regardless of the order in which they may be traditionally given.

If the client's family name includes non-alphabetic characters—for example hyphens (as in Lee-Archer), apostrophes (as in O'Mara) or blank spaces (as in De Vries)—these non-alphabetic characters should be ignored when counting the position of each character.

XX 2nd and 3rd letters of given name

In the fourth and fifth spaces the agency should record the 2nd and 3rd letters of the client's given name.

For example: If the client's given name is Elizabeth the reported value should be LI. If the client's given name is Robert the reported value should be OB.

If the client's given name includes non-alphabetic characters—for example hyphens (as in Jo-Anne) or apostrophes (as in D'Arcy), these non-alphabetic characters should be ignored when counting the position of each character.

Regardless of the length of a person's given name, the reported value should always be two characters long. If the given name of the person is not long enough to supply the requested letters (i.e. a name of less than three letters) then agencies should substitute the number '2' to reflect the missing letters. The placement of a number '2' should always correspond to the same space that the missing letter would have within the 2-digit field. A number (rather than a letter) is used for such substitutions in order to clearly indicate that an appropriate corresponding letter from the person’s name is not available.

For example: If the person’s legal name was Jo then the value reported would be O2 because the 2 is substituting for the missing 3rd letter of the given name.

If the person’s given name is missing altogether the agency should record 99 for the two spaces associated with the given name. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies should always ask the person to specify their given name and their family name separately. These should then be recorded as first given name and family name as appropriate, regardless of the order in which they may be traditionally given.

Date of Birth

DD represents the day in the month a person was born

MM represents the month in the year a person was born

YYYY represents the year a person was born

If date of birth is not known or cannot be obtained, provision should be made to collect or estimate age. Collected or estimated age would usually be in years for adults and to the nearest three months (or less) for children aged less than two years. Additionally, an estimated date flag or a date accuracy indicator should be reported in conjunction with all estimated dates of birth.

For data collections concerned with children’s services, it is suggested that the estimated date of birth of children aged under 2 years should be reported to the nearest 3 month period, i.e. 0101, 0104, 0107, 0110 of the estimated year of birth. For example, a child who is thought to be aged 18 months in October of one year would have his/her estimated date of birth reported as 0104 of the previous year. Again, an estimated date flag or date accuracy indicator http://meteor.aihw.gov.au/content/index.phtml/itemId/294429 should be reported in conjunction with all estimated dates of birth.

Sex

N represents whether or not the person is a 1. Male or 2. Female.

Operationally, sex is the distinction between male and female, as reported by a person or as determined by an interviewer.

When collecting data on sex by personal interview, asking the sex of the respondent is usually unnecessary and may be inappropriate, or even offensive. It is usually a simple matter to infer the sex of the respondent through observation, or from other cues such as the relationship of the person(s) accompanying the respondent, or first name. The interviewer may ask whether persons not present at the interview are male or female.

A person's sex may change during their lifetime as a result of procedures known alternatively as sex change, gender reassignment, transsexual surgery, transgender reassignment or sexual reassignment. Throughout this process, which may be over a considerable period of time, the person's sex could be recorded as either Male or Female.

In data collections that use the ICD-10-AM classification, where sex change is the reason for admission, diagnoses should include the appropriate ICD-10-AM code(s) that clearly identify that the person is undergoing such a process. This code(s) would also be applicable after the person has completed such a process, if they have a procedure involving an organ(s) specific to their previous sex (e.g. where the patient has prostate or ovarian cancer).

Code 3 Intersex or indeterminate

Is normally used for babies for whom sex has not been determined for whatever reason.

Should not generally be used on data collection forms completed by the respondent.

Should only be used if the person or respondent volunteers that the person is intersex or where it otherwise becomes clear during the collection process that the individual is neither male nor female.

Code 9 Not stated/inadequately described

Is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Data that has been produced by linkage for statistical and research purposes should not be used subsequently for client management purposes.

This data cluster contains a set of specific data elements to be reported on in a predetermined combination.

Collection and usage attributes

Guide for use: Where a date of birth is estimated the date accuracy indicator should be used. Please see Relational attributes.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare.

Steward: Australian Institute of Health and Welfare

Origin: AIHW 1998. Home and Community Care (HACC) Data Dictionary Version 1.0. Report prepared for the Commonwealth and State/Territory government HACC Officials.

Reference documents: NCSIMG 2001. Statistical Data Linkage in Community Services Data Collections. Canberra: Australian Institute of Health and Welfare.

Relational attributes

Related metadata references: See also Date—accuracy indicator, code AAA Community Services, Standard 30/09/2005, Housing assistance, Standard 23/08/2010, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Implementation in Data Set Specification: Alcohol and other drug treatment services NMDS 2012-2013 Health, Standard 07/12/2011

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Letters of family name	Mandatory	1
2	Letters of given name	Mandatory	1
3	Date of birth	Mandatory	1
4	Sex	Mandatory	1
5	Statistical linkage key 581	Mandatory	1
6	Date accuracy indicator	Conditional	1

Substances used illicitly cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	413192
Registration status:	Health, Standard 25/08/2011
DSS type:	Data Element Cluster
Scope:	These data elements are used in conjunction with each other to provide information on the type of substances a person has used illicitly in the last 12 months.

Collection and usage attributes

Guide for use:

The Substances used illicitly cluster comprises two data elements that capture information whether a person has possessed an illegal substance, or used a substance in an illegal manner, and the type of substance used illicitly.

These two data elements are: *Person—substance used illicitly indicator, yes/no/not stated/inadequately described code N* and *Person—type of substance used illicitly, drug of concern (ASCDC 2000 extended) code NNNN.*

Collection methods:

Information is collected at the reception assessment on the National Prisoner Health Census Prison Entrants form. This information is based on self-reporting.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification:	Prison entrants DSS Health, Standard 25/08/2011

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Substance used illicitly indicator	Mandatory	1
2	Type of substance used illicitly	Conditional	99

Surgery for cancer cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	418356
Registration status:	Health, Standard 07/12/2011
DSS type:	Data Element Cluster

Scope:

Cancer-directed surgery is surgery that destroys or modifies cancer tissue anywhere in the body and includes biopsies that remove the entire tumour and/or leave only microscopic margins. It may be palliative, (to control symptoms, alleviate pain, or make the patient more comfortable), or curative.

The surgery treatment cluster consists of those data elements recommended for collection as best practice when cancer-directed surgery is performed as part of the initial course of treatment for cancer. The surgery treatment cluster collects information on the target sites of surgery, the procedure types and the date of each procedure.

Information on target sites and procedures is required to evaluate patterns of care, the effectiveness of different treatment modalities and treatment by patient outcome. Collecting the procedure dates will enable an estimate of the time interval from diagnosis to treatment.

The use of standard definitions and formats supports the consistent collection and management of data and enables the integration of data from different sources. It provides a common language facilitating the interpretation and analysis of results, data linkage for statistical purposes, longitudinal studies and patient patterns of care and outcome studies. These results may then inform professional guidelines and training, quality assurance and the planning and evaluation of cancer control activities, potentially improving outcomes for patients.

Collection and usage attributes

Collection methods:

All cancer-directed surgery performed during the initial course of treatment is recorded regardless of treatment intent or timing.

The data element *Healthcare provider—organisation identifier, N(16)* may be recorded for each treatment. It is recommended that, wherever possible, the database be configured to allow entry of different healthcare provider identifiers for each therapeutic course of treatment.

The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

This information should be collected from the patient's medical record.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Relational attributes

Related metadata references: See also Cancer treatment—cancer treatment type, code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specification: Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on the patient receiving cancer-directed surgery.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Surgery target site	Mandatory	99
-	Surgical procedure date	Mandatory	99
-	Surgical procedure for cancer	Mandatory	99

Systemic therapy procedure for cancer cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 418358

Registration status: Health, Standard 07/12/2011

DSS type: Data Element Cluster

Scope: Systemic therapy procedures refers to haematologic transplant and endocrine procedures. Haematologic transplants are bone marrow or stem cell transplants performed to protect patients from myelosuppression or bone marrow ablation associated with the administration of high-dose chemotherapy or radiotherapy.

Endocrine therapy is cancer therapy that achieves its antitumour effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient (when the cancer occurs at another site) and, therefore, alter or affect the long-term control of the cancer’s growth.

The systemic therapy procedure cluster consists of those data elements recommended for collection as best practice when the patient receives a systemic therapy procedure as part of the initial course of treatment for cancer.
The systemic therapy procedure cluster collects information on the systemic therapy procedure type and the dates of treatment.

Information on the systemic procedure type is required to evaluate patterns of care, the effectiveness of different treatment modalities and treatment by patient outcome. Collecting the procedure dates will enable an estimate of the time interval from diagnosis to treatment.

The use of standard definitions and formats supports the consistent collection and management of data and enables the integration of data from different sources. It provides a common language facilitating the interpretation and analysis of results, data linkage for statistical purposes, longitudinal studies and patient patterns of care and outcome studies. These results may then inform professional guidelines and training, quality assurance and the planning and evaluation of cancer control activities, potentially improving outcomes for patients.

Collection and usage attributes

Guide for use:

Systemic therapy procedures captures those infrequent instances whereby a medical, surgical, or radiation procedure is performed on a patient that has an effect on their hormonal or immunological balance.

- Haematologic procedures, such as bone marrow transplants or stem cell harvests, are typically used in conjunction with the administration of a systemic therapy agent(s), usually chemotherapy.
- Endocrine procedures, either radiological or surgical, may be administered in conjuction with systemic therapy agent(s), usually hormone therapy agents.
- As therapy during the initial course of treatment for cancer, haematologic procedures will rarely be administered in conjunction with endocrine radiation or surgery.

Collection methods:

Each systemic therapy procedure and procedure date delivered to the patient during the initial treatment for cancer should be recorded.

The data element *Healthcare provider—organisation identifier, N(16)* may be recorded for each treatment. It is recommended that, wherever possible, the database be configured to allow entry of different healthcare provider identifiers for each therapeutic course of treatment.

The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease recurrence or progression.

This information should be collected from the patient's medical record.

Source and reference attributes

Origin:

Cancer Australia

Reference documents:

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Relational attributes

Related metadata references:

See also Cancer treatment—cancer treatment type, code N[N] Health, Standard 07/12/2011

Implementation in Data Set Specification:

Cancer (clinical) DSS Health, Standard 07/12/2011

Conditional obligation:
Conditional on the patient receiving a systemic therapy procedure.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Systemic therapy procedure	Mandatory	99
-	Systemic therapy procedure date	Mandatory	99

Vaccines administered cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	411936
Registration status:	Health, Standard 25/08/2011
DSS type:	Data Element Cluster
Scope:	These data elements are used in conjunction with each other to describe the vaccination programs offered in Australia's prisons. They are collected together and reported as the number of vaccines administered during the National Prisoner Health Census period against each vaccination type within a prison.

Collection and usage attributes

Guide for use:

The Vaccines administered cluster comprises two data elements that, in combination, describe the number of hepatitis B, human papillomavirus (HPV) and meningococcal vaccines administered to prisoners during the National Prisoner Health Census period.

This is achieved by the combination of the two data elements: *Establishment (prison) – type of vaccine administered, code N* and *Establishment (prison) – number of vaccines administered, number N[NN].*

The Vaccines administered cluster describes the following information:

Vaccine type	Number
Hepatitis B vaccine	N[NN]
HPV vaccine	N[NN]
Meningococcal vaccine	N[NN]

Collection methods:

Information regarding the vaccines administered in a prison is provided by the manager of the prison's health services on the National Prisoner Health Census Prison Establishment form.

Comments:

Immunisation is highly effective in reducing morbidity and mortality caused by vaccine-

	preventable diseases. The National Immunisation Guidelines recommend that prisoners are vaccinated against hepatitis B and that females aged 19–26 years of age are vaccinated against human papillomavirus (HPV) (NHMRC 2008).

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	NHMRC (National Health and Medical Research Council) 2008. The Australian Immunisation Handbook (9th edn). Canberra: Department of Health and Ageing.

Relational attributes

Implementation in Data Set Specification:	Prison establishments DSS Health, Standard 25/08/2011 *Conditional obligation:* Conditional on the prison offering vaccines.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Number of doses of vaccines administered in a prison	Mandatory	1
-	Type of vaccine administered	Mandatory	3

Ventricular ejection fraction cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	351881
Registration status:	Health, Standard 01/10/2008
DSS type:	Data Element Cluster
Scope:	The ventricular ejection fraction is the fraction of blood pumped out of a ventricle with each heart beat. Impaired ventricular ejection fraction can be indicative of damage to the heart muscle, such as that sustained during myocardial infarction. The ventricular ejection fraction cluster collects information on the timing, measurement type and results of a ventricular ejection fraction measurement during the current hospital presentation.

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specification:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Date of ventricular ejection fraction test	Conditional	1
-	Time of ventricular ejection fraction test	Conditional	1
-	Ventricular ejection fraction measurement indicator	Mandatory	1
-	Ventricular ejection fraction test result (percentage)	Conditional	1
-	Ventricular ejection fraction test result (code)	Conditional	1
-	Ventricular ejection fraction test type	Conditional	1

Work setting hours cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	375565
Registration status:	Health, Standard 10/12/2009
DSS type:	Data Element Cluster
Scope:	Registered health professionals listed with the Australian Health Practitioner Regulation Agency who were employed in the profession during the reference week. They may be an employee or they may be self-employed.

Collection and usage attributes

Statistical unit:	The statistical unit is the Registered health professional.
Guide for use:	The data elements in this cluster, when used together, form a matrix of total hours worked distributed across work sector and setting. The matrix assists to describe the supply and distribution of services by health professionals. The data elements in this cluster include all jobs held in the profession.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Registered health professional—hours worked in clinical role, total hours NNN Health, Standard 10/12/2009 See also Registered health professional—hours worked in non-clinical role, total hours NNN Health, Standard 10/12/2009 See also Registered health professional—hours worked in private sector, total hours NNN Health, Standard 10/12/2009 See also Registered health professional—hours worked in public sector, total hours NNN Health, Standard 10/12/2009
Implementation in Data Set Specification:	Registered chiropractic labour force DSS Health, Standard 10/12/2009 Registered dental and allied dental health professional

labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hours worked in health profession - total	Optional	1
-	Work sector - health professional	Optional	1
-	Work setting - registered health professional	Optional	1

Supporting items

Object classes

Address

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	428657
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011 Early Childhood, Standard 09/03/2012
Definition:	A collection of information used for describing the location of an entity and/or details describing how the entity can be contacted.
Specialisation of:	Location

Relational attributes

Data Element Concepts implementing this Object Class:	Address—address site name Community Services, Standard 06/02/2012 Health, Standard 07/12/2011 Address—Australian postcode Community Services, Standard 06/02/2012 Health, Standard 07/12/2011 Early Childhood, Standard 09/03/2012 Address—Australian state/territory identifier Community Services, Standard 06/02/2012 Health, Standard 07/12/2011 Early Childhood, Standard 09/03/2012 Address—complex road name Community Services, Standard 06/02/2012 Health, Standard 07/12/2011 Address—complex road number 1 Community Services, Standard 06/02/2012 Health, Standard 07/12/2011 Address—complex road number 2 Community Services, Standard 06/02/2012 Health, Standard 07/12/2011 Address—complex road type Community Services, Standard 06/02/2012 Health, Standard 07/12/2011 Address—level number Community Services, Standard 06/02/2012 Health, Standard 07/12/2011 Address—road name Community Services, Standard 06/02/2012 Health, Standard 07/12/2011 Address—road number 1 Community Services, Standard 06/02/2012

Health, Standard 07/12/2011

Address—road number 2 Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Address—road type Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Address—secondary complex name Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Address—statistical area Community Services, Standard 06/12/2011
Health, Standard 07/12/2011
Early Childhood, Standard 09/03/2012

Address—sub-dwelling unit number Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Address—suburb/town/locality name Community Services, Standard 06/02/2012
Health, Standard 07/12/2011
Early Childhood, Standard 09/03/2012

Administrative health region

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 288313

Registration status: Health, Standard 05/12/2007

Definition: The administrative unit with responsibility for administering health services in a region, area, district or zone, and for developing and implementing strategic and other plans for health service delivery.

Specialisation of: Party

Relational attributes

Data Element Concepts implementing this Object Class:

Administrative health region—palliative care strategic plan indicator Health, Standard 05/12/2007

Administrative health region—region name Health, Standard 05/12/2007

Admitted patient

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268957
Registration status:	Health, Standard 01/03/2005

Definition: A patient who undergoes a hospital's **admission** process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for **hospital-in-the-home** patients). The patient may be admitted if one or more of the following apply:

- the patient's condition requires clinical management and/or facilities not available in their usual residential environment
- the patient requires observation in order to be assessed or diagnosed
- the patient requires at least daily assessment of their medication needs
- the patient requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available (e.g. cardiac catheterisation)
- there is a legal requirement for admission (e.g. under child protection legislation)
- the patient is aged nine days or less.

Specialisation of: Person/group of persons

Collection and usage attributes

Guide for use: This metadata item should be used in conjunction with the definition of same-day patient in the glossary item same-day patient.

Part 2 of Schedule 3 of the National Health Act (type C) professional attention may be used as a guide for the medical services not normally requiring hospital treatment and therefore not generally related to admitted patients.

All babies born in hospital are admitted patients.

Comments: This definition includes all babies who are nine days old or less. However, all newborn days of stay are further divided into categories of qualified and unqualified for Australian Healthcare Agreements and health insurance benefit purposes. A newborn day is acute (qualified) when a newborn meets at least one of the following criteria:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;

- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Health Minister for the purpose of the provision of special care;
- remains in hospital without its mother;
- is admitted to the hospital without its mother.

Acute (qualified) newborn days are eligible for health insurance benefit purposes and should be counted under the Australian Health Care Agreements. Days when the newborn does not meet these criteria are classified as unqualified (if they are nine days old or less) and should be recorded as such. Unqualified newborn days should not be counted under the Australian Health Care Agreements and are not eligible for health insurance benefit purposes.

Relational attributes

Related metadata references: Supersedes Admitted patient, version 3, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)

Data Element Concepts implementing this Object Class: Admitted patient (neonate)—neonatal morbidity Health, Standard 01/03/2005

Admitted patient care waiting list episode

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	269012
Registration status:	Health, Standard 01/03/2005
Definition:	The period between entry to and removal from a waiting list for admitted patient care.
Specialisation of:	Service episode

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Admitted patient care waiting list episode—scheduled admission date Health, Standard 01/03/2005

Admitted patient hospital stay

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268995
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The period of treatment and/or care and/or accommodation provided between a formal hospital **admission** and **separation**.
Specialisation of:	Service episode

Collection and usage attributes

Comments:	An admitted patient hospital stay is composed of one or more episodes of care, each of which is defined by a single care type (for example acute care, palliative care or rehabilitation care).

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Admitted patient hospital stay—number of patient days (of contracted care) Health, Standard 01/03/2005 Admitted patient hospital stay—operating theatre time Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011

Adult

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	269001
Registration status:	Health, Standard 01/03/2005
Definition:	An individual aged 18 years or older.
Specialisation of:	Person/group of persons

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Adult—body mass index Health, Standard 01/03/2005 Adult—waist circumference risk indicator Health, Standard 01/03/2005 Adult—waist-to-hip ratio Health, Standard 01/03/2005 Adult—weight Health, Superseded 14/07/2005

Available bed

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 373634

Registration status: Health, Standard 03/12/2008

Definition: A suitably located and equipped bed chair, trolley or cot where the necessary financial and human resources are provided for admitted patient care.

Specialisation of: Organisation

Collection and usage attributes

Comments: This item supports a number of metadata items developed during 2007-08 to replace Establishment – number of available beds for admitted patients, average. The new definitions improve on the counting rules, the definition of availability and provide for the separate reporting of overnight-stay beds, same-day beds, hospital-in-the-home beds and neonatal cots (non-special-care).

During the development phase, it became clear that there are a multitude of bed descriptors, other than ‘available’, in use. In order to provide clarity in relation to ‘available beds’ other known terms are defined below:

- Active beds – alternative term for ‘available beds’.
- Approved beds – the maximum number of beds that the hospital is authorised to have. This may exceed the number of physical beds.
- Base beds - alternative term for ‘available beds’.
- Bed alternatives (QLD) – this term is used to describe furniture, other than beds in overnight wards, such as trolleys, chairs and cots, which provide accommodation for admitted patients – e.g. chairs/trolleys accommodating chemotherapy and dialysis patients.
- Bed Equivalents (NSW) – a method of equating same day beds to overnight beds – not necessary if counting overnight and same day beds separately.
- Capacity – term which can be used in conjunction with either available or physical beds, but more often the latter – to indicate the maximum number of beds that could be made available, given the appropriate level of funds and nursing and auxiliary staff.
- Designated beds – term used to describe beds set aside for specialist care, e.g. mental health.
- Flex beds – see ‘surge/flex beds’ below.

- Funded beds – may equate to 'available beds' unless the necessary human resources cannot be provided (e.g. due to a strike or nursing shortage).
- Licensed beds – this is an alternative term for 'approved beds', more commonly used for private hospitals where the maximum number of beds is often specified as part of the registration process.
- Medi-hotel bed – this term is used for beds in a non-ward residential service maintained and/or paid for by the hospital, as a substitute for traditional hospital ward accommodation. Residents may be accommodated in a medi-hotel overnight and be admitted as same-day patients or receive non-admitted patient services during the day. They may be accommodated in the medi-hotel before, during or after a multi-day admitted episode. Unlike hospital-in-the-home, however, no clinical services are provided in the medi-hotel and a significant decline in medical condition would always necessitate return from the medi-hotel to the hospital's Emergency Department or other ward. Thus residents are not reported as admitted while in the medi-hotel (unless they are on leave) and the medi-hotel beds are not counted as available for admitted patients.
- Occupied/Unoccupied beds – categorisation of available beds – a bed is occupied if there is a patient physically in the bed or the bed is being retained for a patient (e.g. the patient is receiving treatment or is on leave). Beds may be available but not occupied, e.g. an 8 bed ward may be fully staffed, but only 7 beds are occupied. Also if a patient has left a bed to receive a different care type and will not be returning within 24 hours, the bed is not occupied.
- Occupancy Rate – calculated by dividing total bed days in a period by the product of the available beds and the days in the period – e.g. if in a non-leap year patients accumulated 33,000 bed days in a hospital with 100 overnight-stay beds, the occupancy rate = 33,000/(365*100) = 90.4%. N.B. Occupancy rates calculated for same-day beds could exceed 100%.
- Open beds - alternative term for 'available beds'.
- Operational beds - alternative term for 'available beds'.
- Physical beds – the maximum number of beds that could be made available, given the appropriate level of funds and nursing and auxiliary staff.
- Seasonal beds – describes the movement in the number of available beds due to seasonal factors.
- Staffed beds – may equate to 'available beds' or may be lower depending on demand.

- Surge/flex beds (NSW) or Flex beds (SA) – the increase in the number of available beds that could be made by making arrangements for additional nursing and auxiliary staff, In other words, the number of surge/flex beds is the difference between the number of physical beds and the number of available beds.
- Swing beds – beds that can alternate between different types of care. Depending on the context, swing beds can be thought of as a sub-category of physical beds or available beds.
- Virtual bed – this term is used to denote a nominal location which the patient is held against in the hospital's patient administration system. This is because in the patient administration system each admitted patient needs to be held against a bed whether or not they are in a physical bed. For example, if a neonate is sharing a bed with the mother (e.g. in a birth centre) a cot may not be set up. Hospital-in-the-home (HITH) patients may also be held in a virtual bed.

Relational attributes

Data Element Concepts implementing this Object Class:	Available bed—neonatal admitted care (Non-special-care) Health, Standard 03/12/2008 Available bed—overnight-stay admitted care Health, Standard 03/12/2008 Available bed—residential mental health care Health, Standard 03/12/2008 Available bed—same-day admitted care Health, Standard 03/12/2008

Birth

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268999
Registration status:	Health, Standard 01/03/2005
Definition:	The complete expulsion or extraction from its mother of a product of conception of at least 20 weeks of gestation or of 400 g or more **birthweight**, where the product can be liveborn or stillborn.
Context:	Perinatal
Specialisation of:	Person/group of persons

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Birth—Apgar score Health, Superseded 07/12/2005 Birth—Apgar score Health, Standard 07/12/2005 Birth—birth order Health, Standard 01/03/2005 Birth—birth status Health, Standard 01/03/2005 Birth—birth weight Health, Standard 01/03/2005

Birth event

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 268965

Registration status: Health, Standard 01/03/2005

Definition: The sequence of actions by which a baby and the afterbirth (placenta) are expelled or extracted from the uterus at childbirth. The process usually starts spontaneously about 280 days after conception with onset of labour, but it may be started by artificial means.

Specialisation of: Life event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: University of Oxford 2002. Concise Colour Medical Dictionary 3rd ed. UK: Oxford University Press

Relational attributes

Data Element Concepts implementing this Object Class:

Birth event—anaesthesia administered Health, Superseded 07/12/2005

Birth event—anaesthesia administered Health, Standard 07/12/2005

Birth event—analgesia administered Health, Superseded 07/12/2005

Birth event—analgesia administered Health, Standard 07/12/2005

Birth event—baby resuscitation method Health, Standard 01/03/2005

Birth event—birth method Health, Standard 06/09/2006

Birth event—birth plurality Health, Standard 01/03/2005

Birth event—birth presentation Health, Standard 06/09/2006

Birth event—birth presentation Health, Superseded 06/09/2006

Birth event—complication Health, Standard 01/03/2005

Birth event—complication (postpartum) Health, Standard 01/03/2005

Birth event—delivery method Health, Superseded 06/09/2006

Birth event—labour augmentation type Health, Standard 01/03/2005

Birth event—labour induction type Health, Standard 01/03/2005

Birth event—labour onset type Health, Standard 01/03/2005

Birth event—setting (intended) Health, Superseded 08/12/2005

Birth event—setting of birth Health, Standard 01/03/2005

Birth event—state/territory of birth Health, Standard 01/03/2005

Cancer staging

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	313434
Registration status:	Health, Standard 13/10/2005
Definition:	System of determining the extent or stage of cancer.
Specialisation of:	Service/care event

Relational attributes

Data Element Concepts implementing this Object Class:	Cancer staging—cancer staging scheme source Health, Superseded 07/12/2011 Cancer staging—cancer staging scheme source Health, Standard 07/12/2011 Cancer staging—cancer staging scheme source edition number Health, Standard 07/12/2011 Cancer staging—cancer staging scheme source edition number Health, Superseded 07/12/2011 Cancer staging—staging basis of cancer Health, Standard 07/12/2011 Cancer staging—staging basis of cancer Health, Superseded 07/12/2011

Cancer treatment

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 288059

Registration status: Health, Standard 04/06/2004

Definition: The course of cancer directed treatment or treatments, with defined dates of commencement and cessation, given to the patient by a treatment provider or team of providers. It includes all treatments administered to the patient before disease progression or recurrence and applies to surgical treatment, radiation therapy and systemic agent therapy for cancer.

Context: This metadata item is required to provide the basis for a standard approach to recording and monitoring patterns of initial treatment for cancer patients.

Specialisation of: Service/care event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Commission on Cancer, Facility Oncology Registry Data Standards (2002)

Relational attributes

Data Element Concepts implementing this Object Class:

Cancer treatment—cancer treatment type Health, Standard 07/12/2011

Cancer treatment—cancer treatment type Health, Superseded 07/12/2011

Cancer treatment—chemotherapy completion date Health, Standard 07/12/2011

Cancer treatment—chemotherapy cycles administered Health, Standard 07/12/2011

Cancer treatment—chemotherapy start date Health, Standard 07/12/2011

Cancer treatment—hormone therapy completion date Health, Standard 07/12/2011

Cancer treatment—hormone therapy start date Health, Standard 07/12/2011

Cancer treatment—immunotherapy completion date Health, Standard 07/12/2011

Cancer treatment—immunotherapy start date Health, Standard

07/12/2011

Cancer treatment—intention of treatment Health, Standard 04/06/2004

Cancer treatment—non-surgical cancer treatment completion date Health, Standard 04/06/2004

Cancer treatment—non-surgical cancer treatment start date Health, Standard 04/06/2004

Cancer treatment—other cancer treatment Health, Standard 07/12/2011

Cancer treatment—outcome of treatment Health, Standard 07/12/2011

Cancer treatment—outcome of treatment Health, Superseded 07/12/2011

Cancer treatment—radiation dose administered Health, Standard 07/12/2011

Cancer treatment—radiation dose received Health, Standard 13/06/2004

Cancer treatment—radiotherapy completion date Health, Standard 07/12/2011

Cancer treatment—radiotherapy fractions administered Health, Standard 07/12/2011

Cancer treatment—radiotherapy start date Health, Standard 07/12/2011

Cancer treatment—radiotherapy target site Health, Standard 07/12/2011

Cancer treatment—radiotherapy treatment type Health, Standard 07/12/2011

Cancer treatment—radiotherapy treatment type Health, Superseded 07/12/2011

Cancer treatment—surgery target site Health, Standard 07/12/2011

Cancer treatment—surgical procedure date Health, Standard 04/06/2004

Cancer treatment—surgical procedure for cancer Health, Standard 07/12/2011

Cancer treatment—surgical procedure for cancer Health, Superseded 07/12/2011

Cancer treatment—systemic therapy agent name (primary cancer) Health, Standard 04/06/2004

Cancer treatment—systemic therapy agent or protocol Health, Standard 07/12/2011

Cancer treatment—systemic therapy procedure Health, Standard 07/12/2011

Cancer treatment—systemic therapy procedure date Health, Standard 07/12/2011

Cancer treatment—target site for cancer treatment Health,

Standard 13/06/2004

Child

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268987
Registration status:	Community Services, Standard 01/12/2004 Housing assistance, Standard 23/08/2010 Health, Standard 25/02/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010
Definition:	An individual under the age of 18 years.
Specialisation of:	Person/group of persons

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Child—body mass index Health, Standard 01/03/2005 Child—recorded as fully immunised indicator Health, Standard 07/12/2011

Client

Identifying and definitional attributes

Metadata item type: Object Class

Synonymous names: Client

METeOR identifier: 268969

Registration status: Community Services, Standard 01/03/2005
Housing assistance, Standard 23/08/2010
Health, Standard 01/03/2005
Homelessness, Standard 23/08/2010

Definition: A person, group or organisation eligible to receive services either directly or indirectly from an agency.

Context: Agencies may provide assistance to individual persons, groups of persons (e.g. support groups) or to other organisations. All of these may be considered clients of an agency. Specific data collections may circumscribe the Type of clients that are included in the collection. For example, at the current stage of development of the Home and Community Care (HACC) Minimum Data Set (MDS), HACC funded agencies are only required to report on clients who are individual persons. Future developments may extend the coverage of the HACC MDS collection to include organisational or group clients.

The definition of a 'client' may also be circumscribed by the definition of 'assistance'. What is included as 'assistance' may depend on what activities are considered significant enough to warrant separate recording and reporting of the nature and/or amount of the assistance provided to a person. For example, an agency worker answering a telephone call from an anonymous member of the public seeking some basic information (e.g. a phone number for someone) would not usually consider that this interaction constituted assistance of sufficient significance to warrant recording that person as a 'client'.

Furthermore, what constitutes 'assistance' may be influenced by the type of assistance the agency was established to provide. In the above example, the agency in question was funded specifically to provide telephone advice, and referral information, to members of the public or specific sub-groups of the public. The agency may have a policy that all persons telephoning the agency for information are classified as clients, albeit anonymous clients.

The level of support or the amount of support given to a person by an agency can also be used to define them as a client or not. For example in the Supported

Accommodation Assistance Program (SAAP) National data collection, clients are defined by either taking up an amount of time of an agency; being accommodated by an agency; or by entering an ongoing support relationship with an agency.

Specialisation of: Person/group of persons

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Client, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (15.7 KB)

Data Element Concepts implementing this Object Class:

Client—injecting drug use status Community Services, Standard 06/02/2012
Health, Standard 01/03/2005

Client—method of drug use (principal drug of concern) Community Services, Standard 06/02/2012
Health, Standard 01/03/2005

Community nursing service episode

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268998
Registration status:	Health, Standard 01/03/2005
Definition:	A period of time during which a person receives care from a community nursing service.
Specialisation of:	Service episode

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Community nursing service episode—first contact date Health, Standard 01/03/2005 Community nursing service episode—goal of care Health, Standard 01/03/2005 Community nursing service episode—last contact date Health, Standard 01/03/2005 Community nursing service episode—nursing intervention Health, Standard 01/03/2005

Contracted hospital care

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 268981

Registration status: Health, Standard 01/03/2005

Definition: Contracted hospital care is provided to a patient under an agreement between a purchaser of hospital care (contracting hospital or external purchaser) and a provider of an admitted or non-admitted service (contracted hospital).

Specialisation of: Service/care event

Collection and usage attributes

Guide for use: Related contracted hospital care metadata items should only be completed where services are provided which represent some, but not all of the contracted hospital's total services. It is not necessary to complete contracted hospital care items where all of the hospital services are contracted by a health authority, e.g. privately owned and/or operated public hospitals.

Contracted hospital care must involve all of the following:

- a purchaser, which can be a public or private hospital, or a health authority (department or region) or another external purchaser
- a contracted hospital, which can be a public or private hospital or day procedure centre
- the purchaser paying the contracted hospital for the contracted service; thus, services provided to a patient in a separate facility during their episode of care, where the patient is directly responsible for payment of this additional service, are not considered contracted services for reporting purposes
- the patient being physically present in the contracted hospital for the provision of the contracted service.

Thus, pathology or other investigations performed at another location on specimens gathered at the contracting hospital would not be considered contracted services for reporting purposes.

Allocation of diagnosis and procedure codes should not be affected by the contract status of an episode: the Australian Coding Standards should be applied when coding all episodes. In particular, procedures which would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.

Procedures performed by a health care service (i.e. not a recognised hospital) should be coded if appropriate but are not considered to be contracted hospital procedures.

Any Diagnosis Related Group (DRG) derived for episodes involving contracted hospital care, should reflect the total treatment provided (all patient days and procedures), even where part of the treatment was provided under contract by another hospital.

Relational attributes

Related metadata references:

Supersedes Contracted hospital care, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.9 KB)

Data Element Concepts implementing this Object Class:

Contracted hospital care—contracted care commencement date Health, Standard 01/03/2005

Contracted hospital care—contracted care completed date Health, Standard 01/03/2005

Contracted hospital care—organisation identifier Health, Standard 01/03/2005

Date

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	294409
Registration status:	Community Services, Standard 30/09/2005 Housing assistance, Standard 23/08/2010 Health, Standard 04/05/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010 Tasmanian Health, Proposed 28/09/2011
Definition:	The day of the month and year as specified by a number.
Specialisation of:	Service/care event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	Oxford English dictionary.

Relational attributes

Data Element Concepts implementing this Object Class:	Date—accuracy indicator Community Services, Standard 30/09/2005 Housing assistance, Standard 23/08/2010 Health, Standard 04/05/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010

Division of general practice

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 268989

Registration status: Health, Standard 01/03/2005

Definition: A geographically based network of general practitioners.

Specialisation of: Service/care provider

Collection and usage attributes

Guide for use: In geographical terms, each Division of General Practice can be described by the postcodes that fall within its jurisdiction.

Source and reference attributes

Submitting organisation: Cardiovascular data working group

Relational attributes

Data Element Concepts implementing this Object Class: Division of general practice—organisation identifier Health, Standard 01/03/2005

Elective care waiting list episode

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268974
Registration status:	Health, Standard 01/03/2005
Definition:	The period between entry to and removal from an elective care waiting list.
Specialisation of:	Service episode

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Elective care waiting list episode—category reassignment date Health, Standard 01/03/2005 Elective care waiting list episode—elective care type Health, Standard 01/03/2005 Elective care waiting list episode—listing date for care Health, Standard 01/03/2005

Elective surgery waiting list episode

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 269007

Registration status: Health, Standard 01/03/2005

Definition: The period between entry to and removal from an elective surgery waiting list.

Specialisation of: Service episode

Source and reference attributes

Submitting organisation: Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:

Elective surgery waiting list episode—anticipated accommodation status Health, Standard 01/03/2005

Elective surgery waiting list episode—clinical urgency Health, Standard 01/03/2005

Elective surgery waiting list episode—extended wait patient indicator Health, Standard 01/03/2005

Elective surgery waiting list episode—indicator procedure Health, Standard 01/03/2005

Elective surgery waiting list episode—overdue patient status Health, Standard 01/03/2005

Elective surgery waiting list episode—patient listing status Health, Standard 01/03/2005

Elective surgery waiting list episode—reason for removal from a waiting list Health, Standard 01/03/2005

Elective surgery waiting list episode—surgical specialty (of scheduled doctor) Health, Standard 01/03/2005

Elective surgery waiting list episode—waiting list removal date Health, Standard 01/03/2005

Elective surgery waiting list episode—waiting time Health, Standard 01/03/2005

Electrocardiogram

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	359999
Registration status:	Health, Standard 01/10/2008
Definition:	A means of studying the activity of the heart from electrical signals.
Specialisation of:	Service/care event

Relational attributes

Data Element Concepts implementing this Object Class:	Electrocardiogram—bundle-branch block status Health, Standard 01/10/2008 Electrocardiogram—change location Health, Standard 01/10/2008 Electrocardiogram—change type Health, Standard 01/10/2008 Electrocardiogram—electrocardiogram date Health, Standard 01/10/2008 Electrocardiogram—electrocardiogram ST-segment-elevation in lead V4R indicator Health, Standard 01/10/2008 Electrocardiogram—electrocardiogram time Health, Standard 01/10/2008 Electrocardiogram—heart rhythm type Health, Standard 01/10/2008 Electrocardiogram—lead V4R presence indicator Health, Standard 01/10/2008 Electrocardiogram—new Q waves indicator Health, Standard 01/10/2008

Emergency department stay

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 472757

Registration status: Health, Standard 22/12/2011

Definition: The period between when a patient presents at an emergency department and when that person is recorded as having physically departed the emergency department.

Context: Emergency department care.

Specialisation of: Service/care event

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: Supersedes Emergency department stay Health, Superseded 22/12/2011, Tasmanian Health, Proposed 28/09/2011

Data Element Concepts implementing this Object Class:

Emergency department stay—physical departure date Health, Standard 22/12/2011

Emergency department stay—physical departure time Health, Standard 22/12/2011

Emergency department stay—presentation date Health, Standard 22/12/2011

Emergency department stay—presentation time Health, Standard 22/12/2011

Emergency department stay—transport mode Health, Standard 22/12/2011

Emergency department stay—type of visit to emergency department Health, Standard 22/12/2011

Emergency department stay—waiting time (to commencement of clinical care) Health, Standard 22/12/2011

Episode of admitted patient care

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268956
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The period of admitted patient care between a formal or statistical **admission** and a formal or statistical **separation**, characterised by only one care type.
Context:	Admitted patient care.
Specialisation of:	Service episode

Collection and usage attributes

Guide for use:	This treatment and/or care provided to a patient during an episode of care can occur in hospital and/or in the person's home (for **hospital-in-the-home** patients).

Source and reference attributes

Origin:	Health Data Standards Committee.

Relational attributes

Related metadata references:	Supersedes Episode of admitted patient care, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005 02/10/2003.pdf (13.0 KB)
Data Element Concepts implementing this Object Class:	Episode of admitted patient care (newborn)—date of change to qualification status Health, Standard 01/03/2005 Episode of admitted patient care (newborn)—number of qualified days Health, Standard 01/03/2005 Episode of admitted patient care (procedure)—procedure commencement date Health, Standard 01/03/2005 Episode of admitted patient care—admission date Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011 Episode of admitted patient care—admission mode Health, Standard 01/03/2005 Episode of admitted patient care—admission time Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011 Episode of admitted patient care—admission urgency status Health, Standard 01/03/2005 Episode of admitted patient care—condition onset flag Health, Standard 05/02/2008 Episode of admitted patient care—diagnosis onset type

Health, Superseded 05/02/2008

Episode of admitted patient care—diagnosis related group
Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of admitted patient care—elected accommodation status Health, Superseded 28/11/2006

Episode of admitted patient care—intended length of hospital stay Health, Standard 01/03/2005

Episode of admitted patient care—length of stay (excluding leave days) Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of admitted patient care—length of stay (including leave days) Health, Standard 01/03/2005

Episode of admitted patient care—length of stay (special/neonatal intensive care) Health, Standard 01/03/2005

Episode of admitted patient care—major diagnostic category Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of admitted patient care—number of days of hospital-in-the-home care Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of admitted patient care—number of leave days
Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of admitted patient care—number of leave periods
Health, Standard 01/03/2005

Episode of admitted patient care—patient election status
Health, Standard 28/11/2006

Episode of admitted patient care—procedure Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of admitted patient care—referral destination
Health, Standard 01/03/2005

Episode of admitted patient care—referral source Health, Standard 01/03/2005

Episode of admitted patient care—separation date Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of admitted patient care—separation mode Health, Standard 01/03/2005

Episode of admitted patient care—separation time Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of care

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 268978

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: A period of health care with a defined start and end.

Specialisation of: Service episode

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Data Element Concepts implementing this Object Class:

Episode of care (procedure)—contracted procedure flag Health, Standard 01/03/2005

Episode of care—additional diagnosis Health, Standard 05/02/2008

Episode of care—additional diagnosis Health, Superseded 05/02/2008

Episode of care—behaviour-related risk factor intervention Health, Standard 01/03/2005

Episode of care—behaviour-related risk factor intervention purpose Health, Standard 01/03/2005

Episode of care—expected principal source of funding Health, Superseded 29/11/2006

Episode of care—first service delivery date (community setting) Health, Standard 01/03/2005

Episode of care—funding eligibility indicator Health, Standard 01/03/2005

Episode of care—inter-hospital contracted patient status Health, Standard 01/03/2005

Episode of care—mental health legal status Health, Standard 01/03/2005

Episode of care—number of psychiatric care days Health, Standard 01/03/2005

Episode of care—nursing diagnosis Health, Standard 01/03/2005

Episode of care—principal diagnosis Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of care—principal source of funding Health, Standard 29/11/2006

Episode of care—source of funding Health, Standard

11/04/2012

Episode of care—specialist private sector rehabilitation care indicator Health, Standard 01/03/2005

Episode of residential care

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 376433

Registration status: Health, Standard 07/12/2011

Definition: The period of care between the start of residential care (either through the formal start of the residential stay or the start of a new reference period) and the end of the residential care (either through the formal end of residential care or the end of the reference period, i.e. 30 June).

Specialisation of: Service episode

Collection and usage attributes

Comments: For **resident**s provided with care intended to be on an overnight basis. This may occasionally include episodes of residential care that unexpectedly ended on the same day as they started (for example, the resident died or left against advice) or began at the end of the reference period (i.e. starting care on 30 June).

Relational attributes

Related metadata references: Supersedes Episode of residential care Health, Superseded 07/12/2011

Data Element Concepts implementing this Object Class:

Episode of residential care—episode end date Health, Standard 07/12/2011

Episode of residential care—episode end mode Health, Standard 07/12/2011

Episode of residential care—episode start date Health, Standard 07/12/2011

Episode of residential care—episode start mode Health, Standard 07/12/2011

Episode of residential care—number of episodes of residential care Health, Standard 07/12/2011

Episode of residential care—number of leave days Health, Standard 07/12/2011

Episode of residential care—referral destination (mental health care) Health, Standard 07/12/2011

Episode of treatment for alcohol and other drugs

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 268961

Registration status: Health, Standard 01/03/2005

Definition: The period of contact, with defined dates of commencement and cessation, between a client and a treatment provider or team of providers in which there is no change in the main treatment type or the principal drug of concern, and there has not been a non-planned absence of contact for greater than three months.

Context: Alcohol and drug treatment services. This concept is required to provide the basis for a standard approach to recording and monitoring patterns of service utilisation by clients.

Specialisation of: Service episode

Collection and usage attributes

Guide for use: A treatment episode must have a defined date of commencement of treatment episode for alcohol and other drugs and a date of cessation of treatment episode for alcohol and other drugs.

A treatment episode can have only one main treatment type for alcohol and other drugs and only one principal drug of concern. If the main treatment or principal drug changes then the treatment episode is closed and a new treatment episode is opened.

A treatment episode may also be considered closed (ceased) if there is a change in the treatment delivery setting or the service delivery outlet. Where the change reflects a substantial alteration in the nature of the treatment episode, for instance where an agency operates in more than one treatment setting (or outlet) they may consider that a change from one setting (or outlet), to another necessitates closure of one episode and commencement of a new one.

Collection methods: Is taken as the period starting from the date of commencement of treatment and ending at the date of cessation of treatment episode.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set - Working Group

Relational attributes

Related metadata references:

Supersedes Treatment episode for alcohol and other drugs, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Data Element Concepts implementing this Object Class:

Episode of treatment for alcohol and other drugs—cessation reason Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—client type Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—drug of concern Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—drug of concern (principal) Health, Superseded 13/10/2005

Episode of treatment for alcohol and other drugs—number of service contacts Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—referral source Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—service delivery setting Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—treatment cessation date Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—treatment commencement date Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—treatment type Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—treatment type (other) Health, Superseded 13/10/2005

Establishment

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 268953

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 05/10/2011

Definition: Institutions, organisations or the community from which health services are provided. The term establishment covers conventional health establishments and also organisations which may provide services in the community.

Specialisation of: Organisation

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Data Element Concepts implementing this Object Class:

Establishment (residential aged care service)—number of occasions of service Health, Standard 01/03/2005

Establishment—accrued mental health care days Health, Standard 08/12/2004

Establishment—Australian state/territory identifier
Community Services, Standard 01/03/2005
Health, Standard 01/03/2005

Establishment—establishment type Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (administrative and clerical staff) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (carer consultants) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (consumer consultants) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (diagnostic and health professionals) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (domestic and other staff) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (enrolled nurses) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (nurses) Health, Standard 07/12/2011

Establishment—full-time equivalent staff (paid) (occupational therapists) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (other medical officers) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (other personal care staff) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (psychologists) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (registered nurses) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (salaried medical officers) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (social workers) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (student nurses) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (trainee/pupil nurses) Health, Standard 01/03/2005

Establishment—geographic location Health, Standard 01/03/2005

Establishment—geographic remoteness Health, Standard 07/12/2011

Establishment—gross capital expenditure (accrual accounting) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (buildings and building services) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (constructions) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (information technology) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (intangible assets) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (land) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (other equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (transport) Health, Standard 01/03/2005

Establishment—gross capital expenditure (computer equipment/installations) Health, Standard 01/03/2005

Establishment—gross capital expenditure (intangible assets) Health, Standard 01/03/2005

Establishment—gross capital expenditure (land and buildings) Health, Standard 01/03/2005

Establishment—gross capital expenditure (major medical equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (other capital expenditure) Health, Standard 01/03/2005

Establishment—gross capital expenditure (plant and other equipment) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (buildings and building services) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (constructions) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (equipment) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (information technology) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (intangible assets) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (land) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (other equipment) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (transport) Health, Standard 01/03/2005

Establishment—number of available beds for admitted patients/residents Health, Superseded 03/12/2008

Establishment—number of day centre attendances Health, Standard 01/03/2005

Establishment—number of group session occasions of service for non-admitted patients Health, Standard 01/03/2005

Establishment—number of group sessions Health, Superseded 04/07/2007

Establishment—number of group sessions Health, Standard 04/07/2007

Establishment—number of individual session occasions of service for non-admitted patients Health, Standard 01/03/2005

Establishment—number of non-admitted patient service events Health, Standard 01/03/2005

Establishment—number of occasions of service Health,

Standard 04/05/2005

Establishment—number of patient days Health, Standard 01/03/2005

Establishment—number of separations Health, Standard 01/03/2005

Establishment—organisation identifier Health, Standard 01/03/2005

Establishment—organisation identifier (state/territory) Health, Standard 01/03/2005

Establishment—outpatient clinic type Health, Standard 04/07/2007

Establishment—outpatient clinic type Health, Superseded 04/07/2007

Establishment—patients/clients in residence at year end Health, Standard 01/03/2005

Establishment—quality accreditation/certification standard indicator Health, Standard 01/03/2005

Establishment—recurrent expenditure Health, Standard 08/12/2004

Establishment—recurrent expenditure (administrative expenses) Health, Standard 01/03/2005

Establishment—recurrent expenditure (Department of Veterans' Affairs funded) Health, Standard 02/12/2009

Establishment—recurrent expenditure (Department of Veterans' Affairs funded) Health, Superseded 02/12/2009

Establishment—recurrent expenditure (depreciation) Health, Standard 01/03/2005

Establishment—recurrent expenditure (domestic services) Health, Standard 01/03/2005

Establishment—recurrent expenditure (drug supplies) Health, Standard 01/03/2005

Establishment—recurrent expenditure (food supplies) Health, Standard 01/03/2005

Establishment—recurrent expenditure (indirect health care) Health, Standard 01/03/2005

Establishment—recurrent expenditure (interest payments) Health, Standard 01/03/2005

Establishment—recurrent expenditure (medical and surgical supplies) Health, Standard 01/03/2005

Establishment—recurrent expenditure (National Mental Health Strategy payments) Health, Standard 08/12/2004

Establishment—recurrent expenditure (non-salary operating costs) Health, Standard 01/03/2005

Establishment—recurrent expenditure (other Commonwealth Government funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (other patient revenue funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (other recurrent expenditure) Health, Standard 01/03/2005

Establishment—recurrent expenditure (other revenue funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (other state or territory funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (patient transport cost) Health, Standard 01/03/2005

Establishment—recurrent expenditure (recoveries funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (repairs and maintenance) Health, Standard 01/03/2005

Establishment—recurrent expenditure (salaries and wages) Health, Standard 01/03/2005

Establishment—recurrent expenditure (state or territory health authority funded) Health, Standard 08/12/2004

Establishment—recurrent expenditure (superannuation employer contributions) Health, Standard 01/03/2005

Establishment—recurrent expenditure (visiting medical officer payments) Health, Standard 01/03/2005

Establishment—region identifier Health, Standard 01/03/2005

Establishment—region name Health, Standard 07/12/2011

Establishment—revenue (other revenue) Health, Standard 05/12/2007

Establishment—revenue (other revenue) Health, Superseded 05/12/2007

Establishment—revenue (patient) Health, Standard 05/12/2007

Establishment—revenue (patient) Health, Superseded 05/12/2007

Establishment—revenue (recoveries) Health, Superseded 05/12/2007

Establishment—revenue (recoveries) Health, Standard 05/12/2007

Establishment—sector Health, Standard 01/03/2005

Establishment—service unit cluster identifier Health, Standard 07/12/2011

Establishment—service unit cluster name Health, Standard 07/12/2011

Establishment—specialised service indicator Health, Standard 01/03/2005

Establishment—teaching status (university affiliation) Health, Standard 01/03/2005

Establishment (prison)

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	403321
Registration status:	Health, Standard 25/08/2011
Definition:	A legally proclaimed prison or remand centre which holds adult prisoners, excluding police prisons or juvenile detention facilities.
Context:	Applicable to the corrective services area.
Specialisation of:	Organisation

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service service provider type Health, Standard 25/08/2011 Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service visitation frequency Health, Standard 25/08/2011 Establishment (prison)—full-time equivalent staff Health, Standard 25/08/2011 Establishment (prison)—health worker type Health, Standard 25/08/2011 Establishment (prison)—number of hospital transfers Health, Standard 25/08/2011 Establishment (prison)—number of pregnant prisoners Health, Standard 25/08/2011 Establishment (prison)—number of prison entrants Health, Standard 25/08/2011 Establishment (prison)—number of prisoners released Health, Standard 25/08/2011 Establishment (prison)—number of vaccine doses administered Health, Standard 25/08/2011 Establishment (prison)—organisation identifier Health, Standard 25/08/2011 Establishment (prison)—planned hospital transfer indicator Health, Standard 25/08/2011 Establishment (prison)—type of vaccine administered Health, Standard 25/08/2011

Female

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 269000

Registration status: Community Services, Standard 06/02/2012
Health, Standard 01/03/2005

Definition: A human being of the sex which conceives and brings forth young.

Specialisation of: Person/group of persons

Source and reference attributes

Submitting organisation: Australia Institute of Health and Welfare

Origin: Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd.

Relational attributes

Data Element Concepts implementing this Object Class:

Female (mother)—postpartum perineal status Health, Standard 01/03/2005

Female (pregnant)—estimated gestational age Health, Standard 01/03/2005

Female (pregnant)—maternal medical condition Health, Standard 01/03/2005

Female (pregnant)—number of cigarettes smoked (after 20 weeks of pregnancy) Health, Standard 03/12/2008

Female (pregnant)—number of cigarettes smoked (first 20 weeks of pregnancy) Health, Standard 03/12/2008

Female (pregnant)—tobacco smoking indicator (after twenty weeks of pregnancy) Health, Standard 03/12/2008

Female (pregnant)—tobacco smoking indicator (first twenty weeks of pregnancy) Health, Standard 03/12/2008

Female—age at first pregnancy Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Female—caesarean section indicator Health, Standard 29/11/2006

Female—cervical screening indicator Health, Standard 25/08/2011

Female—current pregnancy status Health, Superseded 21/09/2005

Female—ever been pregnant indicator Health, Standard 25/08/2011

Female—hysterectomy indicator Health, Standard 07/12/2011

Female—number of antenatal care visits Health, Standard

12/10/2011

Female—number of caesarean sections Health, Standard 29/11/2006

Female—number of previous pregnancies Health, Standard 01/03/2005

Female—parity Health, Standard 29/11/2006

Female—pregnancy indicator Health, Standard 21/09/2005

Functional stress test

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	358931
Registration status:	Health, Standard 01/10/2008
Definition:	A test performed to evaluate arterial blood flow to the myocardium (heart muscle) during physical exercise, compared to blood flow while at rest.
Specialisation of:	Service/care event

Relational attributes

Data Element Concepts implementing this Object Class:	Functional stress test—assessment of cardiac perfusion Health, Standard 01/10/2008 Functional stress test—functional stress test element Health, Standard 01/10/2008 Functional stress test—ischaemic and perfusion outcome result Health, Standard 01/10/2008 Functional stress test—stress test intensity Health, Standard 01/10/2008 Functional stress test—test date Health, Standard 01/10/2008

Health industry relevant organisation

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	352194
Registration status:	Health, Standard 05/12/2007
Definition:	An organisation that provides health care goods and services to prevent or cure disease, care for illness, impairment, disability or handicap, or non-health care good and services to support these activities.
Specialisation of:	Organisation

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Relational attributes

Data Element Concepts implementing this Object Class:	Health industry relevant organisation—main activity type Health, Standard 05/12/2007 Health industry relevant organisation—source of revenue Health, Standard 05/12/2007

Health professional

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268985
Registration status:	Health, Standard 01/03/2005
Definition:	A person whose primary employment role is to diagnose and treat physical and mental illnesses and conditions or recommend, administer, dispense and develop medications and treatment to promote or restore good health.
Specialisation of:	Service/care provider

Collection and usage attributes

Guide for use:	Health professionals include medical practitioners, nursing professionals, dental practitioners, pharmacists, physiotherapists and podiatrists.

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare
Origin:	ABS (Australian Bureau of Statistics) 1997. Australian Standard Classification of Occupations, 2nd ed. Cat. no. 1220.0. Canberra: ABS

Relational attributes

Data Element Concepts implementing this Object Class:	Health professional—area of clinical practice (principal) Health, Standard 01/03/2005 Health professional—establishment type (employment) Health, Standard 01/03/2005 Health professional—hours worked Health, Standard 01/03/2005 Health professional—labour force status Health, Standard 01/03/2005 Health professional—occupation Health, Standard 01/03/2005 Health professional—principal role Health, Standard 01/03/2005

Health service event

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 268979

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: An interaction between one or more health care providers with one or more persons for assessment, care, consultation and/or treatment.

Specialisation of: Service/care event

Source and reference attributes

Submitting organisation: Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:

Health service event—fasting indicator Health, Standard 01/03/2005

Health service event—first service contact date Health, Standard 07/12/2011

Health service event—presentation date Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Health service event—presentation time Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Health service event—prison health clinic visit initiator Health, Standard 25/08/2011

Health service event—prisoner location Health, Standard 25/08/2011

Health service event—prisoner location when service provider was needed, but not utilised Health, Standard 25/08/2011

Health service event—referral to ophthalmologist status Health, Superseded 21/09/2005

Health service event—referral to rehabilitation service date Health, Standard 01/03/2005

Health service event—service commencement date Health, Superseded 07/12/2005

Health service event—service commencement time Health, Superseded 07/12/2005

Health service event—service request received date Health, Standard 07/12/2011

Health service event—type of service provider consulted Health, Standard 25/08/2011

Health-care incident

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	329602
Registration status:	Health, Standard 07/12/2011
Definition:	An event or circumstance resulting from health care that may have led or did lead to unintended and/or unnecessary harm to a person, and/or a complaint or loss.
Specialisation of:	Service/care event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Health-care incident—additional clinician specialty involved in health-care incident Health, Standard 07/12/2011 Health-care incident—clinical service context Health, Standard 07/12/2011 Health-care incident—date health-care incident occurred Health, Standard 07/12/2011 Health-care incident—geographic remoteness Health, Standard 07/12/2011 Health-care incident—principal clinician specialty involved in health-care incident Health, Standard 07/12/2011 Health-care incident—service delivery setting Health, Standard 07/12/2011

Healthcare provider

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	269023
Registration status:	Health, Standard 01/03/2005
Definition:	An organisation or individual that provides a health service.
Specialisation of:	Service/care provider

Source and reference attributes

Submitting organisation:	Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Healthcare provider—organisation identifier Health, Standard 07/12/2011

Hospital

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268971
Registration status:	Health, Standard 01/03/2005
Definition:	A health care facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day procedure unit, and authorised to provide treatment and/or care to patients.
Context:	Admitted patient care, admitted patient palliative care, admitted patient mental health care and public hospital establishments.
Specialisation of:	Organisation

Collection and usage attributes

Comments:

A hospital thus defined may be located at one physical site or may be a multicampus hospital. A multicampus hospital treats movements of patients between sites as ward transfers.

For the purposes of these definitions, the term hospital includes satellite units managed and staffed by the hospital.

This definition includes, but is not limited to, hospitals as recognised under Australian Health Care Agreements.

Residential aged care services as approved under the National Health Act 1953 (Cwlth.) or equivalent state legislation are excluded from this definition.

This definition includes entities with multipurpose facilities (e.g. those which contain both recognised and non-recognised components).

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Hospital, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB)
Data Element Concepts implementing this Object Class:	Hospital—contract role Health, Standard 01/03/2005 Hospital—contract type Health, Standard 01/03/2005 Hospital—hospital identifier Health, Standard 07/12/2011 Hospital—hospital name Health, Standard 07/12/2011

Hospital census

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 269010

Registration status: Health, Standard 01/03/2005

Definition: A point in time count by a hospital of all its admitted patients and/or patients currently on a waiting list.

Context: Admitted patient care.

Specialisation of: Service/care event

Relational attributes

Related metadata references: Supersedes Hospital census, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (11.8 KB)

Data Element Concepts implementing this Object Class: Hospital census (of elective surgery waitlist patients)—census date Health, Standard 01/03/2005

Hospital service

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 269008

Registration status: Health, Standard 01/03/2005

Definition: A service provided within a hospital, characterised by only one care type.

Specialisation of: Service/care event

Collection and usage attributes

Guide for use: Includes hospital services provided to an admitted patient, to a **hospital boarder**, and to an organ donor who has been declared brain dead.

Source and reference attributes

Submitting organisation: Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class: Hospital service—care type Health, Standard 01/03/2005

Household

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268977
Registration status:	Community Services, Superseded 27/04/2007 Housing assistance, Standard 01/03/2005 Health, Standard 04/05/2005
Definition:	A group of two or more related or unrelated people who usually reside in the same dwelling, and who make common provision for food or other essentials for living. Or a single person living in a dwelling who makes provision for his or her own food and other essentials for living, without combining with any other person.
Context:	Together with family, household is considered one of the basic groups of social aggregation. Information on household numbers and composition aids in identifying groups within the population such as Indigenous households or the number of people living alone.
Specialisation of:	Person/group of persons

Collection and usage attributes

Guide for use:	For housing data collections, the number of tenancy agreements is a practical proxy for calculating the number of households receiving housing assistance. The persons in the group may pool their incomes and have a common budget to a greater or lesser extent: they may be related or unrelated persons, or a combination of both. Only usual residents of the household are included as members of the household. Visitors to a household are, by definition, excluded from the household.

Source and reference attributes

Origin:	CSHA Public rental housing data manual 2001-02

Relational attributes

Related metadata references:	Supersedes Household, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (13.7 KB) Supersedes Household, version 2, DEC, NHADD, NHDAMG, Superseded 01/03/2005.pdf (13.6 KB)
Data Element Concepts implementing this Object Class:	Household—gross income Housing assistance, Recorded 28/09/2011 Health, Standard 15/12/2005

Individual service provider

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	269021
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005 Health, Standard 01/03/2005
Definition:	A person who provides a service and/or care.
Specialisation of:	Service/care provider

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Individual service provider—occupation (self-identified) Community Services, Standard 30/09/2005 Health, Standard 04/05/2005 Individual service provider—occupation end date Community Services, Standard 30/09/2005 Health, Standard 04/05/2005 Individual service provider—occupation start date Community Services, Standard 30/09/2005 Health, Standard 04/05/2005

Injury event

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 268967

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: An occurrence of injury, poisoning or other adverse effect inflicted on the person as the direct or indirect result of an environmental event, circumstance or condition.

Specialisation of: Life event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:

Injury event—activity type Health, Standard 01/03/2005

Injury event—external cause Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Injury event—human intent of injury Health, Standard 24/11/2005
Tasmanian Health, Proposed 28/09/2011

Injury event—nature of main injury Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Injury event—place of occurrence Health, Standard 01/03/2005

Jurisdiction

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	352330
Registration status:	Health, Standard 05/12/2007
Definition:	The territory or area over which authority is exercised.
Specialisation of:	Party

Relational attributes

Data Element Concepts implementing this Object Class:	Jurisdiction—Australian state/territory identifier Health, Standard 05/12/2007

Laboratory standard

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	310463
Registration status:	Health, Standard 27/10/2005
Definition:	The acknowledged measure of comparison of a laboratory test result for the specified laboratory. The measure of comparison can vary between laboratories.
Specialisation of:	Service/care provider

Relational attributes

Data Element Concepts implementing this Object Class:	Laboratory standard—upper limit of normal range for creatine kinase isoenzyme Health, Standard 01/10/2008 Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme Health, Standard 04/06/2004 Laboratory standard—upper limit of normal range for microalbumin Health, Standard 01/03/2005 Laboratory standard—upper limit of normal range of glycosylated haemoglobin Health, Standard 01/03/2005 Laboratory standard—upper limit of normal range of troponin assay Health, Standard 04/06/2004

Medical indemnity claim

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	421801
Registration status:	Health, Standard 07/12/2011
Definition:	An umbrella term which includes medical indemnity claims that have materialised and potential claims. A single medical indemnity claim, that is a single record, in the Medical Indemnity National Collection may encompass one or more claims made by a single claimant in respect of a particular health-care incident, and may involve multiple defendants.
Specialisation of:	Service/care event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Medical indemnity claim —medical indemnity claim identifier Health, Standard 07/12/2011 Medical indemnity claim—additional incident or allegation type Health, Standard 07/12/2011 Medical indemnity claim—medical indemnity claim commencement date Health, Standard 07/12/2011 Medical indemnity claim—medical indemnity claim finalisation mode Health, Standard 07/12/2011 Medical indemnity claim—medical indemnity claim size Health, Standard 07/12/2011 Medical indemnity claim—medical indemnity claim status Health, Standard 07/12/2011 Medical indemnity claim—primary incident or allegation type Health, Standard 07/12/2011 Medical indemnity claim—type of compensatory payment to other party Health, Standard 07/12/2011 Medical indemnity claim—type of compensatory payment to patient Health, Standard 07/12/2011

Medical indemnity claim management episode

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	329600
Registration status:	Health, Standard 07/12/2011
Definition:	The management of a medical indemnity claim and recording the information relevant to that claim. Some main tasks in managing a medical indemnity claim include investigation of the allegations and facts related to the claim, engaging legal expertise, setting a **reserve** to cover costs arising from the claim and covering costs as they arise. Documentation of the conduct and outcomes of claim management produces the information relevant to the claim.
Specialisation of:	Service/care event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Medical indemnity claim management episode—Australian state/territory identifier Health, Standard 07/12/2011 Medical indemnity claim management episode—class action indicator Health, Standard 07/12/2011 Medical indemnity claim management episode—medical indemnity claim finalisation date Health, Standard 07/12/2011 Medical indemnity claim management episode—medical indemnity payment recipient type Health, Standard 07/12/2011 Medical indemnity claim management episode—reserve placement date Health, Standard 07/12/2011 Medical indemnity claim management episode—reserve size Health, Standard 07/12/2011

Medical practitioner

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 269005

Registration status: Health, Standard 01/03/2005

Definition: A person whose primary employment role is to diagnose physical and mental illnesses, disorders and injuries and prescribe medications and treatment to promote or restore good health.

Specialisation of: Service/care provider

Source and reference attributes

Submitting organisation: Australia Institute of Health and Welfare

Origin: ABS (Australian Bureau of Statistics) 1997. Australian Standard Classification of Occupations, 2nd ed. Cat. no. 1220.0. Canberra: ABS

Relational attributes

Data Element Concepts implementing this Object Class:

Medical practitioner—hours on-call Health, Standard 01/03/2005

Medical practitioner—hours worked Health, Standard 01/03/2005

Mental health service contact

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	286670
Registration status:	Health, Standard 08/12/2004
Definition:	The provision of a clinically significant service by a specialised mental health service provider(s) for patients/clients, other than those patients/clients admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24 hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.
Specialisation of:	Service/care event

Collection and usage attributes

Guide for use:

A service contact must involve at least two persons, one of whom must be a specialised mental health service provider.

Mobile and outreach services and consultation and liaison services are included as service contacts.

Service contacts are not restricted to in person communication but can include telephone, video link or other forms of direct communication.

Service contacts can either be with a patient/client, or with a third party such as a carer or family member, other professional or mental health worker or other service provider. Services involving only a service provider and a third party(ies) are included as service contacts, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.

There may be multiple service contacts on any one day for a patient/client or a third party(ies) and each service contact should be recorded separately.

A service contact should be recorded for each patient/client for which the service is provided, whether by phone or other electronic means or in person, regardless of the number of patients/clients or third parties participating or the number of service providers providing the service. Service provision is only regarded as a service contact if it is relevant to the clinical condition of the patient/client. This means that it does not include services of an administrative nature (e.g. telephone contact to schedule an appointment) except where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.

There may however be instances where notes are made in the patient/client clinical record that have not been prompted by a service provision for a patient/client (e.g. noting receipt of test results that require no further action). These instances would not be regarded as service contacts.

In instances where documenting the patient/client's service contact details is separated in time from the service provision, this is not counted as a separate service contact. Travel to or from the location at which the service is provided, for example to or from outreach facilities or private homes, is not to be reported as a service contact.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Specialised mental health service—number of service contacts Health, Standard 07/12/2011

See also Specialised mental health service—number of service contacts, total NNNNNN Health, Standard 07/12/2011

Data Element Concepts implementing this Object Class:

Mental health service contact—mental health service contact duration Health, Standard 08/12/2004

Mental health service contact—patient/client participation indicator Health, Standard 08/12/2004

Mental health service contact—service contact date Health, Standard 08/12/2004

Mental health service contact—session type Health, Standard 08/12/2004

Non-admitted patient emergency department service episode

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 474114

Registration status: Health, Standard 30/01/2012

Definition: The treatment or care between when a patient presents at an **emergency department** and when the non-admitted patient emergency department clinical care ends.

Context: Emergency department care.

Specialisation of: Service episode

Collection and usage attributes

Guide for use: Includes patients who do not wait for treatment once registered or **triaged**, and those who are dead on arrival.

Both a non-admitted patient emergency department service episode and an admitted patient episode of care should be recorded for patients who subsequently undergo a formal admission. The end of the non-admitted patient emergency department service episode should indicate the commencement of the admitted episode of care, if applicable.

A non-admitted patient emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient's emergency department non-admitted clinical care is recorded as completed, or when they are recorded as having left at their own risk.

Comments: This metadata item has been defined to support the national minimum data set for Non-admitted patient emergency department care.

Source and reference attributes

Submitting organisation: National reference group for non-admitted patient data development, 2001-02

Relational attributes

Related metadata references: Supersedes Non-admitted patient emergency department service episode Health, Superseded 30/01/2012

Data Element Concepts implementing this Object Class: Non-admitted patient emergency department service episode—clinical care commencement date Health, Standard 30/01/2012

Non-admitted patient emergency department service episode—clinical care commencement time Health, Standard 30/01/2012

Non-admitted patient emergency department service episode—episode end date Health, Standard 30/01/2012

Non-admitted patient emergency department service episode—episode end status Health, Standard 30/01/2012

Non-admitted patient emergency department service episode—episode end time Health, Standard 30/01/2012

Non-admitted patient emergency department service episode—service episode length Health, Standard 30/01/2012

Non-admitted patient emergency department service episode—triage category Health, Standard 30/01/2012

Non-admitted patient emergency department service episode—triage date Health, Standard 30/01/2012

Non-admitted patient emergency department service episode—triage time Health, Standard 30/01/2012

Non-admitted patient service event

Identifying and definitional attributes

Metadata item type: Object Class

Synonymous names: Service event

METeOR identifier: 400604

Registration status: Health, Standard 06/10/2010
Tasmanian Health, Proposed 28/09/2011

Definition: An interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record.

Context: Hospital non-admitted patient care:

This definition applies to non-admitted hospital patients and is not intended to apply to community based services.

Specialisation of: Service/care event

Collection and usage attributes

Guide for use: The Non-admitted patient (NAP) data set is intended to capture instances of healthcare provision from the point of view of the patient. This may be for assessment, examination, consultation, treatment and/or education.

One service event is recorded for each interaction, regardless of the number of healthcare providers present.

Events broken in time:

The period of interaction can be broken but still regarded as one service event if it was intended to be unbroken in time. This covers those circumstances in which treatment during a service event is temporarily interrupted for unexpected reasons, for example, a healthcare provider is called to assess another patient who requires more urgent care. Where a healthcare provider is unable to complete the interaction, it is considered to be a service event only if the definition of service event (above) is met.

Setting:

Service events can occur in an outpatient clinic or other setting.

Mode:

Service events delivered via Information and Communication Technology (ICT) (including but not limited to telephone and where the patient is participating via a video link) are included if:

- they are a substitute for a face-to-face service event, and

- the definition of a service event (above) is met.

Accompanied patients:

If a patient is accompanied by a carer/ relative, or the carer/relative acts on behalf of the patient with or without the patient present (e.g. mother of 2 year old patient or carer for incapacitated patient), only the patient's service event is recorded unless the carer/relative interaction meets the definition of a service event (above).

Note: carer refers to an informal carer only.

Service events delivered in groups:

Care provided to two or more patients by the same service provider(s) at the same time can also be referred to as a group session.

One service event is recorded for each patient who attends a group session regardless of the number of healthcare providers present, where the definition of a service event (above) is met.

Should a patient receive care both as an individual and as part of a group within a single session, this must be reported as two separate service events.

Service requests:

A service event is the result of a service request (including formal referral and self-referral or attendance at a walk-in clinic).

Activities which do not meet the definition of a service event include:

- Work-related services provided in clinics for staff.
- Non-attendances for a booked outpatient or booked outpatient services that did not go ahead.

Collection methods:

Where providers from multiple clinics, establishments or locations are present at a service event, only one service event should be reported nationally. This reflects the reality that, where providers from different organisations are involved, they are likely to record service events separately. This will be resolved into one service event, where possible, by the jurisdiction centrally before national reporting.

Relational attributes

Related metadata references:

Supersedes Non-admitted patient service event Health, Superseded 06/10/2010

Data Element Concepts implementing this Object Class:

Non-admitted patient service event—care type Health, Standard 06/10/2010

Non-admitted patient service event—group session status Health, Standard 06/10/2010

Non-admitted patient service event—outpatient clinic type

Health, Standard 06/10/2010

Non-admitted patient service event—principal source of funding Health, Standard 01/12/2010

Non-admitted patient service event—service date Health, Standard 06/10/2010
Tasmanian Health, Proposed 28/09/2011

Non-admitted patient service event—service delivery mode Health, Standard 06/10/2010

Non-admitted patient service event—service delivery setting Health, Standard 06/10/2010

Non-admitted patient service request

Identifying and definitional attributes

Metadata item type: Object Class

Synonymous names: Service request

METeOR identifier: 400676

Registration status: Health, Standard 06/10/2010

Definition: A request for service for a non-admitted patient(s) to a healthcare provider.

Specialisation of: Service/care event

Source and reference attributes

Submitting organisation: NAP NMDS (Phase 1) working group

Relational attributes

Data Element Concepts implementing this Object Class:

Non-admitted patient service request—service request received date Health, Standard 06/10/2010

Non-admitted patient service request—service request source Health, Standard 06/10/2010

Occupied bed

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 375696

Registration status: Health, Standard 24/03/2009

Definition: An occupied bed is an available bed where there is a patient physically in the bed or the bed is being retained for a patient (e.g. the patient is receiving treatment or is on leave).

Specialisation of: Organisation

Collection and usage attributes

Comments: Beds may be available but not occupied, e.g. an 8 bed ward may be fully staffed, but only 7 beds are occupied. Also if a patient has left a bed to receive a different care type and will not be returning within 24 hours, the bed is not occupied.

The Occupancy Rate is calculated by dividing total bed days in a period by the product of the available beds and the days in the period – e.g. if in a non-leap year patients accumulated 33,000 bed days in a hospital with 100 overnight-stay beds, the occupancy rate = 33,000/(365*100) = 90.4%. N.B. Occupancy rates calculated for same-day beds could exceed 100%.

Relational attributes

Data Element Concepts implementing this Object Class: Occupied bed—hospital in the home care Health, Standard 24/03/2009

Organisation

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	354505
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 05/12/2007 Early Childhood, Standard 09/03/2012
Definition:	The smallest type of accounting unit within a management unit within a State or Territory of Australia which controls its productive activities and for which a specified range of detailed data is available, at least on an annual basis, thus enabling measures such as value added to be calculated.
Specialisation of:	Organisation

Source and reference attributes

Reference documents:	Australian Bureau of Statistics 2002. Standard Economic Sector Classifications of Australia (SESCA). ABS cat. no. 1218.0. Canberra: ABS.

Relational attributes

Data Element Concepts implementing this Object Class:	Organisation—capital consumption expenses Health, Standard 01/04/2009 Organisation—depreciation expenses Health, Superseded 01/04/2009 Organisation—employee related expenses Health, Standard 05/12/2007 Organisation—expenses Health, Standard 05/12/2007 Organisation—purchase of goods and services Health, Standard 05/12/2007 Organisation—revenue Health, Standard 05/12/2007 Organisation—type of health or health related function Health, Standard 05/12/2007

Patient

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 268959

Registration status: Health, Standard 01/03/2005

Definition: A person for whom a health service accepts responsibility for treatment and or care.

Specialisation of: Person/group of persons

Source and reference attributes

Submitting organisation: Australia Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Patient, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.2 KB)

Data Element Concepts implementing this Object Class:

Patient—additional body function or structure affected Health, Standard 07/12/2011

Patient—cancer status Health, Standard 07/12/2011

Patient—clinical emergency indicator Health, Standard 07/12/2011

Patient—compensable status Health, Standard 01/03/2005

Patient—date of last contact Health, Standard 07/12/2011

Patient—diagnosis date Health, Standard 01/03/2005

Patient—diagnosis date of cancer Health, Standard 07/12/2011

Patient—diagnosis date of first recurrence as distant metastasis Health, Standard 07/12/2011

Patient—diagnosis date of first recurrence as locoregional cancer Health, Standard 07/12/2011

Patient—extent of harm from a health-care incident Health, Standard 07/12/2011

Patient—hospital insurance status Health, Standard 01/03/2005

Patient—initial visit since diagnosis indicator (diabetes mellitus) Health, Standard 21/09/2005

Patient—initial visit since diagnosis status (diabetes mellitus) Health, Superseded 21/09/2005

Patient—insulin start date Health, Standard 01/03/2005

Patient—intention of treatment Health, Standard 07/12/2011

Patient—number of psychiatric outpatient clinic/day program attendances Health, Standard 01/03/2005

Patient—previous specialised treatment Health, Standard 01/03/2005

Patient—primary body function or structure affected Health, Standard 07/12/2011

Patient—principal diagnosis Health, Standard 07/12/2011

Patient—radiotherapy start date Health, Standard 07/12/2011

Patient—ready-for-care date Health, Standard 07/12/2011

Patient—relationship to health-care service provider Health, Standard 07/12/2011

Person

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268955
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005 Health, Standard 01/03/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010 Tasmanian Health, Proposed 28/09/2011
Definition:	A human being, whether man, woman or child.
Specialisation of:	Person/group of persons

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Macquarie University 2003. *The Macquarie Dictionary 3rd ed.* Sydney: The Macquarie Library Pty. Ltd

Relational attributes

Data Element Concepts implementing this Object Class:	Person (address)—address line Community Services, Standard 30/09/2005 Health, Standard 04/05/2005 Person (address)—address type Community Services, Superseded 06/02/2012 Health, Standard 01/03/2005 Person (address)—Australian postcode Community Services, Superseded 06/02/2012 Housing assistance, Standard 10/02/2006 Health, Superseded 07/12/2011 Early Childhood, Superseded 09/03/2012 Homelessness, Standard 23/08/2010 Tasmanian Health, Proposed 28/09/2011 Person (address)—building/complex sub-unit identifier Community Services, Superseded 06/02/2012 Health, Superseded 07/12/2011 Person (address)—building/complex sub-unit type Community Services, Standard 30/09/2005 Health, Standard 01/03/2005 Person (address)—building/property name Community Services, Superseded 06/02/2012 Health, Superseded 07/12/2011 Person (address)—country identifier Community Services, Standard 30/09/2005 Health, Standard 04/05/2005

Person (address)—electronic communication address Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Person (address)—electronic communication medium Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Person (address)—electronic communication usage code Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Person (address)—floor/level identifier Community Services, Superseded 06/02/2012
Health, Superseded 07/12/2011

Person (address)—floor/level type Community Services, Superseded 06/02/2012
Health, Standard 01/03/2005

Person (address)—health address line Health, Superseded 04/05/2005

Person (address)—house/property identifier Community Services, Superseded 06/02/2012
Health, Superseded 07/12/2011

Person (address)—international postcode Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Person (address)—lot/section identifier Community Services, Superseded 06/02/2012
Health, Standard 01/03/2005

Person (address)—non-Australian state/province Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Person (address)—postal delivery point identifier Community Services, Superseded 06/02/2012
Health, Standard 01/03/2005

Person (address)—postal delivery service type identifier Health, Standard 01/03/2005

Person (address)—street name Community Services, Superseded 06/02/2012
Health, Superseded 07/12/2011

Person (address)—street suffix Community Services, Superseded 06/02/2012
Health, Standard 01/03/2005

Person (address)—street type Community Services, Superseded 06/02/2012
Health, Superseded 07/12/2011

Person (address)—suburb/town/locality name Community Services, Superseded 06/02/2012
Housing assistance, Standard 23/08/2010
Health, Superseded 07/12/2011

Early Childhood, Superseded 09/03/2012
Homelessness, Standard 23/08/2010
Tasmanian Health, Proposed 28/09/2011

Person (identifier)—identifier type Health, Standard 01/03/2005

Person (male)—erectile dysfunction Health, Standard 01/03/2005

Person (name)—family name Community Services, Standard 01/03/2005
Housing assistance, Standard 28/07/2005
Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Person (name)—given name Community Services, Standard 01/03/2005
Housing assistance, Standard 01/08/2005
Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Person (name)—given name sequence number Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Person (name)—name conditional use flag Community Services, Standard 25/08/2005
Health, Standard 04/05/2005

Person (name)—name context flag Community Services, Superseded 25/08/2005
Health, Superseded 04/05/2005

Person (name)—name suffix Community Services, Standard 01/03/2005
Health, Standard 01/03/2005

Person (name)—name suffix sequence number Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Person (name)—name title Community Services, Standard 01/03/2005
Health, Standard 01/03/2005

Person (name)—name title sequence number Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Person (name)—name type Community Services, Superseded 06/02/2012
Health, Standard 01/03/2005

Person (requiring care)—carer availability status Community Services, Superseded 02/05/2006
Health, Superseded 04/07/2007

Person (telephone)—telephone number type Community Services, Standard 01/03/2005
Health, Standard 01/03/2005

Person— electrocardiogram Q waves indicator Health, Standard 01/10/2008

Person—accommodation type Health, Standard 01/03/2005

Person—activity and participation life area Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—acute coronary syndrome concurrent clinical condition Health, Superseded 01/10/2008

Person—acute coronary syndrome procedure type Health, Standard 04/06/2004

Person—acute coronary syndrome related medical history Health, Standard 01/10/2008

Person—acute coronary syndrome risk stratum Health, Standard 01/10/2008

Person—acute coronary syndrome risk stratum Health, Superseded 01/10/2008

Person—acute coronary syndrome symptoms onset date Health, Standard 01/10/2008

Person—acute coronary syndrome symptoms onset time Health, Standard 01/10/2008

Person—age Community Services, Standard 04/05/2005
Housing assistance, Standard 17/06/2005
Health, Standard 04/05/2005
Early Childhood, Standard 21/05/2010
Tasmanian Health, Proposed 28/09/2011

Person—age range Community Services, Standard 30/11/2007
Health, Standard 04/05/2005

Person—alcohol consumption amount Health, Standard 01/03/2005

Person—alcohol consumption frequency Health, Standard 01/03/2005

Person—alcohol consumption status recorded indicator Health, Standard 07/12/2011

Person—angina status Health, Standard 01/10/2008

Person—angiotensin converting enzyme inhibitors therapy status Health, Standard 04/06/2004

Person—area of usual residence Community Services, Standard 21/05/2010
Health, Standard 01/03/2005
Early Childhood, Standard 21/05/2010

Person—aspirin therapy status Health, Standard 04/06/2004

Person—Australian state/territory identifier Community Services, Standard 01/03/2005
Housing assistance, Standard 10/02/2006
Health, Standard 01/03/2005
Early Childhood, Standard 21/05/2010

Person—beta-blocker therapy status Health, Standard 04/06/2004

Person—birth weight recorded indicator Health, Standard 07/12/2011

Person—bleeding episode status Health, Standard 01/10/2008

Person—bleeding episode status Health, Superseded 01/10/2008

Person—blindness Health, Standard 01/03/2005

Person—blood pressure (diastolic) Health, Standard 01/03/2005

Person—blood pressure (systolic) Health, Standard 01/03/2005

Person—blood pressure measurement result less than or equal to 130/80 mmHg indicator Health, Standard 07/12/2011

Person—blood pressure measurement result recorded indicator Health, Standard 07/12/2011

Person—blow to the head indicator Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Person—bodily location of main injury Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Person—body function Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—body mass index (classification) Health, Standard 01/03/2005

Person—body mass index recorded indicator Health, Standard 07/12/2011

Person—body structure Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—C-reactive protein level (measured) Health, Standard 01/10/2008

Person—C-reactive protein level measured date Health, Standard 01/10/2008

Person—C-reactive protein level measured time Health, Standard 01/10/2008

Person—cardiovascular disease condition targeted by drug therapy Health, Standard 01/03/2005

Person—cardiovascular disease recorded indicator Health, Standard 07/12/2011

Person—cardiovascular medication taken Health, Standard 01/03/2005

Person—carer responsibility indicator Health, Standard 07/12/2011

Person—cataract status Health, Standard 01/03/2005

Person—cerebral stroke due to vascular disease Health, Standard 01/03/2005

Person—chest pain pattern Health, Standard 04/06/2004

Person—cholesterol level Health, Standard 01/03/2005

Person—chronic condition indicator Health, Standard 25/08/2011

Person—chronic obstructive pulmonary disease recorded indicator Health, Standard 07/12/2011

Person—clinical evidence status (acute coronary syndrome related medical history) Health, Standard 01/10/2008

Person—clinical evidence status (chronic lung disease) Health, Superseded 01/10/2008

Person—clinical evidence status (heart failure) Health, Superseded 01/10/2008

Person—clinical evidence status (peripheral arterial disease) Health, Superseded 01/10/2008

Person—clinical evidence status (sleep apnoea syndrome) Health, Superseded 01/10/2008

Person—clinical evidence status (stroke) Health, Superseded 01/10/2008

Person—clinical procedure timing Health, Standard 04/06/2004

Person—clopidogrel therapy status Health, Standard 04/06/2004

Person—congenital malformation Health, Standard 01/03/2005

Person—consumption of 6 or more standard drinks on one occasion Health, Standard 25/08/2011

Person—coronary artery bypass graft date Health, Standard 01/10/2008

Person—coronary artery bypass graft location Health, Standard 01/10/2008

Person—coronary artery disease intervention Health, Standard 01/03/2005

Person—coronary artery stenosis location Health, Standard 01/10/2008

Person—count of angina episodes Health, Standard 01/10/2008

Person—count of coronary artery lesions attempted Health, Standard 01/10/2008

Person—count of coronary artery lesions successfully dilated Health, Standard 01/10/2008

Person—count of coronary artery stents Health, Standard 01/10/2008

Person—country of birth Community Services, Standard 01/03/2005
Housing assistance, Standard 27/07/2005

Health, Standard 01/03/2005
Homelessness, Standard 23/08/2010
Tasmanian Health, Proposed 28/09/2011

Person—creatine kinase isoenzyme level Health, Standard 01/10/2008

Person—creatine kinase myocardial band isoenzyme measured date Health, Standard 04/06/2004

Person—creatine kinase myocardial band isoenzyme measured time Health, Standard 04/06/2004

Person—creatine kinase-myocardial band isoenzyme level Health, Standard 04/06/2004

Person—creatinine serum level Health, Standard 01/03/2005

Person—creatinine serum level measured date Health, Standard 01/10/2008

Person—current opioid pharmacotherapy treatment program indicator Health, Standard 25/08/2011

Person—current smoking status indicator Health, Standard 25/08/2011

Person—date of birth Community Services, Standard 01/03/2005
Housing assistance, Standard 27/07/2005
Health, Standard 01/03/2005
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010
Tasmanian Health, Proposed 28/09/2011

Person—date of death Community Services, Standard 30/09/2005
Health, Standard 04/05/2005
Tasmanian Health, Proposed 28/09/2011

Person—dependency in activities of daily living Community Services, Recorded 16/11/2009
Health, Standard 01/03/2005

Person—diabetes mellitus status Health, Standard 01/03/2005

Person—diabetes therapy type Health, Standard 01/03/2005

Person—diagnostic cardiac catheterisation date Health, Standard 01/10/2008

Person—diagnostic cardiac catheterisation time Health, Standard 01/10/2008

Person—dyslipidaemia treatment status (anti-lipid medication) Health, Superseded 22/09/2005

Person—dyslipidaemia treatment with anti-lipid medication indicator Health, Standard 21/09/2005

Person—electrocardiogram change location Health, Superseded 01/10/2008

Person—electrocardiogram change type Health, Superseded 01/10/2008

Person—eligibility status Community Services, Standard 04/01/2006
Health, Standard 04/01/2006

Person—end-stage renal disease status Health, Standard 01/03/2005

Person—environmental factor Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—estimated glomerular filtration rate (eGFR) recorded indicator Health, Standard 07/12/2011

Person—ever smoked a full cigarette indicator Health, Standard 25/08/2011

Person—extent of environmental factor influence Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—extent of impairment of body function Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—extent of impairment of body structure Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—extent of participation in a life area Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—fibrinolytic drug administered Health, Superseded 01/10/2008

Person—fibrinolytic drug administered Health, Standard 01/10/2008

Person—fibrinolytic therapy status Health, Standard 04/06/2004

Person—first angioplasty balloon inflation or stenting date Health, Superseded 01/10/2008

Person—first angioplasty balloon inflation or stenting time Health, Superseded 01/10/2008

Person—first language spoken Community Services, Standard 01/03/2005
Housing assistance, Standard 01/08/2005
Health, Standard 13/10/2011
Homelessness, Standard 13/10/2011

Person—foot deformity indicator Health, Standard 01/03/2005

Person—foot lesion indicator Health, Standard 01/03/2005

Person—foot ulcer history status Health, Standard 01/03/2005

Person—foot ulcer indicator Health, Standard 21/09/2005

Person—foot ulcer status (current) Health, Superseded 21/09/2005

Person—formal community support access indicator Health,

Standard 01/03/2005

Person—functional stress test element Health, Superseded 01/10/2008

Person—functional stress test ischaemic result Health, Superseded 01/10/2008

Person—functional stress test performed indicator Health, Standard 01/10/2008

Person—glycoprotein IIb/IIIa receptor antagonist status Health, Standard 04/06/2004

Person—glycosylated haemoglobin level Health, Standard 01/03/2005

Person—glycosylated haemoglobin measurement result recorded indicator Health, Standard 07/12/2011

Person—government funding identifier Community Services, Standard 31/08/2007
Housing assistance, Standard 23/08/2010
Health, Standard 01/03/2005
Homelessness, Standard 23/08/2010
Tasmanian Health, Proposed 28/09/2011

Person—GP Management Plan (MBS Item 721) indicator Health, Standard 07/12/2011

Person—health professionals attended for diabetes mellitus Health, Standard 01/03/2005

Person—heart rate Health, Standard 04/06/2004

Person—heart rhythm type Health, Superseded 01/10/2008

Person—height Health, Standard 01/03/2005

Person—high-density lipoprotein cholesterol level Health, Standard 01/03/2005

Person—highest year of school completed Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Person—hip circumference Health, Standard 01/03/2005

Person—hypertension treatment status (antihypertensive medication) Health, Superseded 21/09/2005

Person—hypertension treatment with antihypertensive medication indicator Health, Standard 21/09/2005

Person—implantable cardiac defibrillator procedure date Health, Standard 01/10/2008

Person—implantable cardiac defibrillator procedure time Health, Standard 01/10/2008

Person—Indigenous status Community Services, Standard 01/03/2005
Housing assistance, Standard 01/03/2005
Health, Standard 01/03/2005
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Tasmanian Health, Proposed 30/09/2011

Person—influenza immunisation indicator Health, Standard 07/12/2011

Person—informal carer existence indicator Community Services, Standard 02/05/2006
Health, Standard 04/07/2007

Person—interpreter service required Community Services, Standard 10/04/2006
Health, Standard 08/02/2006
Tasmanian Health, Proposed 28/09/2011

Person—interpreter service required status (health) Health, Superseded 08/02/2006

Person—intra-aortic balloon pump procedure date Health, Standard 01/10/2008

Person—intra-aortic balloon pump procedure time Health, Standard 01/10/2008

Person—intravenous fibrinolytic therapy date Health, Standard 01/10/2008

Person—intravenous fibrinolytic therapy date Health, Superseded 01/10/2008

Person—intravenous fibrinolytic therapy time Health, Standard 04/06/2004

Person—Killip classification Health, Standard 04/06/2004

Person—labour force status Community Services, Standard 01/03/2005
Housing assistance, Standard 01/08/2005
Health, Standard 01/03/2005
Homelessness, Standard 23/08/2010

Person—legal status of prisoner Health, Standard 25/08/2011

Person—letters of family name Community Services, Standard 27/03/2007
Housing assistance, Standard 23/08/2010
Health, Standard 07/12/2011
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Person—letters of given name Community Services, Standard 27/03/2007
Housing assistance, Standard 23/08/2010
Health, Standard 07/01/2011
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Person—level of difficulty with activities in a life area Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—level of highest non-school qualification Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Person—level of satisfaction with participation in a life area Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—lipid-lowering therapy status Health, Standard 04/06/2004

Person—living arrangement Community Services, Standard 01/03/2005
Housing assistance, Standard 23/08/2010
Health, Standard 19/04/2005
Homelessness, Standard 23/08/2010

Person—location of impairment of body structure Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—low-density lipoprotein cholesterol level Health, Standard 01/03/2005

Person—lower limb amputation due to vascular disease Health, Standard 01/03/2005

Person—main language other than English spoken at home Community Services, Standard 01/03/2005
Housing assistance, Standard 10/02/2006
Health, Standard 01/03/2005

Person—marital status Community Services, Standard 01/03/2005
Housing assistance, Standard 10/02/2006
Health, Standard 01/03/2005

Person—maximum stenosis coronary artery Health, Standard 01/10/2008

Person—MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) indicator Health, Standard 07/12/2011

Person—medication for mental health disorder indicator Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Person—medication type Health, Standard 25/08/2011

Person—mental health disorder indicator Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Person—microalbumin level Health, Standard 01/03/2005

Person—microalbumin urine test result recorded indicator Health, Standard 07/12/2011

Person—most recent stroke date Health, Standard 01/10/2008

Person—mother's original family name Community Services, Standard 01/03/2005
Health, Standard 01/03/2005

Person—myocardial infarction Health, Standard 01/03/2005

Person—nature of impairment of body structure Community

Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—need for assistance with activities in a life area
Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—non-invasive ventilation administration date Health, Standard 01/10/2008

Person—non-invasive ventilation administration time Health, Standard 01/10/2008

Person—non-school qualification indicator Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Person—number of cigarettes smoked Health, Standard 01/03/2005

Person—number of service contact dates Health, Standard 01/03/2005

Person—occupation (main) Community Services, Standard 27/03/2007
Housing assistance, Standard 10/08/2007
Health, Standard 04/07/2007
Tasmanian Health, Proposed 28/09/2011

Person—occupation (main) Community Services, Superseded 27/03/2007
Housing assistance, Superseded 10/08/2007
Health, Superseded 04/07/2007

Person—ophthalmological assessment outcome Health, Standard 01/03/2005

Person—ophthalmoscopy performed indicator Health, Standard 21/09/2005

Person—ophthalmoscopy performed status Health, Superseded 21/09/2005

Person—pacemaker insertion date Health, Standard 01/10/2008

Person—pacemaker insertion time Health, Standard 01/10/2008

Person—percutaneous coronary intervention procedure type Health, Standard 01/10/2008

Person—period of residence in Australia Health, Standard 01/03/2005

Person—peripheral neuropathy indicator Health, Standard 01/03/2005

Person—peripheral vascular disease indicator (foot) Health, Standard 01/03/2005

Person—person identifier Community Services, Standard 25/08/2005
Health, Standard 04/05/2005

Person—person identifier (within establishment/agency)
Community Services, Superseded 25/08/2005
Health, Superseded 04/05/2005

Person—physical activity sufficiency status Health, Standard 01/03/2005

Person—pneumococcal disease immunisation indicator Health, Standard 07/12/2011

Person—postal delivery service type Health, Standard 01/03/2005

Person—preferred language Community Services, Standard 10/04/2006
Housing assistance, Standard 13/10/2011
Health, Standard 01/03/2005
Homelessness, Standard 13/10/2011
Tasmanian Health, Proposed 28/09/2011

Person—premature cardiovascular disease family history status Health, Standard 01/03/2005

Person—previous opioid pharmacotherapy treatment program indicator Health, Standard 25/08/2011

Person—primary percutaneous coronary intervention date Health, Standard 01/10/2008

Person—primary percutaneous coronary intervention time Health, Standard 01/10/2008

Person—prisoner health discharge summary indicator Health, Standard 25/08/2011

Person—proficiency in spoken English Community Services, Standard 01/03/2005
Housing assistance, Standard 10/02/2006
Health, Standard 01/03/2005

Person—proteinuria status Health, Standard 01/03/2005

Person—reason for health clinic attendance Health, Standard 25/08/2011

Person—reason for non prescription of pharmacotherapy Health, Standard 01/10/2008

Person—reason for readmission following acute coronary syndrome episode Health, Standard 04/06/2004

Person—reason for readmission following acute coronary syndrome episode Health, Standard 01/10/2008

Person—referral to ophthalmologist indicator Health, Standard 21/09/2005

Person—regular client indicator Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Person—regular tobacco smoking indicator Health, Standard 21/09/2005

Person—renal disease therapy Health, Standard 01/03/2005

Person—rescue percutaneous coronary intervention date Health, Standard 01/10/2008

Person—rescue percutaneous coronary intervention time Health, Standard 01/10/2008

Person—revascularisation percutaneous coronary intervention date Health, Standard 01/10/2008

Person—revascularisation percutaneous coronary intervention time Health, Standard 01/10/2008

Person—self-harm ideation in the last 12 months Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Person—self-harm indicator Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Person—severe hypoglycaemia history Health, Superseded 21/09/2005

Person—severe hypoglycaemia indicator Health, Standard 21/09/2005

Person—sex Community Services, Standard 01/03/2005
Housing assistance, Standard 10/02/2006
Health, Standard 01/03/2005
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Person—smoking status recorded indicator Health, Standard 07/12/2011

Person—specific chronic condition indicator Health, Standard 25/08/2011

Person—state/territory of birth Health, Standard 10/12/2009

Person—substance used illicitly indicator Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Person—Team Care Arrangement (MBS Item 723) indicator Health, Standard 07/12/2011

Person—technical nursing care requirement Health, Standard 13/10/2005

Person—telephone number Community Services, Superseded 06/02/2012
Health, Standard 01/03/2005

Person—time since quitting tobacco smoking Health, Standard 01/03/2005

Person—timing of ACE-inhibitor prescription Health, Standard 01/10/2008

Person—timing of angiotensin II receptor blocker prescription Health, Standard 01/10/2008

Person—timing of antithrombin therapy prescription Health, Standard 01/10/2008

Person—timing of aspirin prescription Health, Standard 01/10/2008

Person—timing of beta-blocker prescription Health, Standard 01/10/2008

Person—timing of clopidogrel prescription Health, Standard 01/10/2008

Person—timing of glycoprotein IIb/IIIa inhibitor prescription Health, Standard 01/10/2008

Person—timing of statin prescription Health, Standard 01/10/2008

Person—tobacco product smoked Health, Standard 01/03/2005

Person—tobacco smoking daily use status Health, Standard 01/03/2005

Person—tobacco smoking duration Health, Standard 01/03/2005

Person—tobacco smoking frequency Health, Standard 01/03/2005

Person—tobacco smoking quit age Health, Standard 01/03/2005

Person—tobacco smoking start age Health, Standard 01/03/2005

Person—tobacco smoking status Health, Standard 01/03/2005

Person—tobacco smoking status (last three months) Health, Superseded 21/09/2005

Person—transgender indicator Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Person—triglyceride level Health, Standard 01/03/2005

Person—troponin assay type Health, Standard 04/06/2004

Person—troponin level Health, Standard 04/06/2004

Person—troponin level measured date Health, Standard 04/06/2004

Person—troponin level measured time Health, Standard 04/06/2004

Person—type of chronic condition Health, Standard 25/08/2011

Person—type of opioid pharmacotherapy treatment Health, Standard 25/08/2011

Person—type of substance used illicitly Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Person—underlying cause of acute coronary syndrome Health, Standard 01/10/2008

Person—underlying cause of death Health, Standard 01/10/2008

Person—units of blood transfused Health, Standard

01/10/2008

Person—vascular condition status Health, Standard 01/03/2005

Person—vascular procedure Health, Standard 01/03/2005

Person—ventricular ejection fraction test performed indicator Health, Standard 01/10/2008

Person—visual acuity Health, Standard 01/03/2005

Person—waist circumference Health, Standard 01/03/2005

Person—weight Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Person—year of first arrival in Australia Community Services, Standard 01/03/2005
Housing assistance, Standard 23/08/2010
Health, Standard 04/05/2005
Homelessness, Standard 23/08/2010

Person with acute coronary syndrome

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	284638
Registration status:	Health, Standard 04/06/2004
Definition:	A person receiving treatment for acute myocardial ischaemia resulting from coronary artery disease.
Specialisation of:	Person/group of persons

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Person with acute coronary syndrome—acute coronary syndrome related clinical event date Health, Standard 01/10/2008 Person with acute coronary syndrome—acute coronary syndrome related clinical event time Health, Standard 01/10/2008 Person with acute coronary syndrome—bleeding location Health, Standard 01/10/2008 Person with acute coronary syndrome—lifestyle counselling type Health, Standard 01/10/2008 Person with acute coronary syndrome—pharmacotherapy type prescribed in hospital Health, Standard 01/10/2008 Person with acute coronary syndrome—pharmacotherapy type taken post discharge from hospital Health, Standard 01/10/2008 Person with acute coronary syndrome—type of acute coronary syndrome related clinical event Health, Standard 01/10/2008

Person with cancer

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 268990

Registration status: Health, Standard 01/03/2005

Definition: A person who has been diagnosed with a cancer.

Specialisation of: Person/group of persons

Source and reference attributes

Submitting organisation: Australia Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:

Person with cancer—degree of spread of a cancer Health, Standard 01/03/2005

Person with cancer—distant metastasis status Health, Standard 07/12/2011

Person with cancer—distant metastasis status Health, Superseded 07/12/2011

Person with cancer—extent of primary cancer Health, Standard 07/12/2011

Person with cancer—extent of primary cancer Health, Superseded 07/12/2011

Person with cancer—histopathological grade Health, Standard 04/06/2004

Person with cancer—human epidermal growth factor receptor-2 test result Health, Standard 06/03/2009

Person with cancer—human epidermal growth factor receptor-2 test type Health, Standard 06/03/2009

Person with cancer—laterality of primary cancer Health, Standard 01/03/2005

Person with cancer—lymphovascular invasion Health, Standard 06/03/2009

Person with cancer—melanoma thickness Health, Standard 01/03/2005

Person with cancer—morphology of cancer Health, Standard 01/03/2005

Person with cancer—most valid basis of diagnosis of a cancer Health, Standard 01/03/2005

Person with cancer—neoadjuvant therapy indicator Health, Standard 06/03/2009

Person with cancer—number of positive regional lymph nodes Health, Standard 04/06/2004

Person with cancer—number of positive sentinel lymph nodes

Health, Standard 06/03/2009

Person with cancer—number of regional lymph nodes examined Health, Superseded 07/12/2011

Person with cancer—number of regional lymph nodes examined Health, Standard 07/12/2011

Person with cancer—number of sentinel lymph nodes examined Health, Standard 06/03/2009

Person with cancer—oestrogen receptor assay result Health, Standard 04/06/2004

Person with cancer—primary site of cancer Health, Standard 01/03/2005

Person with cancer—primary tumour status Health, Standard 07/12/2011

Person with cancer—primary tumour status Health, Superseded 07/12/2011

Person with cancer—progesterone receptor assay results Health, Standard 13/06/2004

Person with cancer—region of first recurrence as distant metastasis Health, Standard 07/12/2011

Person with cancer—region of first recurrence as locoregional cancer Health, Standard 07/12/2011

Person with cancer—region of first recurrence of cancer Health, Standard 04/06/2004

Person with cancer—regional lymph node metastasis status Health, Standard 07/12/2011

Person with cancer—regional lymph node metastasis status Health, Superseded 07/12/2011

Person with cancer—solid tumour size Health, Standard 01/03/2005

Pregnancy

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 268966

Registration status: Health, Standard 01/03/2005

Definition: The period during which a woman carries a developing fetus, normally in the uterus. Pregnancy lasts for approximately 266 days, from conception until the baby is born, or 280 days from the first day of the last menstrual period. During pregnancy menstruation is absent, there may be a great increase in appetite, and the breasts increase in size; the woman may also experience morning sickness. These and other changes brought about by a hormone (progesterone) produced at first by the ovary and later by the placenta. Definite evidence of pregnancy is provided by various pregnancy tests, by the detection of the heartbeat of the fetus, and by ultrasound.

Specialisation of: Life event

Source and reference attributes

Submitting organisation: Australia Institute of Health and Welfare

Origin: University of Oxford 2002. Concise Colour Medical Dictionary 3rd ed. UK: Oxford University Press

Relational attributes

Data Element Concepts implementing this Object Class:

Pregnancy (current)—complication Health, Standard 01/03/2005

Pregnancy (last previous)—pregnancy completion date Health, Standard 01/03/2005

Pregnancy (last previous)—pregnancy outcome Health, Standard 01/03/2005

Pregnancy—estimated duration Health, Standard 02/12/2009

Pregnancy—first day of the last menstrual period Health, Standard 01/03/2005

Prison entrant

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	348021
Registration status:	Health, Standard 25/08/2011
Definition:	An adult (aged at least 18 years) who is entering prison, and whose confinement is the responsibility of a corrective services agency. Juvenile offenders, persons in psychiatric custody, police cell detainees, those in periodic detention, asylum seekers or Australians held in overseas prisons are not included.
Specialisation of:	Person/group of persons

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Prison entrant—age at first detention Health, Standard 25/08/2011 Prison entrant—at risk of suicide or self-harm indicator Health, Standard 25/08/2011 Prison entrant—distress related to current imprisonment indicator Health, Standard 25/08/2011 Prison entrant—education attendance status 30 days prior to imprisonment Health, Standard 25/08/2011 Prison entrant—first time in prison or juvenile detention indicator Health, Standard 25/08/2011 Prison entrant—imprisonment in the last 12 months indicator Health, Standard 25/08/2011 Prison entrant—individual service provider consulted indicator Health, Standard 25/08/2011 Prison entrant—labour force status 30 days prior to imprisonment Health, Standard 25/08/2011 Prison entrant—legal status of prisoner Health, Standard 25/08/2011 Prison entrant—mental health service referral indicator Health, Standard 25/08/2011 Prison entrant—number of times in prison or juvenile detention Health, Standard 25/08/2011 Prison entrant—reason for non-utilisation of health service Health, Standard 25/08/2011 Prison entrant—service provider needed but not utilised indicator Health, Standard 25/08/2011

Prison entrant—type of corrective services facility Health, Standard 25/08/2011

Prison entrant—type of service provider consulted Health, Standard 25/08/2011

Prison entrant—type of service provider needed but not utilised Health, Standard 25/08/2011

Product of conception

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	324090
Registration status:	Health, Standard 02/12/2009
Definition:	A conceptus, embryo, fetus or placenta.
Specialisation of:	Life event

Relational attributes

Data Element Concepts implementing this Object Class:	Product of conception—gestational age Health, Standard 02/12/2009

Record

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 300208

Registration status: Community Services, Standard 27/03/2007
Housing assistance, Standard 23/08/2010
Health, Standard 07/12/2011
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Definition: An account of something, preserved in a lasting form.

Specialisation of: Service/care event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:

Record—identifier Community Services, Standard 27/03/2007
Health, Standard 07/12/2011

Record—linkage key Community Services, Standard 21/05/2010
Housing assistance, Standard 23/08/2010
Health, Standard 07/12/2011
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Registered health professional

Identifying and definitional attributes

Metadata item type: Object Class

Synonymous names: Health professional

METeOR identifier: 372858

Registration status: Health, Standard 10/12/2009

Definition: A person who is listed as a health professional during the reference period with the Australian Health Practitioner Regulatory Agency under the *Health Practitioner Regulation National Law Bill.*

Specialisation of: Service/care provider

Collection and usage attributes

Guide for use: Registered health professionals include

- chiropractors
- dental hygienists
- dental prosthetists
- dental therapists
- dentists
- medical practitioners
- midwives
- nurses - enrolled
- nurses - registered
- nurse practitioners
- optometrists
- osteopaths
- pharmacists
- physiotherapists
- podiatrists
- psychologists.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Health professional Health, Standard 01/03/2005

Data Element Concepts implementing this Object Class: Registered health professional—country of employment in registered profession Health, Standard 10/12/2009

Registered health professional—extended leave status in registered profession Health, Standard 10/12/2009

Registered health professional—hours worked in clinical role Health, Standard 10/12/2009

Registered health professional—hours worked in health profession Health, Standard 10/12/2009

Registered health professional—hours worked in non-clinical role Health, Standard 10/12/2009

Registered health professional—hours worked in private sector Health, Standard 10/12/2009

Registered health professional—hours worked in public sector Health, Standard 10/12/2009

Registered health professional—intended years in profession Health, Standard 10/12/2009

Registered health professional—jobseeker status in registered profession Health, Standard 10/12/2009

Registered health professional—labour force status Health, Standard 10/12/2009

Registered health professional—length of employment in profession in Australia Health, Standard 10/12/2009

Registered health professional—principal area of practice Health, Standard 10/12/2009

Registered health professional—principal field of medicine Health, Standard 10/12/2009

Registered health professional—principal role Health, Standard 10/12/2009

Registered health professional—retirement status in registered profession Health, Standard 10/12/2009

Registered health professional—visa type Health, Standard 10/12/2009

Registered health professional—work sector in registered health profession Health, Standard 10/12/2009

Registered health professional—work setting Health, Standard 10/12/2009

Residential stay

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	268960
Registration status:	Health, Standard 01/03/2005
Definition:	The period of care beginning with a formal start of residential care and ending with a formal end of the residential care and accommodation. It may involve more than one reference period, that is, more than one episode of residential care.
Context:	Specialised mental health services (Residential mental health care).
Specialisation of:	Service episode

Relational attributes

Data Element Concepts implementing this Object Class:	Residential stay—episode start date Health, Standard 01/03/2005

Service contact

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 268983

Registration status: Health, Standard 01/03/2005

Definition: A contact between a patient/client and an ambulatory care health unit (including outpatient and community health units) which results in a dated entry being made in the patient/client record.

Context: Identifies service delivery at the patient level for mental health services (including consultation/liaison, mobile and outreach services).

A service contact can include either face-to-face, telephone or video link service delivery modes. Service contacts would either be with a client, carer or family member or another professional or mental health worker involved in providing care and do not include contacts of an administrative nature (e.g. telephone contact to schedule an appointment) except where a matter would need to be noted on a patient's record.

Service contacts may be differentiated from administrative and other types of contacts by the need to record data in the client record. However, there may be instances where notes are made in the client record that have not been prompted by a service contact with a patient/client (e.g. noting receipt of test results that require no further action). These instances would not be regarded as a service contact.

Specialisation of: Service/care event

Collection and usage attributes

Comments: The proposed definition is not able to measure case complexity or level of resource usage with each service contact alone. This limitation also applies to the concept of occasions of service (in admitted patient care) and hospital separations. The National Health Data Committee also acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant's patient/client record is not currently covered by this metadata item.

Source and reference attributes

Steward: Australian Bureau of Statistics (ABS)

Relational attributes

Related metadata references:	Supersedes Service contact, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)
Data Element Concepts implementing this Object Class:	Service contact—group session status Health, Standard 04/05/2005 Service contact—service contact date Health, Standard 01/03/2005

Service delivery outlet

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 268970

Registration status: Health, Standard 01/03/2005

Definition: A site from which an organisation, or sub-unit of an organisation, delivers a health/community service.

Context: Alcohol and other drug treatment services:

Required to identify the agency sites that conduct treatment episodes, as distinguished from administration centres. Identification of sites from which health care or community services are delivered facilitates assessment of the accessibility of services to the population.

Specialisation of: Organisation

Collection and usage attributes

Comments: An organisation may have one or more service delivery outlets. An organisation with a devolved structure for service delivery may or may not devolve all functions to the service delivery outlet level. It is common for administrative functions, including personnel management, to be retained at a higher or central level of an organisation. The service delivery outlet is the lowest level of an organisation at which, or from which, services are delivered. The site from which a service is delivered relates to the physical location of the service and is to be clearly differentiated from the service delivery setting which refers to the type of physical setting in which a service is actually provided to a client (e.g. client's home, non-residential treatment facility etc).

For example, where a service provider regularly delivers a service at a variety of clients' homes (e.g. home visits every Monday, Wednesday and Friday) or a mobile service delivers a service to a variety of different locations, then the service delivery outlet should be recorded as the location of the clinic in which the service provider is based. However, where a mobile unit regularly (e.g. every Monday) delivers a service from the same geographical location then this location will be recorded as the service delivery outlet.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs NMDS-WG

Relational attributes

Related metadata references: Supersedes Service delivery outlet, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Data Element Concepts implementing this Object Class: Service delivery outlet—geographic location Health, Standard 01/03/2005

Service provider organisation

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 269022

Registration status: Community Services, Standard 01/03/2005
Housing assistance, Standard 01/03/2005
Health, Standard 01/03/2005
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010
Tasmanian Health, Proposed 30/09/2011

Definition: An organisation that provides services and/or care.

Specialisation of: Organisation

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:

Service provider organisation (address)—address line
Community Services, Standard 30/09/2005
Housing assistance, Recorded 13/10/2011
Health, Standard 04/05/2005
Early Childhood, Standard 21/05/2010

Service provider organisation (address)—address type
Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Service provider organisation (address)—Australian postcode
Community Services, Superseded 06/02/2012
Housing assistance, Recorded 13/10/2011
Health, Superseded 07/12/2011
Early Childhood, Superseded 09/03/2012

Service provider organisation (address)—building/complex sub-unit identifier Community Services, Superseded 06/02/2012
Health, Superseded 07/12/2011

Service provider organisation (address)—building/complex sub-unit type Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Service provider organisation (address)—building/property name Community Services, Superseded 06/02/2012
Health, Superseded 07/12/2011

Service provider organisation (address)—electronic communication address Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Service provider organisation (address)—electronic communication medium Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Service provider organisation (address)—floor/level identifier Community Services, Superseded 06/02/2012
Health, Superseded 07/12/2011

Service provider organisation (address)—floor/level type Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Service provider organisation (address)—house/property identifier Community Services, Superseded 06/02/2012
Health, Superseded 07/12/2011

Service provider organisation (address)—international postcode Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Service provider organisation (address)—lot/section identifier Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Service provider organisation (address)—non-Australian state/province Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Service provider organisation (address)—postal delivery point identifier Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Service provider organisation (address)—street name Community Services, Superseded 06/02/2012
Health, Superseded 07/12/2011

Service provider organisation (address)—street suffix Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Service provider organisation (address)—street type Community Services, Superseded 06/02/2012
Health, Superseded 07/12/2011

Service provider organisation (address)—suburb/town/locality name Community Services, Superseded 06/02/2012
Housing assistance, Recorded 13/10/2011
Health, Superseded 07/12/2011
Early Childhood, Superseded 09/03/2012
Tasmanian Health, Proposed 28/09/2011

Service provider organisation (name)—name type Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Service provider organisation (name)—organisation name Community Services, Superseded 06/02/2012
Housing assistance, Recorded 13/10/2011

Health, Standard 04/05/2005
Early Childhood, Superseded 09/03/2012

Service provider organisation—Australian state/territory identifier Community Services, Standard 07/12/2005
Housing assistance, Proposed 01/11/2011
Health, Standard 04/05/2005
Early Childhood, Standard 21/05/2010
Tasmanian Health, Proposed 30/09/2011

Service provider organisation—coordinator of volunteers indicator Health, Standard 05/12/2007

Service provider organisation—feedback collection indicator Health, Standard 05/12/2007

Service provider organisation—feedback collection method Health, Standard 05/12/2007

Service provider organisation—level of service delivery Health, Standard 05/12/2007

Service provider organisation—most common service delivery setting Health, Standard 05/12/2007

Service provider organisation—organisation end date
Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Service provider organisation—organisation start date
Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Service provider organisation—partner organisation type Health, Standard 05/12/2007

Service provider organisation—service delivery setting
Community Services, Standard 29/04/2006
Health, Standard 05/12/2007
Early Childhood, Standard 21/05/2010

Service provider organisation—standards assessment indicator Health, Standard 05/12/2007

Service provider organisation—standards assessment level Health, Standard 05/12/2007

Service provider organisation—standards assessment method Health, Standard 05/12/2007

Service provider organisation—working partnership indicator Health, Standard 05/12/2007

Specialised mental health service

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 268984

Registration status: Health, Standard 01/03/2005

Definition: Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.

Context: Hospitals and community mental health establishments and residential mental health establishments.

Specialisation of: Service/care event

Collection and usage attributes

Guide for use: The concept of a specialised mental health service is not dependent on the inclusion of the service within the state or territory mental health budget.

A service is not defined as a specialised mental health service solely because its clients include people affected by a mental disorder or psychiatric disability.

The definition excludes specialist drug and alcohol services and services for people with intellectual disabilities, except where they are established to assist people affected by a mental disorder who also have drug and alcohol related disorders or intellectual disability.

These services can be a sub-unit of a hospital even where the hospital is not a specialised mental health establishment itself (e.g. designated psychiatric units and wards, outpatient clinics etc.).

Relational attributes

Data Element Concepts implementing this Object Class:

Specialised mental health service—admitted patient care program type Health, Standard 08/12/2004

Specialised mental health service—admitted patient service unit identifier Health, Standard 07/12/2011

Specialised mental health service—admitted patient service unit name Health, Standard 07/12/2011

Specialised mental health service—ambulatory service unit identifier Health, Standard 07/12/2011

Specialised mental health service—ambulatory service unit name Health, Standard 07/12/2011

Specialised mental health service—co-location with acute care hospital Health, Standard 08/12/2004

Specialised mental health service—non-government non-profit indicator Health, Standard 01/12/2010

Specialised mental health service—number of clients receiving services Health, Standard 07/12/2011

Specialised mental health service—number of hours staffed Health, Standard 08/12/2004

Specialised mental health service—number of service contacts Health, Standard 07/12/2011

Specialised mental health service—number of supported public housing places Health, Superseded 07/12/2011

Specialised mental health service—number of supported public housing places Health, Superseded 07/12/2011

Specialised mental health service—residential service unit identifier Health, Standard 07/12/2011

Specialised mental health service—residential service unit name Health, Standard 07/12/2011

Specialised mental health service—residual expenditure (academic positions) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (education and training) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (insurance) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (Mental Health Act Regulation or related legislation) Health, Standard 02/12/2009

Specialised mental health service—residual expenditure (mental health promotion) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (mental health research) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (other indirect expenditure) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (patient transport services) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (program administration) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (property leasing costs) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (service development) Health, Standard 02/12/2009

Specialised mental health service—residual expenditure (superannuation) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (support services) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (workers compensation) Health, Standard 08/12/2004

Specialised mental health service—service setting Health, Standard 01/03/2005

Specialised mental health service—specialised mental health service target population group Health, Standard 08/12/2004

Specialised mental health service—supported mental health housing places Health, Standard 07/12/2011

Specialised mental health service organisation

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	286449
Registration status:	Health, Standard 08/12/2004
Definition:	A separately constituted specialised mental health service that is responsible for the clinical governance, administration and financial management of service units providing specialised mental health care.
Context:	Specialised mental health services.
Specialisation of:	Organisation

Collection and usage attributes

Guide for use:

A specialised mental health service organisation may consist of one or more service units based in different locations and providing services in admitted patient, residential and ambulatory settings. For example, a specialised mental health service organisation may consist of several hospitals or two or more community centres.

Where the specialised mental health service organisation consists of multiple service units, those units can be considered to be components of the same organisation where they:

- operate under a common clinical governance arrangement;
- aim to work together as interlocking services that provide integrated, coordinated care to consumers across all mental health service settings; and
- share clinical records or, in the case where is more than one physical clinical record for each patient, staff may access (if required) the information contained in all of the physical records held by the organisation for that patient.

For most states and territories, the Specialised mental health service organisation object class is equivalent to the Area/District Mental Health Service. These are usually organised to provide the full range of admitted patient, residential and ambulatory services to a given catchment population. However, the object class may also be used to refer to health care organisations which provide only one type of mental health service (e.g. acute admitted patient care) or which serve a specialised or state-wide function.

Source and reference attributes

Origin:

Department of Health and Ageing 2003. Mental Health National Outcomes and Casemix Collection. Technical specification of State and Territory reporting requirements for the outcomes and casemix components of ‘Agreed Data’, Version 1.50. Canberra: Department of Health and Ageing

Relational attributes

Data Element Concepts implementing this Object Class:

Specialised mental health service organisation—accommodation services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—advocacy services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—carer participation arrangements status (carer consultants employed) Health, Standard 08/12/2004

Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys) Health, Standard 08/12/2004

Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism) Health, Standard 08/12/2004

Specialised mental health service organisation—carer participation arrangements status (formal participation policy) Health, Standard 08/12/2004

Specialised mental health service organisation—carer participation arrangements status (regular discussion groups) Health, Standard 08/12/2004

Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—consumer committee representation arrangements Health, Standard 08/12/2004

Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed) Health, Standard 08/12/2004

Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys) Health, Standard 08/12/2004

Specialised mental health service organisation—consumer participation arrangements (formal internal complaints mechanism) Health, Standard 08/12/2004

Specialised mental health service organisation—consumer participation arrangements (formal participation policy) Health, Standard 08/12/2004

Specialised mental health service organisation—consumer participation arrangements (regular discussion groups) Health, Standard 08/12/2004

Specialised mental health service organisation—counselling services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—independent living skills support services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—organisation identifier Health, Standard 07/12/2011

Specialised mental health service organisation—organisation name Health, Standard 07/12/2011

Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations Health, Standard 07/12/2005

Specialised mental health service organisation—other and unspecified services grants to non-government organisations Health, Superseded 07/12/2005

Specialised mental health service organisation—pre-vocational training services grants for non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—psychosocial support services grants for non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—recreation services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—recurrent expenditure (residual mental health) Health, Standard 08/12/2004

Specialised mental health service organisation—respite services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation—self-help support groups services grants for non-government organisations Health, Standard 08/12/2004

Specialised mental health service unit

Identifying and definitional attributes

Metadata item type:	Object Class
METeOR identifier:	287787
Registration status:	Health, Standard 08/12/2004
Definition:	A specialised mental health service unit.
Specialisation of:	Organisation

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class:	Specialised mental health service unit—implementation of National standards for mental health services status Health, Standard 08/12/2004

State or Territory Government

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 301333

Registration status: Community Services, Standard 30/11/2007
Health, Standard 07/12/2005

Definition: A separately constituted legal entity established by political processes which have legislative, judicial or executive authority over a specific state or territory and is responsible for the governance, administration and financial management of that state or territory.

Specialisation of: Party

Source and reference attributes

Reference documents: Australian Bureau of Statistics 2002. Standard Economic Sector Classifications of Australia (SESCA). ABS Cat No. 1218.0. Canberra: ABS.

Relational attributes

Data Element Concepts implementing this Object Class: State or Territory Government—mental health services grants to non-government organisations by non-health departments Health, Standard 07/12/2005

Ventricular ejection fraction test

Identifying and definitional attributes

Metadata item type: Object Class

METeOR identifier: 358951

Registration status: Health, Standard 01/10/2008

Definition: Test used to measure the amount of blood pumped out of a ventricle per heart beat.

Specialisation of: Service/care event

Relational attributes

Data Element Concepts implementing this Object Class:

Ventricular ejection fraction test—test date Health, Standard 01/10/2008

Ventricular ejection fraction test—test type Health, Standard 01/10/2008

Ventricular ejection fraction—test result Health, Standard 01/10/2008

Ventricular ejection fraction—test time Health, Standard 01/10/2008

Property

Aboriginal community controlled health organisation or Aboriginal medical service service provider type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	365474
Registration status:	Health, Standard 25/08/2011
Definition:	The type of individual service provider that provides Aboriginal community controlled health organisation (ACCHO; an organisation governed by an Aboriginal body and elected by the local Aboriginal community) or Aboriginal medical service (AMS; a health service funded principally to provide services to Aboriginal and Torres Strait Islander individuals) services.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service service provider type Health, Standard 25/08/2011

Aboriginal community controlled health organisation or Aboriginal medical service visitation frequency

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	403807
Registration status:	Health, Standard 25/08/2011
Definition:	The frequency of visits by an Aboriginal community controlled health organisation (ACCHO), an organisation governed by an Aboriginal body and elected by the local Aboriginal community, or an Aboriginal medical service (AMS), a health service funded principally to provide services to Aboriginal and Torres Strait Islander individuals.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service visitation frequency Health, Standard 25/08/2011

Accommodation services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	286596
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of accommodation services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—accommodation services grants to non-government organisations Health, Standard 08/12/2004

Accommodation type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269143
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the class of accommodation.
Property group:	Accommodation/living characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—accommodation type Health, Standard 01/03/2005

Accrued mental health care days

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	286766
Registration status:	Health, Standard 08/12/2004
Definition:	Mental health care days are days of admitted patient care provided to admitted patients in psychiatric hospitals, designated psychiatric units and days of residential care provided to residents in residential mental health services. Accrued mental health care days can also be referred to as occupied bed days in specialised mental health services.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—accrued mental health care days Health, Standard 08/12/2004

Accuracy indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	294414
Registration status:	Community Services, Standard 30/09/2005 Housing assistance, Standard 23/08/2010 Health, Standard 04/05/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010
Definition:	The level of detail to which recorded information is correct.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Date—accuracy indicator Community Services, Standard 30/09/2005 Housing assistance, Standard 23/08/2010 Health, Standard 04/05/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010

Activity and participation life area

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 324432

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Definition: Life areas in which individuals may participate or undertake activities.

Property group: Physical characteristics

Relational attributes

Data Element Concepts implementing this Property: Person—activity and participation life area Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Activity type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269042
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the class of activity.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Injury event—activity type Health, Standard 01/03/2005

Acute coronary syndrome procedure type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284640
Registration status:	Health, Standard 04/06/2004
Definition:	The type of procedure performed for the treatment of acute coronary syndrome.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—acute coronary syndrome procedure type Health, Standard 04/06/2004

Acute coronary syndrome related clinical event date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	349641
Registration status:	Health, Standard 01/10/2008
Definition:	The date a clinical event was experienced that can affect the health outcome from acute coronary syndromes.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person with acute coronary syndrome—acute coronary syndrome related clinical event date Health, Standard 01/10/2008

Acute coronary syndrome related clinical event time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	349803
Registration status:	Health, Standard 01/10/2008
Definition:	The time a clinical event was experienced that can affect the health outcomes from acute coronary syndrome.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person with acute coronary syndrome—acute coronary syndrome related clinical event time Health, Standard 01/10/2008

Acute coronary syndrome related medical history

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359152
Registration status:	Health, Standard 01/10/2008
Definition:	A history of medical conditions which are pertinent to the risk stratification and treatment of acute coronary syndrome.
Property group:	Health and wellbeing

Relational attributes

Related metadata references:	Supersedes Acute coronary syndrome concurrent clinical condition Health, Superseded 01/10/2008
Data Element Concepts implementing this Property:	Person—acute coronary syndrome related medical history Health, Standard 01/10/2008

Acute coronary syndrome risk stratum

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284646
Registration status:	Health, Standard 04/06/2004
Definition:	Risk stratum of clinical features consistent with an acute coronary syndrome.
Property group:	Service/care urgency

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—acute coronary syndrome risk stratum Health, Superseded 01/10/2008 Person—acute coronary syndrome risk stratum Health, Standard 01/10/2008

Acute coronary syndrome symptoms onset date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	321193
Registration status:	Health, Standard 01/10/2008
Definition:	The date on which symptoms for acute coronary syndrome first occurred and prompted medical attention, either at the hospital or from a general practitioner.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—acute coronary syndrome symptoms onset date Health, Standard 01/10/2008

Acute coronary syndrome symptoms onset time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	321203
Registration status:	Health, Standard 01/10/2008
Definition:	The time when symptoms for acute coronary syndrome first occurred and prompted medical attention, either at the hospital or from a general practitioner.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—acute coronary syndrome symptoms onset time Health, Standard 01/10/2008

Additional body function or structure affected

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 422023

Registration status: Health, Standard 07/12/2011

Definition: The body function or structure alleged to have been affected, in addition to the primary body function or structure affected.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Patient—additional body function or structure affected Health, Standard 07/12/2011

Additional clinician specialty involved in health-care incident

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	424968
Registration status:	Health, Standard 07/12/2011
Definition:	The clinical specialty of the health-care provider who played a role in the health-care incident in addition to the principal clinician responsible.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health-care incident—additional clinician specialty involved in health-care incident Health, Standard 07/12/2011

Additional diagnosis

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269371

Registration status: Health, Standard 01/03/2005

Definition: A condition or complaint either coexisting with the principal diagnosis or arising during a service event or episode.

Property group: Service provision event

Relational attributes

Data Element Concepts implementing this Property:

Episode of care—additional diagnosis Health, Superseded 05/02/2008

Episode of care—additional diagnosis Health, Standard 05/02/2008

Additional incident or allegation type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	329715
Registration status:	Health, Standard 07/12/2011
Definition:	The type of health-care incident that was of importance in giving rise to a medical indemnity claim, in addition to the primary incident or allegation type.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Medical indemnity claim—additional incident or allegation type Health, Standard 07/12/2011

Address line

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	292741
Registration status:	Community Services, Standard 30/09/2005 Housing assistance, Recorded 13/10/2011 Health, Standard 04/05/2005 Early Childhood, Standard 21/05/2010
Definition:	A composite of one or more standard address components that describes a low level of geographical/physical description of a location.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Health address line Health, Superseded 04/05/2005
Data Element Concepts implementing this Property:	Person (address)—address line Community Services, Standard 30/09/2005 Health, Standard 04/05/2005 Service provider organisation (address)—address line Community Services, Standard 30/09/2005 Housing assistance, Recorded 13/10/2011 Health, Standard 04/05/2005 Early Childhood, Standard 21/05/2010

Address site name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	429196
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	The official place name or culturally accepted name for an address site, including the name of a building, homestead, building complex, agricultural property, park or unbounded address site.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references:	Supersedes Building/property name Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011
Data Element Concepts implementing this Property:	Address—address site name Community Services, Standard 06/02/2012 Health, Standard 07/12/2011

Address type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269037
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 01/03/2005
Definition:	A descriptor of the class of a geographical/physical location.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—address type Community Services, Superseded 06/02/2012 Health, Standard 01/03/2005 Service provider organisation (address)—address type Community Services, Superseded 06/02/2012 Health, Standard 04/05/2005

Admission date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269247

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: The date on which an episode of admitted patient care commences.

Property group: Entry into service event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Episode of admitted patient care—admission date Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Admission mode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269028
Registration status:	Health, Standard 01/03/2005
Definition:	The method by which an episode of admitted patient care commences.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—admission mode Health, Standard 01/03/2005

Admission time

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269046

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: The time at which an episode of admitted patient care commences

Property group: Entry into service event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Episode of admitted patient care—admission time Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Admission urgency status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269032
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the urgency status assigned to an **admission**.
Property group:	Service/care urgency

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—admission urgency status Health, Standard 01/03/2005

Admitted patient care program type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288881
Registration status:	Health, Standard 08/12/2004
Definition:	The type of admitted patient care program.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service—admitted patient care program type Health, Standard 08/12/2004

Admitted patient service unit identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	404397
Registration status:	Health, Standard 07/12/2011
Definition:	A sequence of characters which identify an admitted patient service unit.
Property group:	Identifier characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service—admitted patient service unit identifier Health, Standard 07/12/2011

Admitted patient service unit name

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 407456

Registration status: Health, Standard 07/12/2011

Definition: The appellation by which an admitted patient service unit is known or called.

Property group: Name characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Specialised mental health service—admitted patient service unit name Health, Standard 07/12/2011

Advocacy services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	286876
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of advocacy services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—advocacy services grants to non-government organisations Health, Standard 08/12/2004

Age

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269152
Registration status:	Community Services, Standard 04/05/2005 Housing assistance, Standard 01/03/2005 Health, Standard 04/05/2005 Early Childhood, Standard 21/05/2010 Tasmanian Health, Proposed 28/09/2011
Definition:	The length of life or existence.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

Data Element Concepts implementing this Property:	Person—age Community Services, Standard 04/05/2005 Housing assistance, Standard 17/06/2005 Health, Standard 04/05/2005 Early Childhood, Standard 21/05/2010 Tasmanian Health, Proposed 28/09/2011

Age at first detention

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 399027

Registration status: Health, Standard 25/08/2011

Definition: The age of first placement in either a **juvenile detention centre** or prison.

Property group: Legal characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Prison entrant—age at first detention Health, Standard 25/08/2011

Age at first pregnancy

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	399567
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	The age at which a person first carried a developing embryo or fetus within their body.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Female—age at first pregnancy Community Services, Standard 06/02/2012 Health, Standard 25/08/2011

Age range

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	290491
Registration status:	Community Services, Standard 30/11/2007 Health, Standard 04/05/2005
Definition:	A chronological grouping of age.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—age range Community Services, Standard 30/11/2007 Health, Standard 04/05/2005

Alcohol consumption amount

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Alcohol consumption - concept; Ethanol consumption
METeOR identifier:	269217
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the amount of alcohol consumed.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group
Origin:	Australian Alcohol Guidelines: Health Risks and Benefits, NH&MRC, October 2001

Relational attributes

Related metadata references:	Supersedes Alcohol consumption - concept, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (11.7 KB)
Data Element Concepts implementing this Property:	Person—alcohol consumption amount Health, Standard 01/03/2005

Alcohol consumption frequency

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269363
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of how frequently alcohol is consumed.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—alcohol consumption frequency Health, Standard 01/03/2005

Alcohol consumption status recorded indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 441436

Registration status: Health, Standard 07/12/2011

Definition: An indicator of whether alcohol consumption status has been recorded.

Property group: Performance indicators

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property: Person—alcohol consumption status recorded indicator Health, Standard 07/12/2011

Ambulatory service unit identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	404825
Registration status:	Health, Standard 07/12/2011
Definition:	A sequence of characters which identify an ambulatory service unit. An ambulatory service unit is a unit that provides **ambulatory care**.
Property group:	Identifier characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service—ambulatory service unit identifier Health, Standard 07/12/2011

Ambulatory service unit name

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 409034

Registration status: Health, Standard 07/12/2011

Definition: The appellation by which an ambulatory service unit is known or called.

An ambulatory service unit is a unit that provides **ambulatory care**.

Property group: Name characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Specialised mental health service—ambulatory service unit name Health, Standard 07/12/2011

Anaesthesia administered

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269079
Registration status:	Health, Standard 01/03/2005
Definition:	Drug or other medical intervention administered to cause inability to feel pain.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Data Element Concepts implementing this Property:	Birth event—anaesthesia administered Health, Superseded 07/12/2005 Birth event—anaesthesia administered Health, Standard 07/12/2005

Analgesia administered

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269080
Registration status:	Health, Standard 01/03/2005
Definition:	An agent given to alleviate pain without causing loss of consciousness.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Data Element Concepts implementing this Property:	Birth event—analgesia administered Health, Superseded 07/12/2005 Birth event—analgesia administered Health, Standard 07/12/2005

Angina episodes count

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	338283
Registration status:	Health, Standard 01/10/2008
Definition:	A count of episodes of pain in the centre of chest which may have spread to either of both shoulders, the back, neck or jaws or down the arm.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—count of angina episodes Health, Standard 01/10/2008

Angina status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	338327
Registration status:	Health, Standard 01/10/2008
Definition:	The categorisation of the type of pain caused by reduced blood oxygen supply to an area of heart muscle.
Property group:	Crisis event

Relational attributes

Data Element Concepts implementing this Property:	Person—angina status Health, Standard 01/10/2008

Angiotensin converting enzyme inhibitors therapy status

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	ACE inhibitors therapy status
METeOR identifier:	284728
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the use of angiotensin converting enzyme (ACE) inhibitors therapy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—angiotensin converting enzyme inhibitors therapy status Health, Standard 04/06/2004

Anticipated accommodation status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 319942

Registration status: Health, Standard 01/03/2005

Definition: An indicator of whether a person has nominated to be treated as either a public or private patient. The anticipated accommodation status is not binding on the patient and may vary from the elected accommodation status.

Property group: Funding characteristics

Relational attributes

Data Element Concepts implementing this Property: Elective surgery waiting list episode—anticipated accommodation status Health, Standard 01/03/2005

Apgar score

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269035
Registration status:	Health, Standard 01/03/2005
Definition:	The score used to evaluate the fitness of a newborn infant, based on heart rate, respiration, muscle tone, cough reflex, and colour.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

Data Element Concepts implementing this Property:	Birth—Apgar score Health, Superseded 07/12/2005 Birth—Apgar score Health, Standard 07/12/2005

Area of practice

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 377929

Registration status: Health, Standard 10/12/2009

Definition: The area of practice in which the most hours were spent in the week prior to registration.

Property group: Labour characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Registered health professional—principal area of practice Health, Standard 10/12/2009

Area of usual residence

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269104
Registration status:	Community Services, Standard 21/05/2010 Health, Standard 01/03/2005 Early Childhood, Standard 21/05/2010
Definition:	The geographical region in which a person or group of people usually reside.
Property group:	Location characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—area of usual residence Community Services, Standard 21/05/2010 Health, Standard 01/03/2005 Early Childhood, Standard 21/05/2010

Aspirin therapy status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284754
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the use of aspirin therapy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—aspirin therapy status Health, Standard 04/06/2004

Assessment of cardiac perfusion method

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	344426
Registration status:	Health, Standard 01/10/2008
Definition:	The method of functional assessment of cardiac perfusion undertaken in a stress test.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Functional stress test—assessment of cardiac perfusion Health, Standard 01/10/2008

At risk of suicide or self-harm indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 399644

Registration status: Health, Standard 25/08/2011

Definition: An indicator of being at risk of causing one's own death or of deliberately inflicting physical harm to one's self.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Prison entrant—at risk of suicide or self-harm indicator Health, Standard 25/08/2011

Australian postcode

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269316

Registration status:
Community Services, Standard 01/03/2005
Housing assistance, Standard 22/10/2005
Health, Standard 01/03/2005
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010
Tasmanian Health, Proposed 28/09/2011

Definition: The numeric descriptor for a postal delivery area, aligned with locality, suburb or place.

Context: Postcode is an important part of a postal address and facilitates written communication. It is one of a number of geographic identifiers that can be used to determine a geographic location.

Property group: Location characteristics

Source and reference attributes

Submitting organisation: Standards Australia

Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:

Address—Australian postcode Community Services, Standard 06/02/2012
Health, Standard 07/12/2011
Early Childhood, Standard 09/03/2012

Person (address)—Australian postcode Community Services, Superseded 06/02/2012
Housing assistance, Standard 10/02/2006
Health, Superseded 07/12/2011
Early Childhood, Superseded 09/03/2012
Homelessness, Standard 23/08/2010
Tasmanian Health, Proposed 28/09/2011

Service provider organisation (address)—Australian postcode Community Services, Superseded 06/02/2012
Housing assistance, Recorded 13/10/2011
Health, Superseded 07/12/2011
Early Childhood, Superseded 09/03/2012

Workplace (address)—Australian postcode Health, Superseded 07/12/2011
Tasmanian Health, Proposed 30/09/2011

Australian state/territory identifier

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269056

Registration status: Community Services, Standard 01/03/2005
Housing assistance, Standard 22/10/2005
Health, Standard 01/03/2005
Early Childhood, Standard 21/05/2010
Tasmanian Health, Proposed 30/09/2011

Definition: An identifier of the Australian state or territory.

Context: This is a **geographic indicator** which is used for analysis of the distribution of clients or patients, agencies or establishments and services.

Property group: Location characteristics

Relational attributes

Data Element Concepts implementing this Property:

Address—Australian state/territory identifier Community Services, Standard 06/02/2012
Health, Standard 07/12/2011
Early Childhood, Standard 09/03/2012

Establishment—Australian state/territory identifier Community Services, Standard 01/03/2005
Health, Standard 01/03/2005

Jurisdiction—Australian state/territory identifier Health, Standard 05/12/2007

Medical indemnity claim management episode—Australian state/territory identifier Health, Standard 07/12/2011

Person—Australian state/territory identifier Community Services, Standard 01/03/2005
Housing assistance, Standard 10/02/2006
Health, Standard 01/03/2005
Early Childhood, Standard 21/05/2010

Service provider organisation—Australian state/territory identifier Community Services, Standard 07/12/2005
Housing assistance, Proposed 01/11/2011
Health, Standard 04/05/2005
Early Childhood, Standard 21/05/2010
Tasmanian Health, Proposed 30/09/2011

Baby resuscitation method

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269026

Registration status: Health, Standard 01/03/2005

Definition: The action taken for a baby to revive from apparent death or unconsciousness.

Property group: Birth event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

Data Element Concepts implementing this Property: Birth event—baby resuscitation method Health, Standard 01/03/2005

Behaviour-related risk factor intervention

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269285
Registration status:	Health, Standard 01/03/2005
Definition:	The action taken to address a behaviour-related risk factor.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—behaviour-related risk factor intervention Health, Standard 01/03/2005

Behaviour-related risk factor intervention purpose

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269286
Registration status:	Health, Standard 01/03/2005
Definition:	A lifestyle choice related risk factor associated with an intervention.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—behaviour-related risk factor intervention purpose Health, Standard 01/03/2005

Beta-blocker therapy status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284791
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the use of beta-blocker therapy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—beta-blocker therapy status Health, Standard 04/06/2004

Birth method

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 337674

Registration status: Health, Standard 06/09/2006

Definition: The method of complete expulsion or extraction from its mother of a product of conception.

Property group: Birth event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Delivery method Health, Superseded 06/09/2006

Data Element Concepts implementing this Property: Birth event—birth method Health, Standard 06/09/2006

Birth order

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269038
Registration status:	Health, Standard 01/03/2005
Definition:	The sequence number in the multiple birth.
Context:	National Minimum Data Set (NMDS) Perinatal: Required to analyse pregnancy outcome according to birth order and identify the individual baby resulting from a multiple birth pregnancy. Multiple births have higher risks of perinatal mortality and morbidity. Multiple birth pregnancies are often associated with obstetric complications, labour and delivery complications, higher rates of neonatal morbidity, low **birthweight**, and a higher perinatal death rate. Data Set Specification (DSS) - Health care client identification: While this piece of information is normally recorded for multiple births against the mother's record, if the health care client volunteers the information, it should be recorded.
Property group:	Birth event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS5017 Health Care Client Identification

Relational attributes

Data Element Concepts implementing this Property:	Birth—birth order Health, Standard 01/03/2005

Birth plurality

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269039

Registration status: Health, Standard 01/03/2005

Definition: An indicator of multiple birth, showing the total number of births resulting from a single pregnancy.

Context: National Minimum Data Set (NMDS) Perinatal:

Multiple pregnancy increases the risk of complications during pregnancy, labour and delivery and is associated with higher risk of perinatal morbidity and mortality.

Data Set Specification (DSS) Health Care Client Identification:

While this piece of information is normally recorded for multiple births against the mother's record, if the health care client volunteers the information, it should be recorded.

Property group: Birth event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Birth event—birth plurality Health, Standard 01/03/2005

Birth presentation

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269062

Registration status: Health, Standard 01/03/2005

Definition: Presenting part of the fetus (at lower segment of uterus).

Property group: Birth event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Birth event—birth presentation Health, Standard 06/09/2006
Birth event—birth presentation Health, Superseded 06/09/2006

Birth status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269064
Registration status:	Health, Standard 01/03/2005
Definition:	Status of the baby at birth as an outcome of pregnancy.
Property group:	Birth event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth—birth status Health, Standard 01/03/2005

Birth weight

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269347
Registration status:	Health, Standard 01/03/2005
Definition:	The weight of a newborn as recorded at birth.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth—birth weight Health, Standard 01/03/2005

Birth weight recorded indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	441697
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether **birth weight** has been recorded.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property:	Person—birth weight recorded indicator Health, Standard 07/12/2011

Bleeding episode status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	360954
Registration status:	Health, Standard 01/10/2008
Definition:	An episode of bleeding.
Property group:	Health and wellbeing

Relational attributes

Related metadata references:	Supersedes Bleeding episode status Health, Superseded 01/10/2008
Data Element Concepts implementing this Property:	Person—bleeding episode status Health, Standard 01/10/2008

Bleeding location

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	344781
Registration status:	Health, Standard 01/10/2008
Definition:	The source of bleeding or escape of blood from a vessel.
Property group:	Crisis event

Relational attributes

Data Element Concepts implementing this Property:	Person with acute coronary syndrome—bleeding location Health, Standard 01/10/2008

Blindness

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269103
Registration status:	Health, Standard 01/03/2005
Definition:	Blindness is less than 6/60 vision in the better eye with glasses. Vision 6/60 is the ability to see only at 6 metres what the normal eye can see at 60 metres. An indicator of the presence or development of a visual impairment or inability to see.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—blindness Health, Standard 01/03/2005

Blood pressure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269105
Registration status:	Health, Standard 01/03/2005
Definition:	The pressure exerted by blood against the inner walls of the blood vessels
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

Data Element Concepts implementing this Property:	Person—blood pressure (diastolic) Health, Standard 01/03/2005 Person—blood pressure (systolic) Health, Standard 01/03/2005

Blood pressure measurement result less than or equal to 130/80 mmHg indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	443226
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a **blood pressure** measurement result was less than or equal to 130/80mmHg.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW).

Relational attributes

Data Element Concepts implementing this Property:	Person—blood pressure measurement result less than or equal to 130/80 mmHg indicator Health, Standard 07/12/2011

Blood pressure measurement result recorded indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	441400
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a **blood pressure** measurement result has been recorded.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property:	Person—blood pressure measurement result recorded indicator Health, Standard 07/12/2011

Blow to the head indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	358829
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	An indicator of whether a blow to the head resulting in a loss of consciousness has ever been experienced.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—blow to the head indicator Community Services, Standard 06/02/2012 Health, Standard 25/08/2011

Bodily location of main injury

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Site
METeOR identifier:	269098
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The position on the body of the primary injury of concern.
Property group:	Crisis event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—bodily location of main injury Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011

Body function

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320237
Registration status:	Community Services, Standard 16/10/2006 Health, Standard 29/11/2006
Definition:	The physiological or psychological function of body system.
Property group:	Physical characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—body function Community Services, Standard 16/10/2006 Health, Standard 29/11/2006

Body mass index

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269114

Registration status: Health, Standard 01/03/2005

Definition: A measure of body fat that gives an indication of nutritional status. Body mass index is the weight in kilograms divided by the square of the height in meters.

Property group: Health and wellbeing

Source and reference attributes

Origin: Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Data Element Concepts implementing this Property:

Adult—body mass index Health, Standard 01/03/2005

Child—body mass index Health, Standard 01/03/2005

Person—body mass index (classification) Health, Standard 01/03/2005

Body mass index recorded indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 443079

Registration status: Health, Standard 07/12/2011

Definition: An indicator of whether body mass index (BMI) has been recorded.

Property group: Performance indicators

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property: Person—body mass index recorded indicator Health, Standard 07/12/2011

Body structure

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 320249

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Definition: An anatomical part of the body such as organs, limbs or their components.

Property group: Physical characteristics

Relational attributes

Data Element Concepts implementing this Property: Person—body structure Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Building/complex sub-unit type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269380
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 01/03/2005
Definition:	The specification of the type of a separately identifiable portion within a building/complex, marina, etc. to clearly distinguish it from another.
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Health Data Standards Committee
Origin:	Australia Post Address Presentation Standard.

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—building/complex sub-unit type Community Services, Standard 30/09/2005 Health, Standard 01/03/2005 Service provider organisation (address)—building/complex sub-unit type Community Services, Standard 30/09/2005 Health, Standard 04/05/2005

Bundle-branch block status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	343860
Registration status:	Health, Standard 01/10/2008
Definition:	The status of an abnormal conduction through one of the conductive branches which normally supply the right and left ventricles of the heart.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Electrocardiogram—bundle-branch block status Health, Standard 01/10/2008

C-reactive protein level

Identifying and definitional attributes

Metadata item type: Property

Synonymous names: CRP

METeOR identifier: 338236

Registration status: Health, Standard 01/10/2008

Definition: The measured level of the inflammatory marker C-reactive protein.

Property group: Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property: Person—C-reactive protein level (measured) Health, Standard 01/10/2008

C-reactive protein level measured date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	338273
Registration status:	Health, Standard 01/10/2008
Definition:	The date the level of the inflammatory marker C-reactive protein (CRP) is measured.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—C-reactive protein level measured date Health, Standard 01/10/2008

C-reactive protein level measured time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	343849
Registration status:	Health, Standard 01/10/2008
Definition:	The time the level of the inflammatory marker C-reactive protein measured.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—C-reactive protein level measured time Health, Standard 01/10/2008

Caesarean section indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	302129
Registration status:	Health, Standard 29/11/2006
Definition:	Pregnancy resulting in a live birth or a stillbirth.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Data Element Concepts implementing this Property:	Female—caesarean section indicator Health, Standard 29/11/2006

Cancer staging scheme source

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	296984
Registration status:	Health, Standard 04/06/2004
Definition:	The reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	UICC TNM Classification of Malignant Tumours (5th Edition) (1997)

Relational attributes

Data Element Concepts implementing this Property:	Cancer staging—cancer staging scheme source Health, Superseded 07/12/2011 Cancer staging—cancer staging scheme source Health, Standard 07/12/2011

Cancer staging scheme source edition number

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	402076
Registration status:	Health, Standard 07/12/2011
Definition:	The edition number of the reference used for the purpose of staging a cancer. Refers to the reference that describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer.
Property group:	Health and wellbeing

Relational attributes

Related metadata references:	Supersedes Cancer staging scheme source edition number Health, Superseded 07/12/2011
Data Element Concepts implementing this Property:	Cancer staging—cancer staging scheme source edition number Health, Standard 07/12/2011

Cancer status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	394063
Registration status:	Health, Standard 07/12/2011
Definition:	Clinical evidence of the presence or absence of cancer. Clinical evidence describes the result of evaluation of a patient's physical condition and prognosis based on information gathered from physical examination, laboratory tests, imaging and the patient's medical history.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Myers T (Editor) 2009. Mosby's Medical Dictionary, 8th Edition. Missouri: Mosby Elsevier page 394

Relational attributes

Data Element Concepts implementing this Property:	Patient—cancer status Health, Standard 07/12/2011

Cancer treatment type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288143
Registration status:	Health, Standard 04/06/2004
Definition:	The type of cancer treatment provided.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—cancer treatment type Health, Superseded 07/12/2011 Cancer treatment—cancer treatment type Health, Standard 07/12/2011

Capital consumption expenses

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	376395
Registration status:	Health, Standard 01/04/2009
Definition:	Expenses of an organisation consisting of consumption of fixed capital (depreciation).
Property group:	Financial characteristics

Relational attributes

Related metadata references:	Supersedes Depreciation expenses Health, Superseded 01/04/2009
Data Element Concepts implementing this Property:	Organisation—capital consumption expenses Health, Standard 01/04/2009

Cardiac catheterisation date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359783
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a catheter is inserted into a chamber or vessel of the heart for diagnostic purposes.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—diagnostic cardiac catheterisation date Health, Standard 01/10/2008

Cardiac catheterisation time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359770
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a catheter is inserted into a chamber or vessel of the heart for diagnostic purposes.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—diagnostic cardiac catheterisation time Health, Standard 01/10/2008

Cardiovascular disease condition targeted by drug therapy

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269329
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the cardiovascular disease condition for which a drug therapy is being used.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—cardiovascular disease condition targeted by drug therapy Health, Standard 01/03/2005

Cardiovascular disease recorded indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	465944
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a cardiovascular disease has been recorded.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property:	Person—cardiovascular disease recorded indicator Health, Standard 07/12/2011

Cardiovascular medication taken

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269391
Registration status:	Health, Standard 01/03/2005
Definition:	Medication taken for a cardiovascular condition.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—cardiovascular medication taken Health, Standard 01/03/2005

Care type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269177
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the overall nature of a service provided.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Hospital service—care type Health, Standard 01/03/2005 Non-admitted patient service event—care type Health, Standard 06/10/2010

Carer participation arrangements

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288821
Registration status:	Health, Standard 08/12/2004
Definition:	Mechanisms in place to promote the participation of mental health carers in the planning, delivery and evaluation of a service.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—carer participation arrangements status (carer consultants employed) Health, Standard 08/12/2004 Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys) Health, Standard 08/12/2004 Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism) Health, Standard 08/12/2004 Specialised mental health service organisation—carer participation arrangements status (formal participation policy) Health, Standard 08/12/2004 Specialised mental health service organisation—carer participation arrangements status (regular discussion groups) Health, Standard 08/12/2004

Carer responsibility indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 378320

Registration status: Health, Standard 07/12/2011

Definition: A self-reported indicator of whether or not a person has carer responsibilities.

Property group: Informal assistance characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Carer availability status Community Services, Superseded 02/05/2006, Health, Superseded 04/07/2007

Data Element Concepts implementing this Property: Person—carer responsibility indicator Health, Standard 07/12/2011

Cataract status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269230
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of previous experience with cataracts.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—cataract status Health, Standard 01/03/2005

Category reassignment date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269115
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a clinical urgency category or patient listing status category is reassigned.
Property group:	Service/care urgency

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective care waiting list episode—category reassignment date Health, Standard 01/03/2005

Census date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269364
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a population is officially enumerated and characterised.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Hospital census (of elective surgery waitlist patients)—census date Health, Standard 01/03/2005

Cerebral stroke due to vascular disease

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269298
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of previous experience of a cerebral stroke due to vascular disease and the recency of the stroke.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—cerebral stroke due to vascular disease Health, Standard 01/03/2005

Cervical screening indicator

Identifying and definitional attributes

Metadata item type: Property

Synonymous names: Pap smear indicator

METeOR identifier: 358912

Registration status: Health, Standard 25/08/2011

Definition: An indicator of whether a cervical screening has been conducted.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Female—cervical screening indicator Health, Standard 25/08/2011

Cessation reason

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269077
Registration status:	Health, Standard 01/03/2005
Definition:	The reason for ending an event or process.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of treatment for alcohol and other drugs—cessation reason Health, Standard 01/03/2005

Chemotherapy completion date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	393546
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which chemotherapy was completed. Chemotherapy is the treatment of disease by means of chemical substances or drugs; the term is usually used in reference to neoplastic disease. Chemotherapy for the treatment of cancer achieves its antitumour effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis. Chemotherapy may involve treatment with a single agent or a combination of two or more drugs that are administered in treatment cycles and according to a prespecified regimen or protocol.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Stedman TL 2006. Stedman's Medical Dictionary, 28th Edition. Maryland: Lippincott Williams & Wilkins page 358 American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2011 revision. Commission on Cancer page 26

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—chemotherapy completion date Health, Standard 07/12/2011

Chemotherapy cycles administered

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 393825

Registration status: Health, Standard 07/12/2011

Definition: The number of cycles of chemotherapy administered.

Chemotherapy is the treatment of disease by means of chemical substances or drugs; usually used in reference to neoplastic disease. Chemotherapy for the treatment of cancer achieves its antitumour effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Chemotherapy may involve treatment with a single agent or a combination of two or more drugs that are administered in treatment cycles and according to a prespecified regimen or protocol.

Chemotherapy cycles reflect the timing, frequency and duration of treatment.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Stedman TL 2006. Stedman's Medical Dictionary, 28th Edition. Maryland: Lippincott Williams & Wilkins page 358

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2011 revision. Commission on Cancer page 26

Relational attributes

Data Element Concepts implementing this Property: Cancer treatment—chemotherapy cycles administered Health, Standard 07/12/2011

Chemotherapy start date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	413837
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which chemotherapy commenced. Chemotherapy is the treatment of disease by means of chemical substances or drugs; usually used in reference to neoplastic disease. Chemotherapy for the treatment of cancer achieves its antitumour effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis. Chemotherapy may involve treatment with a single agent or a combination of two or more drugs that are administered in treatment cycles and according to a prespecified regimen or protocol.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Stedman TL 2006. Stedman's Medical Dictionary, 28th Edition. Maryland: Lippincott Williams & Wilkins page 358 American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2011 revision. Commission on Cancer page 26

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—chemotherapy start date Health, Standard 07/12/2011

Chest pain pattern

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 284815

Registration status: Health, Standard 04/06/2004

Definition: Identification of the frequency and severity of chest pain of myocardial ischaemic origin.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—chest pain pattern Health, Standard 04/06/2004

Cholesterol level

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269323
Registration status:	Health, Standard 01/03/2005
Definition:	The amount of cholesterol in the blood, usually indicated by a number within a range going from low to high, these numbers being correlated with the risk of coronary heart disease.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd.

Relational attributes

Data Element Concepts implementing this Property:	Person—cholesterol level Health, Standard 01/03/2005

Chronic condition indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	399228
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of the current presence of a previously diagnosed health condition which is long term; has a pattern of recurrence, or deterioration; has a poor prognosis and produces consequences, or sequelae that impact on the individual's quality of life.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—chronic condition indicator Health, Standard 25/08/2011

Chronic obstructive pulmonary disease (COPD) recorded indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	464916
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a chronic obstructive pulmonary disease (COPD) has been recorded.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property:	Person—chronic obstructive pulmonary disease recorded indicator Health, Standard 07/12/2011

Class action indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	466017
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a lawsuit is a **class action**.
Property group:	Legal characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Medical indemnity claim management episode—class action indicator Health, Standard 07/12/2011

Client type

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269128

Registration status: Health, Standard 01/03/2005

Definition: Whether treatment is focused on the client's conditions and problems or on those of another person.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Episode of treatment for alcohol and other drugs—client type Health, Standard 01/03/2005

Clinical care commencement date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	472793
Registration status:	Health, Standard 22/12/2011
Definition:	The date on which clinical care commences.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—clinical care commencement date Health, Superseded 30/01/2012 Non-admitted patient emergency department service episode—clinical care commencement date Health, Standard 30/01/2012

Clinical care commencement time

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 472809

Registration status: Health, Standard 22/12/2011

Definition: The time at which clinical care commences.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:

Non-admitted patient emergency department service episode—clinical care commencement time Health, Superseded 30/01/2012

Non-admitted patient emergency department service episode—clinical care commencement time Health, Standard 30/01/2012

Clinical emergency indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	447056
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether the care, treatment or assistance required is clinically assessed as an emergency.
Property group:	Service/care urgency

Relational attributes

Data Element Concepts implementing this Property:	Patient—clinical emergency indicator Health, Standard 07/12/2011

Clinical evidence status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285279
Registration status:	Health, Standard 04/06/2004
Definition:	Indicator of the status of evidence of a pre-existing clinical condition.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Acute Coronary Syndrome Data Working Group

Relational attributes

Data Element Concepts implementing this Property:	Person—clinical evidence status (acute coronary syndrome related medical history) Health, Standard 01/10/2008 Person—clinical evidence status (chronic lung disease) Health, Superseded 01/10/2008 Person—clinical evidence status (heart failure) Health, Superseded 01/10/2008 Person—clinical evidence status (peripheral arterial disease) Health, Superseded 01/10/2008 Person—clinical evidence status (sleep apnoea syndrome) Health, Superseded 01/10/2008 Person—clinical evidence status (stroke) Health, Superseded 01/10/2008

Clinical procedure timing

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 284841

Registration status: Health, Standard 04/06/2004

Definition: Identifies when a clinical procedure was performed.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—clinical procedure timing Health, Standard 04/06/2004

Clinical service context

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	329816
Registration status:	Health, Standard 07/12/2011
Definition:	The area of clinical practice providing a health-care service.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health-care incident—clinical service context Health, Standard 07/12/2011

Clinical urgency

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269075
Registration status:	Health, Standard 01/03/2005
Definition:	A clinical assessment of the urgency with which care, treatment or assistance is required.
Property group:	Service/care urgency

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—clinical urgency Health, Standard 01/03/2005

Clopidogrel therapy status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284865
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the use of clopidogrel therapy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—clopidogrel therapy status Health, Standard 04/06/2004

Co-location with acute care hospital

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 286929

Registration status: Health, Standard 08/12/2004

Definition: The co-location of a service with an acute care hospital.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Specialised mental health service—co-location with acute care hospital Health, Standard 08/12/2004

Community awareness/health promotion services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287005
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of community awareness/health promotion services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations Health, Standard 08/12/2004

Compensable status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269123
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of an entitlement for compensation.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Patient—compensable status Health, Standard 01/03/2005

Complex road name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	429363
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	The name of the road or thoroughfare within a complex.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references:	Supersedes Street name Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011
Data Element Concepts implementing this Property:	Address—complex road name Community Services, Standard 06/02/2012 Health, Standard 07/12/2011

Complex road number 1

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	429183
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	The number, or start number in a ranged address, of the building/dwelling in the road or thoroughfare within a complex.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references:	Supersedes House/property identifier Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011
Data Element Concepts implementing this Property:	Address—complex road number 1 Community Services, Standard 06/02/2012 Health, Standard 07/12/2011

Complex road number 2

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 429257

Registration status: Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Definition: The last number for a ranged address in the road or thoroughfare in which a complex is located.

Property group: Location characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references: Supersedes House/property identifier Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Data Element Concepts implementing this Property: Address—complex road number 2 Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Complex road type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	429381
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	A descriptor of the class of road or thoroughfare within a complex.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references:	Supersedes Street type Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011
Data Element Concepts implementing this Property:	Address—complex road type Community Services, Standard 06/02/2012 Health, Standard 07/12/2011

Complication

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269096
Registration status:	Health, Standard 01/03/2005
Definition:	A disease or disorder concurrent with another disease, disorder or condition.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Data Element Concepts implementing this Property:	Birth event—complication Health, Standard 01/03/2005 Birth event—complication (postpartum) Health, Standard 01/03/2005 Pregnancy (current)—complication Health, Standard 01/03/2005

Condition onset flag

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 354805

Registration status: Health, Standard 05/02/2008

Definition: A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Diagnosis onset type Health, Superseded 05/02/2008

Data Element Concepts implementing this Property: Episode of admitted patient care—condition onset flag Health, Standard 05/02/2008

Congenital malformation

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269324
Registration status:	Health, Standard 01/03/2005
Definition:	An anomaly that is present at birth.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—congenital malformation Health, Standard 01/03/2005

Consumer committee representation arrangements

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 288847

Registration status: Health, Standard 08/12/2004

Definition: An indicator of the extent of formal committee mechanisms in place to promote the participation of mental health consumers.

Property group: Organisational characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare.

Relational attributes

Data Element Concepts implementing this Property: Specialised mental health service organisation—consumer committee representation arrangements Health, Standard 08/12/2004

Consumer participation arrangements

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288859
Registration status:	Health, Standard 08/12/2004
Definition:	An indicator of whether mechanisms are in place to promote the participation of mental health consumers.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed) Health, Standard 08/12/2004 Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys) Health, Standard 08/12/2004 Specialised mental health service organisation—consumer participation arrangements (formal internal complaints mechanism) Health, Standard 08/12/2004 Specialised mental health service organisation—consumer participation arrangements (formal participation policy) Health, Standard 08/12/2004 Specialised mental health service organisation—consumer participation arrangements (regular discussion groups) Health, Standard 08/12/2004

Consumption of 6 or more standard drinks on one occasion

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	403103
Registration status:	Health, Standard 25/08/2011
Definition:	The frequency of consuming six or more alcoholic beverages, containing 10 grams of alcohol (a standard drink), on one occasion.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—consumption of 6 or more standard drinks on one occasion Health, Standard 25/08/2011

Contract role

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269131
Registration status:	Health, Standard 01/03/2005
Definition:	The assigned responsibility under a contractual arrangement.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Hospital—contract role Health, Standard 01/03/2005

Contract type

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269174

Registration status: Health, Standard 01/03/2005

Definition: A descriptor of the class of a contractual agreement.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Hospital—contract type Health, Standard 01/03/2005

Contracted care commencement date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269263
Registration status:	Health, Standard 01/03/2005
Definition:	The date the period of contracted care commenced.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Contracted hospital care—contracted care commencement date Health, Standard 01/03/2005

Contracted care completed date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269102
Registration status:	Health, Standard 01/03/2005
Definition:	The date the period of contracted care is completed.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Contracted hospital care—contracted care completed date Health, Standard 01/03/2005

Contracted procedure flag

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269345
Registration status:	Health, Standard 01/03/2005
Definition:	Indicator that a procedure was performed as a contracted service.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care (procedure)—contracted procedure flag Health, Standard 01/03/2005

Coordinator of volunteers indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	352858
Registration status:	Health, Standard 05/12/2007
Definition:	An indicator of whether a person is designated to coordinate the volunteer labour force.
Property group:	Organisational characteristics

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—coordinator of volunteers indicator Health, Standard 05/12/2007

Coronary artery bypass graft date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	344420
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a coronary artery bypass graft (CABG) is performed.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—coronary artery bypass graft date Health, Standard 01/10/2008

Coronary artery bypass graft location

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	347157
Registration status:	Health, Standard 01/10/2008
Definition:	The artery where a coronary artery bypass graft has been performed.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—coronary artery bypass graft location Health, Standard 01/10/2008

Coronary artery disease intervention

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269207
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of whether treatment has been received for a coronary artery condition.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—coronary artery disease intervention Health, Standard 01/03/2005

Coronary artery stenosis location

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	361082
Registration status:	Health, Standard 01/10/2008
Definition:	The coronary artery in which abnormal narrowing is located.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—coronary artery stenosis location Health, Standard 01/10/2008

Counselling services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287013
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of counselling services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—counselling services grants to non-government organisations Health, Standard 08/12/2004

Count of coronary artery lesions attempted

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	344400
Registration status:	Health, Standard 01/10/2008
Definition:	A count of coronary artery lesions into which an attempt was made to pass a guidewire.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—count of coronary artery lesions attempted Health, Standard 01/10/2008

Count of coronary artery lesions successfully dilated

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	344407
Registration status:	Health, Standard 01/10/2008
Definition:	A count of successful dilatation of lesions (blockages) to restore adequate blood flow through the coronary artery.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—count of coronary artery lesions successfully dilated Health, Standard 01/10/2008

Count of coronary artery stents

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 344413

Registration status: Health, Standard 01/10/2008

Definition: A count of tubes made of metal or plastic inserted during an angioplasty procedure into a coronary artery to keep the lumen open and prevent closure.

Property group: Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property: Person—count of coronary artery stents Health, Standard 01/10/2008

Country identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288063
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	The country component of an address.
Property group:	Identifier characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—country identifier Community Services, Standard 30/09/2005 Health, Standard 04/05/2005

Country of birth

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269206
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005 Health, Standard 01/03/2005 Homelessness, Standard 23/08/2010 Tasmanian Health, Proposed 28/09/2011
Definition:	The country in which an individual was born.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—country of birth Community Services, Standard 01/03/2005 Housing assistance, Standard 27/07/2005 Health, Standard 01/03/2005 Homelessness, Standard 23/08/2010 Tasmanian Health, Proposed 28/09/2011

Country of employment in registered profession

Identifying and definitional attributes

Metadata item type: Property

Synonymous names: Country of employment

METeOR identifier: 383396

Registration status: Health, Standard 10/12/2009

Definition: The country in which a person is working in the registered profession.

Property group: Labour characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Registered health professional—country of employment in registered profession Health, Standard 10/12/2009

Creatine kinase isoenzyme level

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	319418
Registration status:	Health, Standard 01/10/2008
Definition:	The level of creatine kinase enzymes found in the blood which (if elevated) indicate damage to either the muscle or brain.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—creatine kinase isoenzyme level Health, Standard 01/10/2008

Creatine kinase myocardial band isoenzyme measured date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284969
Registration status:	Health, Standard 04/06/2004
Definition:	The date creatine kinase myocardial band (CK-MB) isoenzyme was measured.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—creatine kinase myocardial band isoenzyme measured date Health, Standard 04/06/2004

Creatine kinase myocardial band isoenzyme measured time

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 285175

Registration status: Health, Standard 04/06/2004

Definition: The time at which the creatine kinase myocardial band (CK-MB) isoenzyme was measured.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Data Element Concepts implementing this Property: Person—creatine kinase myocardial band isoenzyme measured time Health, Standard 04/06/2004

Creatine kinase-myocardial band isoenzyme level

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	284893
Registration status:	Health, Standard 04/06/2004
Definition:	The level of creatine kinase-myocardial band (CK-MB) isoenzyme.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—creatine kinase-myocardial band isoenzyme level Health, Standard 04/06/2004

Creatinine serum level

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269319

Registration status: Health, Standard 01/03/2005

Definition: The amount of creatinine in the blood.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—creatinine serum level Health, Standard 01/03/2005

Creatinine serum level measured date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	343839
Registration status:	Health, Standard 01/10/2008
Definition:	The date when the level of creatinine serum was measured.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—creatinine serum level measured date Health, Standard 01/10/2008

Current opioid pharmacotherapy treatment indicator

Identifying and definitional attributes

Metadata item type: Property

Synonymous names: OPT; opioid replacement program

METeOR identifier: 404757

Registration status: Health, Standard 25/08/2011

Definition: An indicator of current participation in a drug-based opioid dependence treatment program.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—current opioid pharmacotherapy treatment program indicator Health, Standard 25/08/2011

Current smoking status indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	399534
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether cigarettes or other tobacco products are smoked at present.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—current smoking status indicator Health, Standard 25/08/2011

Date health-care incident occurred

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	329654
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which an event or circumstance resulting from health care occurred.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health-care incident—date health-care incident occurred Health, Standard 07/12/2011

Date of birth

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269318
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005 Health, Standard 01/03/2005 Early Childhood, Standard 21/05/2010 Homelessness, Proposed 23/08/2010 Tasmanian Health, Proposed 28/09/2011
Definition:	The date on which an individual was born.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—date of birth Community Services, Standard 01/03/2005 Housing assistance, Standard 27/07/2005 Health, Standard 01/03/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010 Tasmanian Health, Proposed 28/09/2011

Date of change to qualification status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269082

Registration status: Health, Standard 01/03/2005

Definition: The date on which a **newborn qualification status** changes.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Episode of admitted patient care (newborn)—date of change to qualification status Health, Standard 01/03/2005

Date of death

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 287292

Registration status: Community Services, Standard 30/09/2005
Health, Standard 04/05/2005
Tasmanian Health, Proposed 28/09/2011

Definition: Date on which an individual died.

Context:

Property group: Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—date of death Community Services, Standard 30/09/2005
Health, Standard 04/05/2005
Tasmanian Health, Proposed 28/09/2011

Date of last contact

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	394052
Registration status:	Health, Standard 07/12/2011
Definition:	The date of the most recent contact with the patient.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Cancer Australia

Relational attributes

Data Element Concepts implementing this Property:	Patient—date of last contact Health, Standard 07/12/2011

Degree of spread of a cancer

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269182

Registration status: Health, Standard 01/03/2005

Definition: The progression/extent of a cancer measured at a particular point in time.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person with cancer—degree of spread of a cancer Health, Standard 01/03/2005

Dependency in activities of daily living

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269342

Registration status: Community Services, Recorded 16/11/2009
Health, Standard 01/03/2005

Definition: An indicator of the extent to which help is required for tasks of everyday life.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—dependency in activities of daily living Community Services, Recorded 16/11/2009
Health, Standard 01/03/2005

Diabetes mellitus status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269209

Registration status: Health, Standard 01/03/2005

Definition: An indicator of a risk of developing diabetes mellitus or a diagnosis of diabetes mellitus.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—diabetes mellitus status Health, Standard 01/03/2005

Diabetes therapy type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269378
Registration status:	Health, Standard 01/03/2005
Definition:	The class of treatment received for diabetes.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	National diabetes data working group

Relational attributes

Data Element Concepts implementing this Property:	Person—diabetes therapy type Health, Standard 01/03/2005

Diagnosis date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269392
Registration status:	Health, Standard 01/03/2005
Definition:	The date a disease or condition is diagnosed.
Context:	Health services and clinical setting: Diagnostic information provides the basis for analysis of health service usage, epidemiological studies and monitoring of specific disease entities and conditions.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Patient—diagnosis date Health, Standard 01/03/2005

Diagnosis date of cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	447400
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which cancer was first diagnosed.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Cancer Australia

Relational attributes

Data Element Concepts implementing this Property:	Patient—diagnosis date of cancer Health, Standard 07/12/2011

Diagnosis date of first recurrence as distant metastasis

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	447402
Registration status:	Health, Standard 07/12/2011
Definition:	The date of first recurrence as distant metastatic disease. The term recurrence defines the return, reappearance or metastasis of cancer (of the same histology) after a disease-free intermission or remission. Distant metastasis refers to the spread of cancer of the same histology as the original (primary) tumour to distant organs or distant lymph nodes.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II, Commission on Cancer

Relational attributes

Data Element Concepts implementing this Property:	Patient—diagnosis date of first recurrence as distant metastasis Health, Standard 07/12/2011

Diagnosis date of first recurrence as locoregional cancer

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 447405

Registration status: Health, Standard 07/12/2011

Definition: The date of first recurrence as locoregional cancer.

The term recurrence defines the return, reappearance or metastasis of cancer (of the same histology) after a disease free period.

Locoregional recurrence refers to the recurrence of cancer cells at the same site as the original (primary) tumour or the regional lymph nodes after a disease free period.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II, Commission on Cancer

Relational attributes

Data Element Concepts implementing this Property: Patient—diagnosis date of first recurrence as locoregional cancer Health, Standard 07/12/2011

Diagnosis related group

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269188

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: A resource utilisation classification based on diagnosed conditions, usage of hospital resources, and demographic characteristics of the patient.

Context: The development of Australian refined diagnosis related groups has created a descriptive framework for studying hospitalisation. Diagnosis related groups provide a summary of the varied reasons for hospitalisation and the complexity of cases a hospital treats. Moreover, as a framework for describing the products of a hospital (that is, patients receiving services), they allow meaningful comparisons of hospitals' efficiency and effectiveness under alternative systems of health care provision.

Property group: Service provision event

Relational attributes

Data Element Concepts implementing this Property: Episode of admitted patient care—diagnosis related group
Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Distant metastasis status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	293228
Registration status:	Health, Standard 13/06/2004
Definition:	The absence or presence of distant metastasis.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Sobin LH (Editors) (1997) International Union Against Cancer (UICC) TNM classification of malignant tumours, 5th edition. Wiley-Liss, New York

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—distant metastasis status Health, Superseded 07/12/2011 Person with cancer—distant metastasis status Health, Standard 07/12/2011

Distress related to current imprisonment indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 376085

Registration status: Health, Standard 25/08/2011

Definition: An indicator of whether any feelings of distress are related to being in prison.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Prison entrant—distress related to current imprisonment indicator Health, Standard 25/08/2011

Drug of concern

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269127
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the psychoactive substance that is of concern.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of treatment for alcohol and other drugs—drug of concern Health, Standard 01/03/2005 Episode of treatment for alcohol and other drugs—drug of concern (principal) Health, Superseded 13/10/2005

Dyslipidaemia treatment with anti-lipid medication indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	304483
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of the receipt of treatment for abnormal lipid levels using anti-lipid medication.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Dyslipidaemia treatment status Health, Superseded 22/09/2005
Data Element Concepts implementing this Property:	Person—dyslipidaemia treatment with anti-lipid medication indicator Health, Standard 21/09/2005

Education attendance status 30 days prior to imprisonment

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 412955

Registration status: Health, Standard 25/08/2011

Definition: The status of attendance at an education institution, 30 days prior to imprisonment.

Property group: Educational characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Prison entrant—education attendance status 30 days prior to imprisonment Health, Standard 25/08/2011

Elective care type

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Waiting list category
METeOR identifier:	269040
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the class of elective hospital care.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Elective care waiting list episode—elective care type Health, Standard 01/03/2005

Electrocardiogram change location

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	356839
Registration status:	Health, Standard 01/10/2008
Definition:	The area in which the change is located on an electrocardiogram (ECG).
Property group:	Service provision event

Relational attributes

Related metadata references:	Supersedes Electrocardiogram change location Health, Superseded 01/10/2008
Data Element Concepts implementing this Property:	Electrocardiogram—change location Health, Standard 01/10/2008

Electrocardiogram change type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285301
Registration status:	Health, Standard 04/06/2004
Definition:	The type of change to the heart rhythm as seen on an electrocardiogram (ECG).
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Electrocardiogram—change type Health, Standard 01/10/2008 Person—electrocardiogram change type Health, Superseded 01/10/2008

Electrocardiogram date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	343816
Registration status:	Health, Standard 01/10/2008
Definition:	Date when an electrocardiogram (ECG) is recorded to measure the electrical activity of the heart.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Electrocardiogram—electrocardiogram date Health, Standard 01/10/2008

Electrocardiogram lead V4R indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	349651
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether lead V4R is present on the electrocardiogram (ECG).
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Electrocardiogram—lead V4R presence indicator Health, Standard 01/10/2008

Electrocardiogram Q waves

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	343892
Registration status:	Health, Standard 01/10/2008
Definition:	The initial downward deflection of the QRS complex in an electrocardiogram.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Electrocardiogram—new Q waves indicator Health, Standard 01/10/2008

Electrocardiogram Q waves indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	347706
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether Q waves that are greater than or equal to 0.03 seconds in width and greater than or equal to 1mm (0.1mV) in depth are present in at least 2 contiguous leads of the electrocardiogram (ECG).
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person— electrocardiogram Q waves indicator Health, Standard 01/10/2008

Electrocardiogram ST-segment-elevation in lead V4R indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	343883
Registration status:	Health, Standard 01/10/2008
Definition:	Presence of ST-segment-elevation of greater than or equal to 1mm (0.1mV) in lead V4R
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Electrocardiogram—electrocardiogram ST-segment-elevation in lead V4R indicator Health, Standard 01/10/2008

Electrocardiogram time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	343825
Registration status:	Health, Standard 01/10/2008
Definition:	Time when an electrocardiogram (ECG) is recorded, to measure the electrical activity of the heart.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Electrocardiogram—electrocardiogram time Health, Standard 01/10/2008

Electronic communication address

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 287451

Registration status: Community Services, Standard 30/09/2005
Health, Standard 04/05/2005
Tasmanian Health, Proposed 30/09/2011

Definition: The characters used for the purpose of communication by electronic means.

Property group: Location characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person (address)—electronic communication address
Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Service provider organisation (address)—electronic communication address Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Electronic communication medium

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287501
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	The type of mechanism used for electronic communication.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—electronic communication medium Community Services, Standard 30/09/2005 Health, Standard 04/05/2005 Service provider organisation (address)—electronic communication medium Community Services, Standard 30/09/2005 Health, Standard 04/05/2005

Electronic communication usage code

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287523
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	The manner of use of an electronic communication address.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—electronic communication usage code Community Services, Superseded 06/02/2012 Health, Standard 04/05/2005

Eligibility status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	304551
Registration status:	Community Services, Standard 04/01/2006 Health, Standard 05/01/2006
Definition:	An indicator of eligibility for services.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—eligibility status Community Services, Standard 04/01/2006 Health, Standard 04/01/2006

Employee related expenses

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 360140

Registration status: Health, Standard 05/12/2007

Definition: The expenditure incurred for wages, salaries and supplements, superannuation employer contributions, workers compensation premiums and payouts.

Property group: Financial characteristics

Relational attributes

Data Element Concepts implementing this Property: Organisation—employee related expenses Health, Standard 05/12/2007

End-stage renal disease status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269307

Registration status: Health, Standard 01/03/2005

Definition: An indicator of the development of end-stage renal disease.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—end-stage renal disease status Health, Standard 01/03/2005

Environmental factor

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 320223

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Definition: Environmental factors make up the physical, social and attitudinal environment in which individuals live and conduct their lives.

Property group: Environmental characteristics

Relational attributes

Data Element Concepts implementing this Property: Person—environmental factor Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Episode end date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269252
Registration status:	Community Services, Standard 16/05/2006 Housing assistance, Standard 23/08/2010 Health, Standard 01/03/2005 Homelessness, Standard 23/08/2010
Definition:	The date on which an episode is completed.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of residential care—episode end date Health, Superseded 07/12/2011 Episode of residential care—episode end date Health, Standard 07/12/2011 Non-admitted patient emergency department service episode—episode end date Health, Superseded 22/12/2011 Non-admitted patient emergency department service episode—episode end date Health, Superseded 30/01/2012 Non-admitted patient emergency department service episode—episode end date Health, Standard 30/01/2012

Episode end mode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269144
Registration status:	Health, Standard 01/03/2005
Definition:	The method by which an episode ends.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of residential care—episode end mode Health, Superseded 07/12/2011 Episode of residential care—episode end mode Health, Standard 07/12/2011

Episode end status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 322637

Registration status: Health, Standard 24/03/2006

Definition: The status of the patient at the end of the episode of care or service episode.

Property group: Exit/leave from service event

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: Supersedes Patient departure status Health, Superseded 24/03/2006

Data Element Concepts implementing this Property:

Non-admitted patient emergency department service episode—episode end status Health, Superseded 22/12/2011

Non-admitted patient emergency department service episode—episode end status Health, Superseded 30/01/2012

Non-admitted patient emergency department service episode—episode end status Health, Standard 30/01/2012

Episode end time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	322612
Registration status:	Health, Standard 24/03/2006
Definition:	The time at which an episode is completed.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing.

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—episode end time Health, Superseded 22/12/2011 Non-admitted patient emergency department service episode—episode end time Health, Superseded 30/01/2012 Non-admitted patient emergency department service episode—episode end time Health, Standard 30/01/2012

Episode start date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269253
Registration status:	Community Services, Standard 16/05/2006 Housing assistance, Standard 23/08/2010 Health, Standard 01/03/2005 Homelessness, Standard 23/08/2010
Definition:	The date on which an episode commenced.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of residential care—episode start date Health, Standard 07/12/2011 Episode of residential care—episode start date Health, Superseded 07/12/2011 Residential stay—episode start date Health, Standard 01/03/2005

Episode start mode

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269106

Registration status: Health, Standard 01/03/2005

Definition: The method by which an episode begins.

Property group: Entry into service event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Episode of residential care—episode start mode Health, Superseded 07/12/2011

Episode of residential care—episode start mode Health, Standard 07/12/2011

Erectile dysfunction

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Impotence
METeOR identifier:	269149
Registration status:	Health, Standard 01/03/2005
Definition:	The inability to achieve or maintain an erection of sufficient rigidity to perform sexual intercourse successfully.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (male)—erectile dysfunction Health, Standard 01/03/2005

Establishment type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269027
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the class of establishment.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—establishment type Health, Standard 01/03/2005 Health professional—establishment type (employment) Health, Standard 01/03/2005

Estimated duration

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	379592
Registration status:	Health, Standard 02/12/2009
Definition:	The period of time during which something continues.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Pregnancy—estimated duration Health, Standard 02/12/2009

Estimated glomerular filtration rate (eGFR) recorded indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 464957

Registration status: Health, Standard 07/12/2011

Definition: An indicator of whether an estimated glomerular filtration rate (eGFR) has been recorded.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property: Person—estimated glomerular filtration rate (eGFR) recorded indicator Health, Standard 07/12/2011

Ever been pregnant indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 399553

Registration status: Health, Standard 25/08/2011

Definition: An indicator of whether a person has ever carried a developing embryo or fetus within their body.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Female—ever been pregnant indicator Health, Standard 25/08/2011

Ever smoked a full cigarette indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	399267
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of having, in the past, smoked a cigarette in its entirety.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—ever smoked a full cigarette indicator Health, Standard 25/08/2011

Expenses

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 356286

Registration status: Health, Standard 05/12/2007

Definition: Expenses consisting mainly of wages, salaries and supplements, purchases of goods and services and consumption of fixed capital (depreciation).

Property group: Financial characteristics

Collection and usage attributes

Collection methods: Data are collected and nationally collated for the reporting period—the financial year ending in 30 June each year.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents: Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.asb.com.au>.

Relational attributes

Data Element Concepts implementing this Property: Organisation—expenses Health, Standard 05/12/2007

Extended leave status in registered profession

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	383409
Registration status:	Health, Standard 10/12/2009
Definition:	Whether a person is on extended leave from their position of employment in the registered profession.
Context:	Employed persons.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Registered health professional—extended leave status in registered profession Health, Standard 10/12/2009

Extended wait patient indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269074

Registration status: Health, Standard 01/03/2005

Definition: An indicator of a patient who has experienced a prolonged wait for care.

Property group: Performance indicators

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Elective surgery waiting list episode—extended wait patient indicator Health, Standard 01/03/2005

Extent of environmental factor influence

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320232
Registration status:	Community Services, Standard 16/10/2006 Health, Standard 29/11/2006
Definition:	The degree to which specified environmental factors influence functioning and disability.
Property group:	Environmental characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—extent of environmental factor influence Community Services, Standard 16/10/2006 Health, Standard 29/11/2006

Extent of harm from a health-care incident

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 330187

Registration status: Health, Standard 07/12/2011

Definition: The overall effect of a health-care incident in terms of impairment, activity limitation or participation restriction.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Patient—extent of harm from a health-care incident Health, Standard 07/12/2011

Extent of impairment of body function

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320240
Registration status:	Community Services, Standard 16/10/2006 Health, Standard 29/11/2006
Definition:	The degree of impairment in a specified body function.
Property group:	Physical characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—extent of impairment of body function Community Services, Standard 16/10/2006 Health, Standard 29/11/2006

Extent of impairment of body structure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320252
Registration status:	Community Services, Standard 16/10/2006 Health, Standard 29/11/2006
Definition:	The degree of impairment in a specified body structure.
Property group:	Physical characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—extent of impairment of body structure Community Services, Standard 16/10/2006 Health, Standard 29/11/2006

Extent of participation in a life area

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	324449
Registration status:	Community Services, Standard 16/10/2006 Health, Standard 29/11/2006
Definition:	The degree of participation in a life area.
Property group:	Lifestyle characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—extent of participation in a life area Community Services, Standard 16/10/2006 Health, Standard 29/11/2006

Extent of primary cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	296911
Registration status:	Health, Standard 04/06/2004
Definition:	Degree of spread of the primary cancer.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—extent of primary cancer Health, Superseded 07/12/2011 Person with cancer—extent of primary cancer Health, Standard 07/12/2011

External cause

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269034
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The circumstances in which an injury, poisoning or other adverse effect has occurred.
Property group:	Crisis event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	International Classification of Diseases - Tenth Revision - Australian Modification National Centre for Classification in Health, Sydney

Relational attributes

Data Element Concepts implementing this Property:	Injury event—external cause Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011

Family name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269355
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005 Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	A designation for a family.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—family name Community Services, Standard 01/03/2005 Housing assistance, Standard 28/07/2005 Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011

Fasting indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269148

Registration status: Health, Standard 01/03/2005

Definition: An indicator of abstinence from all food and drink except water.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Dorland I & Newman W.A 2003. Dorland's illustrated medical dictionary, 30th ed. Philadelphia: Saunders.

Relational attributes

Data Element Concepts implementing this Property: Health service event—fasting indicator Health, Standard 01/03/2005

Feedback collection indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	290389
Registration status:	Health, Standard 05/12/2007
Definition:	An indicator of whether feedback relating to services and service delivery is actively and routinely collected.
Property group:	Performance indicators

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—feedback collection indicator Health, Standard 05/12/2007

Feedback collection method

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 356484

Registration status: Health, Standard 05/12/2007

Definition: The method employed to actively and routinely collect feedback.

Property group: Performance indicators

Relational attributes

Data Element Concepts implementing this Property: Service provider organisation—feedback collection method Health, Standard 05/12/2007

Fibrinolytic drug administered

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	356876
Registration status:	Health, Standard 01/10/2008
Definition:	The type of fibrinolytic drug therapy administered.
Property group:	Service provision event

Relational attributes

Related metadata references:	Supersedes Fibrinolytic drug administered Health, Superseded 01/10/2008
Data Element Concepts implementing this Property:	Person—fibrinolytic drug administered Health, Standard 01/10/2008

Fibrinolytic therapy status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285081
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the use of fibrinolytic therapy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—fibrinolytic therapy status Health, Standard 04/06/2004

First contact date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269337
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which first contact between a service provider and a patient/client occurred.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Community nursing service episode—first contact date Health, Standard 01/03/2005

First day of the last menstrual period

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269086
Registration status:	Health, Standard 01/03/2005
Definition:	Date of the first day of the last menstrual period (LMP).
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Pregnancy—first day of the last menstrual period Health, Standard 01/03/2005

First language spoken

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269243
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 01/08/2005 Health, Standard 13/10/2011 Homelessness, Standard 13/10/2011
Definition:	The language first used for oral communication.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—first language spoken Community Services, Standard 01/03/2005 Housing assistance, Standard 01/08/2005 Health, Standard 13/10/2011 Homelessness, Standard 13/10/2011

First service contact date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269346
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 23/08/2010 Health, Standard 07/12/2011 Homelessness, Standard 23/08/2010
Definition:	Date on which the first service contact occurs.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health service event—first service contact date Health, Standard 07/12/2011

First service delivery date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269359

Registration status: Health, Standard 01/03/2005

Definition: Date on which service is delivered for the first time.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Episode of care—first service delivery date (community setting) Health, Standard 01/03/2005

First time in prison or juvenile detention indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	415739
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether the current imprisonment is the first time in prison or juvenile detention.
Property group:	Legal characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Prison entrant—first time in prison or juvenile detention indicator Health, Standard 25/08/2011

Floor/level type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269379
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 01/03/2005
Definition:	Descriptor used to classify the type of floor or level of a multi-storey building/complex.
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Health Data Standards Committee

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—floor/level type Community Services, Superseded 06/02/2012 Health, Standard 01/03/2005 Service provider organisation (address)—floor/level type Community Services, Superseded 06/02/2012 Health, Standard 04/05/2005

Foot deformity indicator

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Foot malformation
METeOR identifier:	269160
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the presence of a distortion of the normal shape or size of either foot.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	United States National Library of Medicine 2004. Medical Subject Headings (MESH) Browser. National Library of Medicine, Maryland. Viewed 21 June 2004,

Relational attributes

Data Element Concepts implementing this Property:	Person—foot deformity indicator Health, Standard 01/03/2005

Foot lesion indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269162
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the presence of a foot lesion other than an ulcer on either foot.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—foot lesion indicator Health, Standard 01/03/2005

Foot ulcer indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269163
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the presence of a lesion on the surface of the skin of either foot, produced by the sloughing of inflammatory necrotic tissue.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	Dorland I & Newman W.A 2003. Dorland's illustrated medical dictionary, 30th ed. Philadelphia: Saunders United States National Library of Medicine 2004. Medical Subject Headings (MESH) Browser. National Library of Medicine, Maryland. Viewed 21 June 2004,

Relational attributes

Data Element Concepts implementing this Property:	Person—foot ulcer indicator Health, Standard 21/09/2005 Person—foot ulcer status (current) Health, Superseded 21/09/2005

Formal community support access indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269170
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the receipt of community-based assistance from paid workers or volunteers organised by formal services (including paid staff in funded group houses).
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—formal community support access indicator Health, Standard 01/03/2005

Full-time equivalent staff

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269172

Registration status: Community Services, Standard 01/03/2005
Health, Standard 13/05/2005

Definition: Hours actually worked divided by the number of normal hours worked by a full-time staff member.

Property group: Labour characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:

Establishment (prison)—full-time equivalent staff Health, Standard 25/08/2011

Establishment—full-time equivalent staff (paid) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (administrative and clerical staff) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (carer consultants) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (consumer consultants) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (diagnostic and health professionals) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (domestic and other staff) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (enrolled nurses) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (nurses) Health, Standard 07/12/2011

Establishment—full-time equivalent staff (paid) (occupational therapists) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (other medical officers) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (other personal care staff) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (psychologists) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (registered nurses) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (salaried medical officers) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (social workers) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (student nurses) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (trainee/pupil nurses) Health, Standard 01/03/2005

Fully immunised indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	457652
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether immunisation status has been recorded as fully immunised.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property:	Child—recorded as fully immunised indicator Health, Standard 07/12/2011

Functional stress test date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 347049

Registration status: Health, Standard 01/10/2008

Definition: The date when a functional stress test is performed.

Property group: Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property: Functional stress test—test date Health, Standard 01/10/2008

Functional stress test element

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	356901
Registration status:	Health, Standard 01/10/2008
Definition:	The element used to monitor the changes in heart function that occur during a functional stress test.
Property group:	Service provision event

Relational attributes

Related metadata references:	Supersedes Functional stress test element Health, Superseded 01/10/2008
Data Element Concepts implementing this Property:	Functional stress test—functional stress test element Health, Standard 01/10/2008

Functional stress test performed indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	347692
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether a functional stress test was performed.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—functional stress test performed indicator Health, Standard 01/10/2008

Funding eligibility indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269120
Registration status:	Health, Standard 01/03/2005
Definition:	Whether eligible services are actually funded.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—funding eligibility indicator Health, Standard 01/03/2005

Geographic location

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269234
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Retired 10/02/2006 Health, Standard 01/03/2005 Early Childhood, Standard 21/05/2010
Definition:	A description of physical location.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—geographic location Health, Standard 01/03/2005 Service delivery outlet—geographic location Health, Standard 01/03/2005

Geographic remoteness

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 396537

Registration status: Housing assistance, Proposed 01/11/2011
Health, Standard 07/12/2011

Definition: The remoteness of a location, based on the physical road distance to the nearest urban centre and its population size.

Context: Geographic remoteness is essentially a measure of a physical location's level of access to goods and services. Large population centres tend to have a greater range of goods and services available than small centres. Typically, a population centre is not likely to provide a full range of goods and services until its population reaches around 250,000 people.

Property group: Location characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Establishment—geographic remoteness Health, Standard 07/12/2011

Health-care incident—geographic remoteness Health, Standard 07/12/2011

Gestational age

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 324353

Registration status: Health, Standard 02/12/2009

Definition: The period of development of a product of conception from the time of fertilisation.

Property group: Health and wellbeing

Relational attributes

Related metadata references: Supersedes Estimated gestational age Health, Superseded 02/12/2009

Data Element Concepts implementing this Property: Product of conception—gestational age Health, Standard 02/12/2009

Given name

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269222

Registration status: Community Services, Standard 01/03/2005
Housing assistance, Standard 22/10/2005
Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: A designation for an individual within the family group or by which the individual is socially identified.

Property group: Name characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person (name)—given name Community Services, Standard 01/03/2005
Housing assistance, Standard 01/08/2005
Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Given name sequence number

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287587
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	An order of given name or initials.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—given name sequence number Community Services, Standard 30/09/2005 Health, Standard 04/05/2005

Glycoprotein IIb/IIIa receptor antagonist therapy status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285107
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the use of glycoprotein IIb/IIIa receptor antagonist therapy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—glycoprotein IIb/IIIa receptor antagonist status Health, Standard 04/06/2004

Glycosylated haemoglobin level

Identifying and definitional attributes

Metadata item type: Property

Synonymous names: HbA1c

METeOR identifier: 269273

Registration status: Health, Standard 01/03/2005

Definition: An indicator of the level of blood glucose.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—glycosylated haemoglobin level Health, Standard 01/03/2005

Glycosylated haemoglobin measurement result recorded indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	441487
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a blood sugar levels measurement result has been recorded.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property:	Person—glycosylated haemoglobin measurement result recorded indicator Health, Standard 07/12/2011

Goal of care

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269203
Registration status:	Health, Standard 01/03/2005
Definition:	The expected outcome of planned care.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Community nursing service episode—goal of care Health, Standard 01/03/2005

Government funding identifier

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269238

Registration status: Community Services, Standard 31/08/2007
Housing assistance, Standard 23/08/2010
Health, Standard 01/03/2005
Homelessness, Standard 23/08/2010
Tasmanian Health, Proposed 28/09/2011

Definition: An identifier allocated by a government department for the purpose of identifying those eligible for specific services.

Property group: Identifier characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—government funding identifier Community Services, Standard 31/08/2007
Housing assistance, Standard 23/08/2010
Health, Standard 01/03/2005
Homelessness, Standard 23/08/2010
Tasmanian Health, Proposed 28/09/2011

GP Management Plan (MBS Item 721) indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 441506

Registration status: Health, Standard 07/12/2011

Definition: An indicator of whether a GP Management Plan (MBS Item 721) has been received.

Property group: Performance indicators

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property: Person—GP Management Plan (MBS Item 721) indicator Health, Standard 07/12/2011

Gross capital expenditure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269024
Registration status:	Housing assistance, Standard 10/02/2006 Health, Standard 01/03/2005
Definition:	Expenditure on the acquisition or enhancement of a **non-financial asset**.
Property group:	Financial characteristics

Collection and usage attributes

Guide for use:

National health data dictionary specific:

Gross capital expenditure is capital expenditure as reported by the particular establishment having regard to state health authority and other authoritative guidelines as to the differentiation between capital and recurrent expenditure. (A concise indication of the basis on which capital and recurrent expenditure have been differentiated is to form part of national minimum data sets).

National housing assistance data dictionary specific:

Expenditure on the acquisition or enhancement of an asset (excluding financial assets). A non-financial asset is an entity functioning as a store of value, over which ownership may be derived over a period of time, and which is not a financial asset. Capital includes: acquisitions (purchase of properties); construction costs; redevelopment and improvement (of properties); land acquisitions and development; joint ventures.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Data Element Concepts implementing this Property:

Establishment—gross capital expenditure (accrual accounting) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (buildings and building services) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (constructions) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (information technology) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (intangible assets) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (land) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (other equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (transport) Health, Standard 01/03/2005

Establishment—gross capital expenditure (computer equipment/installations) Health, Standard 01/03/2005

Establishment—gross capital expenditure (intangible assets) Health, Standard 01/03/2005

Establishment—gross capital expenditure (land and buildings) Health, Standard 01/03/2005

Establishment—gross capital expenditure (major medical equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (other capital expenditure) Health, Standard 01/03/2005

Establishment—gross capital expenditure (plant and other equipment) Health, Standard 01/03/2005

Gross income

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269270

Registration status: Community Services, Standard 06/02/2012
Housing assistance, Standard 01/03/2005
Health, Standard 04/05/2005

Definition: The total income before business and tax deductions are accounted for.

Property group: Financial characteristics

Source and reference attributes

Origin: Australian taxation office 2004. Definitions. Australian taxation office, Canberra. Viewed 22 October 2004

Relational attributes

Data Element Concepts implementing this Property: Household—gross income Housing assistance, Recorded 28/09/2011
Health, Standard 15/12/2005

Group session status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 294406

Registration status: Health, Standard 17/05/2005

Definition: An indicator of services, care or assistance simultaneously being provided to more than one person.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:

Non-admitted patient service event—group session status Health, Standard 06/10/2010

Service contact—group session status Health, Standard 04/05/2005

Health professionals attended for diabetes mellitus

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269315
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the class of health professional that has been consulted for diabetes mellitus.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—health professionals attended for diabetes mellitus Health, Standard 01/03/2005

Health worker type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	413009
Registration status:	Health, Standard 25/08/2011
Definition:	The type of health professional providing health-care services.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment (prison)—health worker type Health, Standard 25/08/2011

Heart rate

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285117
Registration status:	Health, Standard 04/06/2004
Definition:	The number of heart beats per unit time, usually expressed as beats per minute.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—heart rate Health, Standard 04/06/2004

Heart rhythm type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285127
Registration status:	Health, Standard 04/06/2004
Definition:	The rhythm of a beating heart.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Electrocardiogram—heart rhythm type Health, Standard 01/10/2008 Person—heart rhythm type Health, Superseded 01/10/2008

Height

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Stature
METeOR identifier:	269299
Registration status:	Health, Standard 01/03/2005
Definition:	The standing height or recumbent length of a body.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—height Health, Standard 01/03/2005

High-density lipoprotein cholesterol level

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	310764
Registration status:	Health, Standard 27/10/2005
Definition:	The level of the serum cholesterol carried on high-density lipoproteins, approximately 20 to 30 percent of the total serum cholesterol.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Data Element Concepts implementing this Property:	Person—high-density lipoprotein cholesterol level Health, Standard 01/03/2005

Highest year of school completed

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	375992
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	The highest level of schooling completed.
Property group:	Educational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—highest year of school completed Community Services, Standard 06/02/2012 Health, Standard 25/08/2011

Hip circumference

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269302

Registration status: Health, Standard 01/03/2005

Definition: The distance around the human body at the level of maximum posterior extension of the buttocks.

Property group: Physical characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—hip circumference Health, Standard 01/03/2005

Histopathological grade

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 288655

Registration status: Health, Standard 04/06/2004

Definition: An indicator of how a tumour resembles the normal tissue from which it arose.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person with cancer—histopathological grade Health, Standard 04/06/2004

Hormone therapy completion date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	393564
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which hormone therapy was completed. Hormone therapy is the treatment of disease with hormones obtained from endocrine glands or substances that stimulate hormonal effects.
Property group:	Exit/leave from service event

Collection and usage attributes

Guide for use:	An example is the administration of hormones, agents acting via hormonal mechanisms, antihormones and steroids for the treatment of cancer.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Myers T (Editor) 2009. Mosby's Medical Dictionary, 8th Edition. Missouri: Mosby Elsevier page 890 American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision, Commission on Cancer page 28D

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—hormone therapy completion date Health, Standard 07/12/2011

Hormone therapy start date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 393523

Registration status: Health, Standard 07/12/2011

Definition: The date on which hormone therapy commenced.

The treatment of disease with hormones obtained from endocrine glands or substances that stimulate hormonal effects.

Property group: Entry into service event

Collection and usage attributes

Guide for use: An example is the administration of hormones, agents acting via hormonal mechanisms, antihormones and steroids for the treatment of cancer.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Myers T (Editor) 2009. Mosby's Medical Dictionary, 8th Edition. Missouri: Mosby Elsevier page 890

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision, Commission on Cancer page 28D

Relational attributes

Data Element Concepts implementing this Property: Cancer treatment—hormone therapy start date Health, Standard 07/12/2011

Hospital identifier

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 404235

Registration status: Health, Standard 07/12/2011

Definition: A sequence of characters which identify a hospital.

Property group: Identifier characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Hospital—hospital identifier Health, Standard 07/12/2011

Hospital in the home care

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	373951
Registration status:	Health, Standard 24/03/2009
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.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Occupied bed—hospital in the home care Health, Standard 24/03/2009

Hospital insurance status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269219
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of private insurance cover for hospital expenses.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Patient—hospital insurance status Health, Standard 01/03/2005

Hospital name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	407426
Registration status:	Health, Standard 07/12/2011
Definition:	The appellation by which a hospital is known or called.
Property group:	Identifier characteristics

Relational attributes

Data Element Concepts implementing this Property:	Hospital—hospital name Health, Standard 07/12/2011

Hours on-call

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269154
Registration status:	Health, Standard 01/03/2005
Definition:	The amount of time devoted to being available to provide advice, respond to any emergencies etc. over a specified period.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Medical practitioner—hours on-call Health, Standard 01/03/2005

Hours worked in clinical role

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	375155
Registration status:	Health, Standard 10/12/2009
Definition:	The amount of time worked in the registered profession undertaking diagnosis, care and treatment of patients.
Context:	Health labour force
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Registered health professional—hours worked in clinical role Health, Standard 10/12/2009

Hours worked in health profession

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	375152
Registration status:	Health, Standard 10/12/2009
Definition:	The amount of time spent at work in the health profession.
Context:	Health labour force
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Registered health professional—hours worked in health profession Health, Standard 10/12/2009

Hours worked in non-clinical role

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	375281
Registration status:	Health, Standard 10/12/2009
Definition:	The amount of time spent at work in the health profession, undertaking a role other than the diagnosis, care and treatment of patients. This includes time spent as an administrator, teacher/educator, research or other non-clinician role in the profession.
Context:	Health labour force
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Registered health professional—hours worked in non-clinical role Health, Standard 10/12/2009

Hours worked in private sector

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	382891
Registration status:	Health, Standard 10/12/2009
Definition:	The amount of time spent working in non-government sector employment in the registered profession.
Context:	Health labour force
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Registered health professional—hours worked in private sector Health, Standard 10/12/2009

Hours worked in public sector

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	382898
Registration status:	Health, Standard 10/12/2009
Definition:	The amount of time spent working in the registered profession in government sector employment.
Context:	Health labour force
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Registered health professional—hours worked in public sector Health, Standard 10/12/2009

Human epidermal growth factor receptor-2 test result

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	370564
Registration status:	Health, Standard 06/03/2009
Definition:	The result of human epidermal growth factor receptor-2 (HER2) tests. HER2 is a protein involved in normal cell growth. It is found in high levels on some breast cancer cells.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—human epidermal growth factor receptor-2 test result Health, Standard 06/03/2009

Human epidermal growth factor receptor-2 test type

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 370578

Registration status: Health, Standard 06/03/2009

Definition: The test used to determine the results of human epidermal growth factor receptor-2 (HER2) at the time of diagnosis of the primary tumour.

Property group: Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property: Person with cancer—human epidermal growth factor receptor-2 test type Health, Standard 06/03/2009

Human intent of injury

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	313828
Registration status:	Health, Standard 03/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The human intent of an injury.
Property group:	Crisis event

Relational attributes

Data Element Concepts implementing this Property:	Injury event—human intent of injury Health, Standard 24/11/2005 Tasmanian Health, Proposed 28/09/2011

Hypertension treatment with antihypertensive medication indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	304493
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of receipt of therapy for hypertension using antihypertensive medication.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	National diabetes data working group

Relational attributes

Related metadata references:	Supersedes Hypertension treatment status Health, Superseded 22/09/2005
Data Element Concepts implementing this Property:	Person—hypertension treatment with antihypertensive medication indicator Health, Standard 21/09/2005

Hysterectomy indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 457768

Registration status: Health, Standard 07/12/2011

Definition: An indicator of whether a hysterectomy has been performed.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property: Female—hysterectomy indicator Health, Standard 07/12/2011

Identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	323304
Registration status:	Community Services, Standard 27/03/2007 Health, Standard 07/12/2011
Definition:	A sequence of characters which uniquely identifies an entity.
Property group:	Identifier characteristics

Relational attributes

Data Element Concepts implementing this Property:	Record—identifier Community Services, Standard 27/03/2007 Health, Standard 07/12/2011

Identifier type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269094
Registration status:	Health, Standard 01/03/2005
Definition:	The class of identifier based on the extent to which it applies across geographic or administrative boundaries.
Property group:	Identifier characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (identifier)—identifier type Health, Standard 01/03/2005

Immunotherapy completion date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 393580

Registration status: Health, Standard 07/12/2011

Definition: The date on which immunotherapy was completed.

The application of immunologic knowledge and techniques to prevent and treat disease.

Property group: Exit/leave from service event

Collection and usage attributes

Guide for use: Examples include the administration of increasing doses of allergens in the treatment of allergies, the use of immunostimulants and immunosuppressants, the transfer of immunocompetent cells and tissues from one person to another, and the use of interferon for its antiviral and antitumor properties.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Myers T (Editor) 2009. Mosby's Medical Dictionary , 8th Edition. Missouri: Mosby Elsevier page 945

Relational attributes

Data Element Concepts implementing this Property: Cancer treatment—immunotherapy completion date Health, Standard 07/12/2011

Immunotherapy start date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	393536
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which immunotherapy commenced. The application of immunologic knowledge and techniques to prevent and treat disease.
Property group:	Entry into service event

Collection and usage attributes

Guide for use:	Examples include the administration of increasing doses of allergens in the treatment of allergies, the use of immunostimulants and immunosuppressants, the transfer of immunocompetent cells and tissues from one person to another, and the use of interferon for its antiviral and antitumor properties.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Myers T (Editor) 2009. Mosby's Medical Dictionary , 8th Edition. Missouri: Mosby Elsevier page 945

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—immunotherapy start date Health, Standard 07/12/2011

Implantable cardiac defibrillator procedure date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359606
Registration status:	Health, Standard 01/10/2008
Definition:	The date when an implantable cardiac defibrillator is inserted to detect and treat (by way of an electrical shock) cardiac arrhythmias.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—implantable cardiac defibrillator procedure date Health, Standard 01/10/2008

Implantable cardiac defibrillator procedure time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359672
Registration status:	Health, Standard 01/10/2008
Definition:	The time when an implantable cardiac defibrillator is inserted to detect and treat (by way of an electrical shock) cardiac arrhythmias.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—implantable cardiac defibrillator procedure time Health, Standard 01/10/2008

Implementation of National standards for mental health services status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287789
Registration status:	Health, Standard 08/12/2004
Definition:	Indicator of National standards for mental health services implementation.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service unit—implementation of National standards for mental health services status Health, Standard 08/12/2004

Imprisonment in the last 12 months indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	408423
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of having been in prison in the last 12 months.
Property group:	Legal characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Prison entrant—imprisonment in the last 12 months indicator Health, Standard 25/08/2011

Independent living skills support services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287744
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of independent living skills support.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—independent living skills support services grants to non-government organisations Health, Standard 08/12/2004

Indicator procedure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269365
Registration status:	Health, Standard 01/03/2005
Definition:	The type of procedure that is high volume and often associated with long waiting periods.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—indicator procedure Health, Standard 01/03/2005

Indigenous status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269161
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005 Health, Standard 01/03/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010 Tasmanian Health, Proposed 30/09/2011
Definition:	An indicator of identification as an Aboriginal and/or Torres Strait Islander.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—Indigenous status Community Services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005 Health, Standard 01/03/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010 Tasmanian Health, Proposed 30/09/2011

Individual service provider consulted indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	402418
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether a person who provides a service and/or care has been consulted.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Prison entrant—individual service provider consulted indicator Health, Standard 25/08/2011

Influenza immunisation indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	457682
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of immunisation against influenza.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property:	Person—influenza immunisation indicator Health, Standard 07/12/2011

Informal carer existence indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	313244
Registration status:	Community Services, Standard 02/05/2006 Health, Standard 04/07/2007
Definition:	An indicator of whether or not an informal carer exists.
Property group:	Informal assistance characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Carer availability status Community Services, Superseded 02/05/2006, Health, Superseded 04/07/2007
Data Element Concepts implementing this Property:	Person—informal carer existence indicator Community Services, Standard 02/05/2006 Health, Standard 04/07/2007

Initial visit since diagnosis indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	303970
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of whether a visit to a health professional in relation to a specific condition is the first visit since diagnosis.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Initial visit since diagnosis Health, Superseded 22/09/2005
Data Element Concepts implementing this Property:	Patient—initial visit since diagnosis indicator (diabetes mellitus) Health, Standard 21/09/2005

Injecting drug use status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269129
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 01/03/2005
Definition:	An indicator of the administration of psychoactive substances by injection.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Client—injecting drug use status Community Services, Standard 06/02/2012 Health, Standard 01/03/2005

Insulin start date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269048
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which insulin injections commenced.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Patient—insulin start date Health, Standard 01/03/2005

Intended length of hospital stay

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269327
Registration status:	Health, Standard 01/03/2005
Definition:	The expected duration of a stay in hospital.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—intended length of hospital stay Health, Standard 01/03/2005

Intended years in profession

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	375481
Registration status:	Health, Standard 10/12/2009
Definition:	The length of time intending to remain practicing in the registered profession.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Registered health professional—intended years in profession Health, Standard 10/12/2009

Intention of treatment

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288666
Registration status:	Health, Standard 04/06/2004
Definition:	Reason for which treatment is provided for a particular condition.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—intention of treatment Health, Standard 04/06/2004 Patient—intention of treatment Health, Standard 07/12/2011

Inter-hospital contracted patient status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269338

Registration status: Health, Standard 01/03/2005

Definition: An indicator identifying a patient as being treated as part of a contracted hospital care agreement.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Episode of care—inter-hospital contracted patient status Health, Standard 01/03/2005

International postcode

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 288969

Registration status: Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Definition: A descriptor for a postal delivery area, aligned with locality, suburb or place.

Property group: Location characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person (address)—international postcode Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Service provider organisation (address)—international postcode Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Interpreter service required status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269289
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Retired 10/02/2006 Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	An indicator of a need for a translation service.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—interpreter service required Community Services, Standard 10/04/2006 Health, Standard 08/02/2006 Tasmanian Health, Proposed 28/09/2011 Person—interpreter service required status (health) Health, Superseded 08/02/2006

Intra-aortic balloon pump procedure date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359618
Registration status:	Health, Standard 01/10/2008
Definition:	The date when an intra-aortic balloon pump is inserted to improve the strength of the hearts contraction.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—intra-aortic balloon pump procedure date Health, Standard 01/10/2008

Intra-aortic balloon pump procedure time

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 359686

Registration status: Health, Standard 01/10/2008

Definition: The time when an intra-aortic balloon pump is inserted to improve the strength of the hearts contraction.

Property group: Service provision event

Relational attributes

Data Element Concepts implementing this Property: Person—intra-aortic balloon pump procedure time Health, Standard 01/10/2008

Intravenous fibrinolytic therapy date

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	IV fibrinolytic therapy
METeOR identifier:	284981
Registration status:	Health, Standard 04/06/2004
Definition:	The date of intravenous (IV) fibrinolytic therapy.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—intravenous fibrinolytic therapy date Health, Superseded 01/10/2008 Person—intravenous fibrinolytic therapy date Health, Standard 01/10/2008

Intravenous fibrinolytic therapy time

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 285193

Registration status: Health, Standard 04/06/2004

Definition: The time intravenous (IV) fibrinolytic therapy was first administered.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Data Element Concepts implementing this Property: Person—intravenous fibrinolytic therapy time Health, Standard 04/06/2004

Ischaemic and perfusion outcome result

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 349698

Registration status: Health, Standard 01/10/2008

Definition: Imbalances of relative blood flow to the left ventricular muscle tissue reflected through the ischaemic and perfusion outcomes of a functional stress test.

Property group: Health and wellbeing

Relational attributes

Related metadata references: Supersedes Functional stress test ischaemic result Health, Superseded 01/10/2008

Data Element Concepts implementing this Property: Functional stress test—ischaemic and perfusion outcome result Health, Standard 01/10/2008

Jobseeker status in registered profession

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	383436
Registration status:	Health, Standard 10/12/2009
Definition:	Whether a person is seeking employment in their registered profession.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Registered health professional—jobseeker status in registered profession Health, Standard 10/12/2009

Killip classification

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 285143

Registration status: Health, Standard 04/06/2004

Definition: Identifies the Killip class, as a measure of haemodynamic compromise.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—Killip classification Health, Standard 04/06/2004

Labour augmentation type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269084
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the method used to assist progress of labour.
Property group:	Birth event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth event—labour augmentation type Health, Standard 01/03/2005

Labour force status

Identifying and definitional attributes

Metadata item type: Property

Synonymous names: Employment status

METeOR identifier: 269067

Registration status: Community Services, Standard 01/03/2005
Housing assistance, Standard 22/10/2005
Health, Standard 01/03/2005
Homelessness, Standard 23/08/2010

Definition: An indicator of participation in paid employment or economic inactivity.

Property group: Labour characteristics

Relational attributes

Data Element Concepts implementing this Property: Health professional—labour force status Health, Standard 01/03/2005

Person—labour force status Community Services, Standard 01/03/2005
Housing assistance, Standard 01/08/2005
Health, Standard 01/03/2005
Homelessness, Standard 23/08/2010

Registered health professional—labour force status Health, Standard 10/12/2009

Labour force status 30 days prior to imprisonment

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	410612
Registration status:	Health, Standard 25/08/2011
Definition:	Participation in paid employment or economic inactivity 30 days prior to imprisonment.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Prison entrant—labour force status 30 days prior to imprisonment Health, Standard 25/08/2011

Labour induction type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269085
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of the method used to induce labour.
Property group:	Birth event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth event—labour induction type Health, Standard 01/03/2005

Labour onset type

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269058

Registration status: Health, Standard 01/03/2005

Definition: A descriptor of the manner in which labour commences.

Property group: Birth event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Birth event—labour onset type Health, Standard 01/03/2005

Last contact date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269344
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which last contact between a service provider and a patient/client occurred.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Community nursing service episode—last contact date Health, Standard 01/03/2005

Laterality of primary cancer

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269179

Registration status: Health, Standard 01/03/2005

Definition: An indicator of which side of a paired organ is the origin of the primary cancer.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person with cancer—laterality of primary cancer Health, Standard 01/03/2005

Legal status of prisoner

Identifying and definitional attributes

Metadata item type: Property

Synonymous names: Prisoner custody status; detention status of prisoner

METeOR identifier: 412275

Registration status: Health, Standard 25/08/2011

Definition: The legal basis for detaining a prisoner, determined by warrant or court order/s.

Property group: Legal characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: ABS (Australian Bureau of Statistics) 2010. Prisoners in Australia. Cat. no. 4517.0. Canberra: ABS

Relational attributes

Data Element Concepts implementing this Property: Person—legal status of prisoner Health, Standard 25/08/2011

Prison entrant—legal status of prisoner Health, Standard 25/08/2011

Length of employment in profession

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	375472
Registration status:	Health, Standard 10/12/2009
Definition:	The length of time spent working in the registered profession.
Context:	Registered health labour force
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Registered health professional—length of employment in profession in Australia Health, Standard 10/12/2009

Length of stay

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269031

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: The duration of an episode of care or service event that includes the provision of accommodation and/or residential care.

Property group: Performance indicators

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:

Episode of admitted patient care—length of stay (excluding leave days) Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of admitted patient care—length of stay (including leave days) Health, Standard 01/03/2005

Episode of admitted patient care—length of stay (special/neonatal intensive care) Health, Standard 01/03/2005

Letters of family name

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 349486

Registration status: Community Services, Standard 27/03/2007
Housing assistance, Standard 23/08/2010
Health, Standard 07/12/2011
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Definition: A specific combination of letters selected from a family name (surname).

Property group: Identifier characteristics

Relational attributes

Data Element Concepts implementing this Property: Person—letters of family name Community Services, Standard 27/03/2007
Housing assistance, Standard 23/08/2010
Health, Standard 07/12/2011
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Letters of given name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	314125
Registration status:	Community Services, Standard 27/03/2007 Housing assistance, Standard 23/08/2010 Health, Standard 07/12/2011 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010
Definition:	A specific combination of letters selected from a person's first name.
Property group:	Identifier characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—letters of given name Community Services, Standard 27/03/2007 Housing assistance, Standard 23/08/2010 Health, Standard 07/01/2011 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010

Level number

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	429053
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	The number used to distinguish the floor or level of a multi-storey building/sub-complex.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references:	Supersedes Floor/level identifier Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011
Data Element Concepts implementing this Property:	Address—level number Community Services, Standard 06/02/2012 Health, Standard 07/12/2011

Level of difficulty with activities in a life area

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 320312

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Definition: An expression of the ease of which tasks and actions in a life area are performed.

Property group: Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property: Person—level of difficulty with activities in a life area
Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Level of highest non-school qualification

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Level of education
METeOR identifier:	398736
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	The highest level of post-secondary school education attained.
Property group:	Educational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—level of highest non-school qualification Community Services, Standard 06/02/2012 Health, Standard 25/08/2011

Level of satisfaction with participation in a life area

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 324441

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Definition: The level of satisfaction with participation in a life area, in relation to current life goals.

Property group: Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property: Person—level of satisfaction with participation in a life area
Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Level of service delivery

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 334501

Registration status: Health, Standard 05/12/2007

Definition: Level of specialisation of a health service delivered within a defined speciality.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Data Element Concepts implementing this Property: Service provider organisation—level of service delivery Health, Standard 05/12/2007

Lifestyle counselling type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	344705
Registration status:	Health, Standard 01/10/2008
Definition:	The type of counselling or advice provided to modify lifestyle behaviour.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person with acute coronary syndrome—lifestyle counselling type Health, Standard 01/10/2008

Linkage key

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	349889
Registration status:	Community Services, Standard 21/05/2010 Housing assistance, Standard 23/08/2010 Health, Standard 07/12/2011 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010
Definition:	A key that enables the bringing together of two or more things.
Property group:	Identifier characteristics

Relational attributes

Data Element Concepts implementing this Property:	Record—linkage key Community Services, Standard 21/05/2010 Housing assistance, Standard 23/08/2010 Health, Standard 07/12/2011 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010

Lipid-lowering therapy status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285153
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the use of lipid-lowering therapy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—lipid-lowering therapy status Health, Standard 04/06/2004

Listing date for care

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269112
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a patient/client is accepted onto a list for care/treatment.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective care waiting list episode—listing date for care Health, Standard 01/03/2005

Living arrangement

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269314
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 23/08/2010 Health, Standard 19/04/2005 Homelessness, Standard 23/08/2010
Definition:	An arrangement of living alone or with others.
Property group:	Accommodation/living characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—living arrangement Community Services, Standard 01/03/2005 Housing assistance, Standard 23/08/2010 Health, Standard 19/04/2005 Homelessness, Standard 23/08/2010

Location of impairment of body structure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320262
Registration status:	Community Services, Standard 16/10/2006 Health, Standard 29/11/2006
Definition:	The site where a specified body structure differs from the accepted population standard.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—location of impairment of body structure Community Services, Standard 16/10/2006 Health, Standard 29/11/2006

Lot/section identifier

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269059

Registration status: Community Services, Superseded 06/02/2012
Health, Standard 01/03/2005

Definition: The lot/section reference allocated to an address in the absence of street numbering.

Context: Australian addresses.

Property group: Location characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person (address)—lot/section identifier Community Services, Superseded 06/02/2012
Health, Standard 01/03/2005

Service provider organisation (address)—lot/section identifier Community Services, Superseded 06/02/2012
Health, Standard 04/05/2005

Low-density lipoprotein cholesterol level

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 310787

Registration status: Health, Standard 27/10/2005

Definition: The level of the serum cholesterol carried on low-density lipoproteins, approximately 60 to 70 percent of the total serum cholesterol.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Data Element Concepts implementing this Property: Person—low-density lipoprotein cholesterol level Health, Standard 01/03/2005

Lower limb amputation due to vascular disease

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269165
Registration status:	Health, Standard 01/03/2005
Definition:	The removal of a toe, forefoot or leg (above or below knee), due to vascular disease.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—lower limb amputation due to vascular disease Health, Standard 01/03/2005

Lymphovascular invasion

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	370612
Registration status:	Health, Standard 06/03/2009
Definition:	Presence or absence of the invasion of the cancer cells into the blood vessels or lymphatic channels.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—lymphovascular invasion Health, Standard 06/03/2009

Main activity type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	356578
Registration status:	Community Services, Recorded 04/03/2010 Health, Standard 05/12/2007
Definition:	A descriptor of the main activity type of an organisation.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Relational attributes

Data Element Concepts implementing this Property:	Health industry relevant organisation—main activity type Health, Standard 05/12/2007

Main language other than English spoken at home

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269176
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005 Health, Standard 01/03/2005 Homelessness, Standard 13/10/2011
Definition:	The primary language spoken at home, excluding English.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—main language other than English spoken at home Community Services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006 Health, Standard 01/03/2005

Major diagnostic category

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269328
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The classification of diagnoses (and Australian refined diagnosis related groups) by body system or aetiology.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—major diagnostic category Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011

Marital status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269101

Registration status: Community Services, Standard 01/03/2005
Housing assistance, Standard 22/10/2005
Health, Standard 01/03/2005

Definition: An indicator of involvement in a couple relationship or marriage.

Property group: Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—marital status Community Services, Standard 01/03/2005
Housing assistance, Standard 10/02/2006
Health, Standard 01/03/2005

Maternal medical condition

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269069
Registration status:	Health, Standard 01/03/2005
Definition:	Pre-existing and concurrent conditions that affect a pregnancy or its outcome.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Female (pregnant)—maternal medical condition Health, Standard 01/03/2005

Maximum stenosis coronary artery

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	344331
Registration status:	Health, Standard 01/10/2008
Definition:	The greatest point of an abnormal narrowing in the coronary artery.
Property group:	Physical characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—maximum stenosis coronary artery Health, Standard 01/10/2008

MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	441367
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a Medicare Benefits Schedule (MBS) Health Assessment for Aboriginal and Torres Strait Islander People (Item 715) has been received.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property:	Person—MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) indicator Health, Standard 07/12/2011

Medical indemnity claim commencement date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 329612

Registration status: Health, Standard 07/12/2011

Definition: The date on which a medical indemnity claim commenced, as signalled by a trigger such as the issue of a letter of demand, issue of writ, or an offer made by the defendant to the claimant.

Property group: Legal characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Medical indemnity claim—medical indemnity claim commencement date Health, Standard 07/12/2011

Medical indemnity claim finalisation date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 329628

Registration status: Health, Standard 07/12/2011

Definition: The date on which a medical indemnity claim was settled, a final court decision was delivered, or the claim file was closed (whichever occurred first).

Property group: Legal characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Medical indemnity claim management episode—medical indemnity claim finalisation date Health, Standard 07/12/2011

Medical indemnity claim finalisation mode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	330104
Registration status:	Health, Standard 07/12/2011
Definition:	The process by which a medical indemnity claim was finalised including state/territory-based complaints processes, court-based alternative dispute resolution processes, court decision, statutorily mandated conference process or discontinuation.
Property group:	Legal characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Medical indemnity claim—medical indemnity claim finalisation mode Health, Standard 07/12/2011

Medical indemnity claim identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	329767
Registration status:	Health, Standard 07/12/2011
Definition:	An identifier for each medical indemnity claim, unique within a health authority.
Property group:	Legal characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Medical indemnity claim —medical indemnity claim identifier Health, Standard 07/12/2011

Medical indemnity claim size

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 330114

Registration status: Health, Standard 07/12/2011

Definition: The amount agreed to be paid to the patient or some other party claiming for loss allegedly resulting from harm involving health care, in total settlement of a medical indemnity claim, plus defence investigative and legal costs.

Property group: Legal characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Medical indemnity claim—medical indemnity claim size
Health, Standard 07/12/2011

Medical indemnity claim status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 329640

Registration status: Health, Standard 07/12/2011

Definition: The status of a medical indemnity claim in terms of the stage it has reached in the claims management process from a reserve being set to file closure.

Property group: Legal characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Medical indemnity claim—medical indemnity claim status
Health, Standard 07/12/2011

Medical indemnity payment recipient type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	421923
Registration status:	Health, Standard 07/12/2011
Definition:	The recipient of a damages payment arising from a medical indemnity claim.
Property group:	Legal characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Medical indemnity claim management episode—medical indemnity payment recipient type Health, Standard 07/12/2011

Medication for mental health disorder indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	376077
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	An indicator of the current use of a legally prescribed medication for a **mental health disorder**, including drug and alcohol abuse.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—medication for mental health disorder indicator Community Services, Standard 06/02/2012 Health, Standard 25/08/2011

Medication type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	365465
Registration status:	Health, Standard 25/08/2011
Definition:	The type of prescribed pharmaceutical drug administered.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—medication type Health, Standard 25/08/2011

Melanoma thickness

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269185

Registration status: Health, Standard 01/03/2005

Definition: The measured depth of penetration of tumour cells below the basal layer of the skin.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person with cancer—melanoma thickness Health, Standard 01/03/2005

Mental health disorder indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	358778
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	An indicator of whether a doctor, psychiatrist, psychologist or mental health nurse has reported the existence of a **mental health disorder** (including drug and alcohol abuse).
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—mental health disorder indicator Community Services, Standard 06/02/2012 Health, Standard 25/08/2011

Mental health legal status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269297

Registration status: Health, Standard 01/03/2005

Definition: An indicator of whether care was provided under relevant state or territory mental health legislation compulsory treatment provisions.

Property group: Legal characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Episode of care—mental health legal status Health, Standard 01/03/2005

Mental health service duration

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 285847

Registration status: Health, Standard 08/12/2004

Definition: The duration of a mental health service contact.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Mental health service contact—mental health service contact duration Health, Standard 08/12/2004

Mental health service referral indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 365456

Registration status: Health, Standard 25/08/2011

Definition: An indicator of whether a person has been directed to a mental health service for observation and further assessment.

Property group: Referral event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Prison entrant—mental health service referral indicator Health, Standard 25/08/2011

Mental health services grants to non-government organisations from non-health departments

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	298935
Registration status:	Health, Standard 07/12/2005
Definition:	Grants made to non-government organisations for the provision of mental health services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	State or Territory Government—mental health services grants to non-government organisations by non-health departments Health, Standard 07/12/2005

Method of drug use

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269130
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 01/03/2005
Definition:	The manner in which a psychoactive substance is administered.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Client—method of drug use (principal drug of concern) Community Services, Standard 06/02/2012 Health, Standard 01/03/2005

Microalbumin level

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269284
Registration status:	Health, Standard 01/03/2005
Definition:	The amount of microalbumin detected in the urine.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—microalbumin level Health, Standard 01/03/2005

Microalbumin urine test result recorded indicator

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Urinary micro albumin test result recorded indicator
METeOR identifier:	464965
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a microalbumin urine test result has been recorded.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property:	Person—microalbumin urine test result recorded indicator Health, Standard 07/12/2011

Morphology of cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269181
Registration status:	Health, Standard 01/03/2005
Definition:	The histology and likely course of development of a tumour.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—morphology of cancer Health, Standard 01/03/2005

Most common service delivery setting

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	297675
Registration status:	Health, Standard 05/12/2007
Definition:	The setting in which most service delivery occurs.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—most common service delivery setting Health, Standard 05/12/2007

Most recent stroke date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	338258
Registration status:	Health, Standard 01/10/2008
Definition:	Date when most recent cerebrovascular accident / stroke occurred.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—most recent stroke date Health, Standard 01/10/2008

Most valid basis of diagnosis of a cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269183
Registration status:	Health, Standard 01/03/2005
Definition:	The most reliable basis of a cancer diagnosis.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—most valid basis of diagnosis of a cancer Health, Standard 01/03/2005

Mother’s original family name

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Mother’s maiden name
METeOR identifier:	269229
Registration status:	Community Services, Standard 01/03/2005 Health, Standard 01/03/2005
Definition:	The family name of an individual’s mother before the mother’s first marriage.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—mother’s original family name Community Services, Standard 01/03/2005 Health, Standard 01/03/2005

Multi-disciplinary team status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269126

Registration status: Health, Standard 01/03/2005

Definition: An indicator of the involvement of providers from more than one profession or occupation.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Non-admitted patient service event—multi-disciplinary team status Health, Standard 01/03/2005

Myocardial infarction

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269235
Registration status:	Health, Standard 01/03/2005
Definition:	Gross necrosis of the myocardium as a result of interruption of the blood supply to the area; it is almost always caused by atherosclerosis of the coronary arteries, upon which coronary thrombosis is usually superimposed.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Data Element Concepts implementing this Property:	Person—myocardial infarction Health, Standard 01/03/2005

Name conditional use flag

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287051
Registration status:	Community Services, Standard 25/08/2005 Health, Standard 04/05/2005
Definition:	An indicator of specific conditions which should be applied to a recorded name.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Name context flag Community Services, Superseded 25/08/2005, Health, Superseded 04/05/2005
Data Element Concepts implementing this Property:	Person (name)—name conditional use flag Community Services, Standard 25/08/2005 Health, Standard 04/05/2005

Name suffix

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269224
Registration status:	Community Services, Standard 01/03/2005 Health, Standard 01/03/2005
Definition:	An additional term following a name.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—name suffix Community Services, Standard 01/03/2005 Health, Standard 01/03/2005

Name suffix sequence number

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288187
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	An order of additional terms at the conclusion of a name.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—name suffix sequence number Community Services, Standard 30/09/2005 Health, Standard 04/05/2005

Name title

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269225
Registration status:	Community Services, Standard 01/03/2005 Health, Standard 01/03/2005
Definition:	An honorific form of address commencing a name.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—name title Community Services, Standard 01/03/2005 Health, Standard 01/03/2005

Name title sequence number

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288244
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	The numeric order of an honorific form of address commencing a name.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—name title sequence number Community Services, Standard 30/09/2005 Health, Standard 04/05/2005

Name type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269227
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 01/03/2005
Definition:	A descriptor of the class of name.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (name)—name type Community Services, Superseded 06/02/2012 Health, Standard 01/03/2005 Service provider organisation (name)—name type Community Services, Superseded 06/02/2012 Health, Standard 04/05/2005

Nature of impairment of body structure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	320276
Registration status:	Community Services, Standard 16/10/2006 Health, Standard 29/11/2006
Definition:	The qualitative or quantitative change to the characteristics of a specified body structure compared with accepted population standards.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—nature of impairment of body structure Community Services, Standard 16/10/2006 Health, Standard 29/11/2006

Nature of main injury

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269100

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: The nature of the injury chiefly responsible for the attendance at a health care facility.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Injury event—nature of main injury Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Need for assistance with activities in a life area

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	324428
Registration status:	Community Services, Standard 16/10/2006 Health, Standard 29/11/2006
Definition:	The need for personal assistance and/or supervision to perform tasks and actions in a life area.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—need for assistance with activities in a life area Community Services, Standard 16/10/2006 Health, Standard 29/11/2006

Neoadjuvant therapy indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	370010
Registration status:	Health, Standard 06/03/2009
Definition:	An indicator of the receipt of neoadjuvant therapy such as radiotherapy or systemic therapy (chemotherapy, hormone therapy, immunotherapy).
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—neoadjuvant therapy indicator Health, Standard 06/03/2009

Neonatal admitted care (Non-special-care)

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	373636
Registration status:	Health, Standard 03/12/2008
Definition:	Care provided to non-special-care neonatal patients. This is neonatal care not provided in an intensive care facility nor in accommodation approved by the Commonwealth Health Minister for the purpose of the provision of special care.
Property group:	Material resource characteristics

Relational attributes

Data Element Concepts implementing this Property:	Available bed—neonatal admitted care (Non-special-care) Health, Standard 03/12/2008

Neonatal morbidity

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269087
Registration status:	Health, Standard 01/03/2005
Definition:	A diseased condition or state during first 28 days of life.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Admitted patient (neonate)—neonatal morbidity Health, Standard 01/03/2005

Net capital expenditure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269033
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure less trade-in values of replaced items and receipts from the sale of replaced or otherwise disposed items.
Property group:	Financial characteristics

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Data Element Concepts implementing this Property:	Establishment—net capital expenditure (accrual accounting) (buildings and building services) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (constructions) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (equipment) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (information technology) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (intangible assets) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (land) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (other equipment) Health, Standard 01/03/2005 Establishment—net capital expenditure (accrual accounting) (transport) Health, Standard 01/03/2005

New/repeat service event status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269292

Registration status: Health, Standard 01/03/2005

Definition: An indicator of whether a service event involves a problem not previously addressed at the same clinical service.

Property group: Service provision event

Collection and usage attributes

Guide for use: Examples of clinical services are included in the Guide for use for Non-admitted patient service event—service event type (clinical), code N[N].

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Non-admitted patient service event—new/repeat service event status Health, Standard 01/03/2005

Non-Australian state/province

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 288616

Registration status: Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Definition: The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country.

Property group: Location characteristics

Source and reference attributes

Submitting organisation: Standards Australia

Relational attributes

Data Element Concepts implementing this Property: Person (address)—non-Australian state/province Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Service provider organisation (address)—non-Australian state/province Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Non-government non-profit indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 390911

Registration status: Health, Standard 01/12/2010

Definition: An indicator of whether an entity is non-government non-profit.

Property group: Financial characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Specialised mental health service—non-government non-profit indicator Health, Standard 01/12/2010

Non-invasive ventilation administration date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359630
Registration status:	Health, Standard 01/10/2008
Definition:	The date when non-invasive ventilation is administered through a Continuous Positive Airway Pressure (CPAP) machine.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—non-invasive ventilation administration date Health, Standard 01/10/2008

Non-invasive ventilation administration time

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 359642

Registration status: Health, Standard 01/10/2008

Definition: The time of administration of non-invasive ventilation through a Continuous Positive Airway Pressure (CPAP) machine.

Property group: Service provision event

Relational attributes

Data Element Concepts implementing this Property: Person—non-invasive ventilation administration time Health, Standard 01/10/2008

Non-school qualification indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	398672
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	An indicator of whether a post-secondary education qualification has been attained.
Property group:	Educational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—non-school qualification indicator Community Services, Standard 06/02/2012 Health, Standard 25/08/2011

Non-surgical cancer treatment completion date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288113
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which non-surgical treatment for cancer was completed.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—non-surgical cancer treatment completion date Health, Standard 04/06/2004

Non-surgical cancer treatment start date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 288069

Registration status: Health, Standard 04/06/2004

Definition: The date on which non-surgical treatment for cancer was started.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Cancer treatment—non-surgical cancer treatment start date
Health, Standard 04/06/2004

Number of antenatal care visits

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 426460

Registration status: Health, Standard 12/10/2011

Definition: A count of **antenatal care visits** attended.

The number of antenatal care visits is an indicator of access and use of health care during pregnancy. The antenatal period presents opportunities for reaching pregnant women with interventions that may be vital to their health and wellbeing and that of their infants. Receiving antenatal care at least four times, as recommended by World Health Organization (WHO), increases the likelihood of receiving effective maternal health interventions during antenatal visits (WHO 2011).

Antenatal care visits for women with an uncomplicated pregnancy should include advice, education, reassurance, support and treatment for minor problems of pregnancy, as well as effective screening throughout the pregnancy, to identify problems as they arise, with referral as appropriate (Breeze & Kean 2009).

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: National Perinatal Epidemiology and Statistics Unit

Reference documents: Breeze A & Kean L 2009. Routine antenatal management at the booking clinic. Obstetrics and Gynaecology and Reproductive Medicine 20 (1): 1-6.

World Health Organization (WHO) 2011. Indicator code book: World health statistics - World health statistics indicators. WHO, Geneva. Viewed 15 September 2011, <http://www.who.int/whosis/indicators/WHS2011_IndicatorCompendium_20110530.pdf>

Relational attributes

Data Element Concepts implementing this Property: Female—number of antenatal care visits Health, Standard 12/10/2011

Number of cigarettes smoked

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269281
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the number of cigarettes smoked during a specified period.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—number of cigarettes smoked Health, Standard 01/03/2005

Number of cigarettes smoked after 20 weeks of pregnancy

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 375082

Registration status: Health, Standard 03/12/2008

Definition: The number of cigarettes smoked after the first twenty weeks of pregnancy.

Property group: Lifestyle characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Female (pregnant)—number of cigarettes smoked (after 20 weeks of pregnancy) Health, Standard 03/12/2008

Number of cigarettes smoked first 20 weeks of pregnancy

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	375323
Registration status:	Health, Standard 03/12/2008
Definition:	The number of cigarettes smoked during the first twenty weeks of pregnancy.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Female (pregnant)—number of cigarettes smoked (first 20 weeks of pregnancy) Health, Standard 03/12/2008

Number of clients receiving services

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 425392

Registration status: Health, Standard 07/12/2011

Definition: The number of people or clients receiving services from a service provider.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Specialised mental health service—number of clients receiving services Health, Standard 07/12/2011

Number of day centre attendances

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269214
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the number of patient/client visits to a day centre.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—number of day centre attendances Health, Standard 01/03/2005

Number of days of hospital-in-the-home care

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269242
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	A count of the days of **hospital-in-the-home care** received.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—number of days of hospital-in-the-home care Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011

Number of episodes of residential care

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287923
Registration status:	Health, Standard 08/12/2004
Definition:	The total number of episodes of completed residential care. This includes both formal and statistical episodes of residential care.
Context:	Specialised residential mental health services.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of residential care—number of episodes of residential care Health, Superseded 07/12/2011 Episode of residential care—number of episodes of residential care Health, Standard 07/12/2011

Number of group session occasions of service for non-admitted patients.

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269119

Registration status: Health, Standard 01/03/2005

Definition: A count of the non-admitted occasions of service provided as a group session.

Property group: Performance indicators

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Establishment—number of group session occasions of service for non-admitted patients Health, Standard 01/03/2005

Number of group sessions

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269304
Registration status:	Health, Standard 01/03/2005
Definition:	A count of groups of patients/clients receiving services.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—number of group sessions Health, Superseded 04/07/2007 Establishment—number of group sessions Health, Standard 04/07/2007

Number of hospital transfers

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 412978

Registration status: Health, Standard 25/08/2011

Definition: A count of transfers from an establishment to a hospital that is located in the community.

Property group: Transport characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Establishment (prison)—number of hospital transfers Health, Standard 25/08/2011

Number of hours staffed

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288870
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of hours per day that appropriately trained staff are employed on-site.
Property group:	Performance indicators

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service—number of hours staffed Health, Standard 08/12/2004

Number of individual session occasions of service for non-admitted patients

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	313837
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the non-admitted occasions of service provided as an individual session.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—number of individual session occasions of service for non-admitted patients Health, Standard 01/03/2005

Number of leave days

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269218
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	A count of the number of days spent on leave from a health care service.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—number of leave days Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011 Episode of residential care—number of leave days Health, Superseded 07/12/2011 Episode of residential care—number of leave days Health, Standard 07/12/2011

Number of leave periods

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269097
Registration status:	Health, Standard 01/03/2005
Definition:	A count of discrete periods of formal absence during an episode of care.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—number of leave periods Health, Standard 01/03/2005

Number of non-admitted patient service events

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269288
Registration status:	Health, Standard 01/03/2005
Definition:	A count of service events provided to non-admitted patients.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—number of non-admitted patient service events Health, Standard 01/03/2005

Number of occasions of service

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	316229
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the occasions of service provided.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Establishment (residential aged care service)—number of occasions of service Health, Standard 01/03/2005 Establishment—number of occasions of service Health, Standard 04/05/2005

Number of patient days

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269090
Registration status:	Health, Standard 01/03/2005
Definition:	A count of days of patient care.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Admitted patient hospital stay—number of patient days (of contracted care) Health, Standard 01/03/2005 Establishment—number of patient days Health, Standard 01/03/2005

Number of positive regional lymph nodes

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 289189

Registration status: Health, Standard 04/06/2004

Definition: The total number of regional lymph nodes examined by a pathologist and reported as containing tumour. A regional lymph node is a lymph node that drains lymph from the region around a tumor.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person with cancer—number of positive regional lymph nodes Health, Standard 04/06/2004

Number of positive sentinel lymph nodes

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	370545
Registration status:	Health, Standard 06/03/2009
Definition:	The total number of sentinel lymph nodes examined by a pathologist and reported as containing tumour. Sentinel lymph nodes are the first nodes that filter fluid draining away from the area of cancer. The number of lymph nodes with metastasis is important for cancer staging
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—number of positive sentinel lymph nodes Health, Standard 06/03/2009

Number of pregnant prisoners

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	365486
Registration status:	Health, Standard 25/08/2011
Definition:	A count of women prisoners carrying a developing fetus, normally in the uterus, anytime over a specified 12 month period.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment (prison)—number of pregnant prisoners Health, Standard 25/08/2011

Number of previous caesarean sections

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	298035
Registration status:	Health, Standard 29/11/2006
Definition:	A count of the number of previous caesarean sections.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Data Element Concepts implementing this Property:	Female—number of caesarean sections Health, Standard 29/11/2006

Number of previous pregnancies

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269051
Registration status:	Health, Standard 01/03/2005
Definition:	A count of previous pregnancies.
Context:	Perinatal statistics: The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.
Property group:	Health and wellbeing

Collection and usage attributes

Guide for use:

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

A pregnancy resulting in multiple births should be counted as one pregnancy.

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Female—number of previous pregnancies Health, Standard 01/03/2005

Number of prison entrants

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	412248
Registration status:	Health, Standard 25/08/2011
Definition:	A count of persons entering prison.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment (prison)—number of prison entrants Health, Standard 25/08/2011

Number of prisoners released

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	410572
Registration status:	Health, Standard 25/08/2011
Definition:	A count of the persons, held in prison, who have been released.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment (prison)—number of prisoners released Health, Standard 25/08/2011

Number of psychiatric care days

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269361
Registration status:	Health, Standard 01/03/2005
Definition:	A count of days of in which specialised psychiatric care was received.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—number of psychiatric care days Health, Standard 01/03/2005

Number of psychiatric outpatient clinic/day program attendances

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269353

Registration status: Health, Standard 01/03/2005

Definition: A count of the days on which a psychiatric outpatient clinic or a day program was attended.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Patient—number of psychiatric outpatient clinic/day program attendances Health, Standard 01/03/2005

Number of qualified days

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269081
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the days within an episode of admitted patient care that are designated as having a **newborn qualification status**.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care (newborn)—number of qualified days Health, Standard 01/03/2005

Number of regional lymph nodes examined

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	415982
Registration status:	Health, Standard 07/12/2011
Definition:	A count of the number of regional lymph nodes, which drain lymph from the region around the tumour, examined by a pathologist.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Number of regional lymph nodes examined Health, Superseded 07/12/2011 See also Person with cancer—number of positive regional lymph nodes, total N[N] Health, Standard 07/12/2011
Data Element Concepts implementing this Property:	Person with cancer—number of regional lymph nodes examined Health, Standard 07/12/2011

Number of sentinel lymph nodes examined

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 370554

Registration status: Health, Standard 06/03/2009

Definition: The total number of sentinel lymph nodes examined by the pathologist. A sentinel lymph node is the first lymph node to which cancer is likely to spread from the primary tumour.

Property group: Health and wellbeing

Source and reference attributes

Reference documents: National Cancer Institute, U.S National Institutes of Health
http://www.cancer.gov/Templates/db_alpha.aspx?CdrID=45876

Relational attributes

Data Element Concepts implementing this Property: Person with cancer—number of sentinel lymph nodes examined Health, Standard 06/03/2009

Number of separations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269336
Registration status:	Health, Standard 01/03/2005
Definition:	A count of separations.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—number of separations Health, Standard 01/03/2005

Number of service contact dates

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269340
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the dates on which there is a service contact.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—number of service contact dates Health, Standard 01/03/2005

Number of service contacts

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269134
Registration status:	Health, Standard 01/03/2005
Definition:	A count of service contacts between a service recipient and a service provider.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of treatment for alcohol and other drugs—number of service contacts Health, Standard 01/03/2005

Number of service contacts

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	427093
Registration status:	Health, Standard 07/12/2011
Definition:	The number of service contacts provided to individual patients or clients by a service provider.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service—number of service contacts Health, Standard 07/12/2011

Number of times in prison or juvenile detention

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Number of times imprisoned
METeOR identifier:	399004
Registration status:	Health, Standard 25/08/2011
Definition:	A count of the number of times a person has been detained in a prison and/or in a **juvenile detention centre**.
Property group:	Legal characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Prison entrant—number of times in prison or juvenile detention Health, Standard 25/08/2011

Number of vaccine doses administered

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 411911

Registration status: Health, Standard 25/08/2011

Definition: A count of doses of vaccines administered.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Establishment (prison)—number of vaccine doses administered Health, Standard 25/08/2011

Nursing diagnosis

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269198
Registration status:	Health, Standard 01/03/2005
Definition:	The nursing diagnosis most related to the reason for **admission**.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—nursing diagnosis Health, Standard 01/03/2005

Nursing intervention

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269201
Registration status:	Health, Standard 01/03/2005
Definition:	An action undertaken by a nurse in order to relieve or alter a person's responses to actual or potential health problems.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Community nursing service episode—nursing intervention Health, Standard 01/03/2005

Occupation

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269099
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005 Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	A descriptor of the class of job based on similarities in the tasks undertaken.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health professional—occupation Health, Standard 01/03/2005 Individual service provider—occupation (self-identified) Community Services, Standard 30/09/2005 Health, Standard 04/05/2005 Person—occupation (main) Community Services, Superseded 27/03/2007 Housing assistance, Superseded 10/08/2007 Health, Superseded 04/07/2007 Person—occupation (main) Community Services, Standard 27/03/2007 Housing assistance, Standard 10/08/2007 Health, Standard 04/07/2007 Tasmanian Health, Proposed 28/09/2011

Occupation end date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 289049

Registration status: Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Definition: When the class of job based on similarities in the tasks undertaken concludes.

Property group: Labour characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Individual service provider—occupation end date Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Occupation start date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	289055
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	When the class of job based on similarities in the tasks undertaken commences.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Individual service provider—occupation start date Community Services, Standard 30/09/2005 Health, Standard 04/05/2005

Oestrogen receptor assay result

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 291318

Registration status: Health, Standard 04/06/2004

Definition: The results of an oestrogen receptor test. The test is used to find out if cancer cells have oestrogen receptors (proteins to which oestrogen will bind). If the cells have oestrogen receptors, they may need oestrogen to grow, and this may affect how the cancer is treated.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person with cancer—oestrogen receptor assay result Health, Standard 04/06/2004

Operating theatre time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269294
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The length of time spent in an operating theatre.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Admitted patient hospital stay—operating theatre time Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011

Ophthalmological assessment outcome

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269301
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's ophthalmological assessment.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—ophthalmological assessment outcome Health, Standard 01/03/2005

Ophthalmoscopy performed indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	303979
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of whether an ophthalmoscopy has been undertaken.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Ophthalmoscopy performed Health, Superseded 22/09/2005
Data Element Concepts implementing this Property:	Person—ophthalmoscopy performed indicator Health, Standard 21/09/2005

Organisation end date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288650
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	The date on which operations or practice were concluded.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—organisation end date Community Services, Standard 30/09/2005 Health, Standard 04/05/2005

Organisation identifier

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269367

Registration status: Community Services, Standard 01/03/2005
Housing assistance, Standard 01/03/2005
Health, Standard 01/03/2005
Early Childhood, Standard 21/05/2010
Homelessness, Standard 23/08/2010

Definition: A sequence of characters which identify an organisation.

Property group: Identifier characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:

Contracted hospital care—organisation identifier Health, Standard 01/03/2005

Division of general practice—organisation identifier Health, Standard 01/03/2005

Establishment (prison)—organisation identifier Health, Standard 25/08/2011

Establishment—organisation identifier Health, Standard 01/03/2005

Establishment—organisation identifier (state/territory) Health, Standard 01/03/2005

Healthcare provider—organisation identifier Health, Standard 07/12/2011

Specialised mental health service organisation—organisation identifier Health, Standard 07/12/2011

Organisation name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288901
Registration status:	Community Services, Standard 30/09/2005 Housing assistance, Recorded 13/10/2011 Health, Standard 04/05/2005 Early Childhood, Standard 07/06/2011
Definition:	The appellation by which an establishment, agency or organisation is known or called.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Standards Australia

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation (name)—organisation name Community Services, Superseded 06/02/2012 Housing assistance, Recorded 13/10/2011 Health, Standard 04/05/2005 Early Childhood, Superseded 09/03/2012 Specialised mental health service organisation—organisation name Health, Standard 07/12/2011

Organisation start date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288941
Registration status:	Community Services, Standard 30/09/2005 Health, Standard 04/05/2005
Definition:	The date on which operations or a service commenced.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—organisation start date Community Services, Standard 30/09/2005 Health, Standard 04/05/2005

Other and unspecified mental health services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	306256
Registration status:	Health, Standard 07/12/2005
Definition:	Grants made to non-government organisations for provision of mental health services not elsewhere classified and grants not allocatable to specific service types.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Other and unspecified services grants to non-government organisations Health, Superseded 07/12/2005
Data Element Concepts implementing this Property:	Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations Health, Standard 07/12/2005

Other cancer treatment

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 403842

Registration status: Health, Standard 07/12/2011

Definition: Treatments used for the treatment of cancer other than surgery, radiation or systemic therapy.

Property group: Service provision event

Collection and usage attributes

Guide for use: Examples include:

- Treatment unique to hematopoietic diseases, for example, phlebotomy, transfusions or aspirin.
- Any experimental or newly developed treatment that cannot be appropriately assigned to other specific treatment data items.
- Cancer treatments administered by non-medical personnel. For instance, unconventional methods whether administered as single therapy or in combination with conventional therapies.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision, Commission on Cancer

Relational attributes

Data Element Concepts implementing this Property: Cancer treatment—other cancer treatment Health, Standard 07/12/2011

Outcome of treatment

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	289298
Registration status:	Health, Standard 04/06/2004
Definition:	The outcome for which treatment is provided for a particular condition.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—outcome of treatment Health, Superseded 07/12/2011 Cancer treatment—outcome of treatment Health, Standard 07/12/2011

Outpatient clinic type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	291073
Registration status:	Health, Standard 04/05/2005
Definition:	The nature of services which are provided by **outpatient clinic services**.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—outpatient clinic type Health, Superseded 04/07/2007 Establishment—outpatient clinic type Health, Standard 04/07/2007 Non-admitted patient service event—outpatient clinic type Health, Standard 06/10/2010

Overdue patient status

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Timeliness of care/service
METeOR identifier:	269076
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a patient whose wait for care exceeded the time determined as clinically desirable.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—overdue patient status Health, Standard 01/03/2005

Overnight-stay admitted care

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	374147
Registration status:	Health, Standard 03/12/2008
Definition:	The care provided for a minimum of one night, to a patient who is admitted to and separated from the hospital on different dates.
Property group:	Service provision event

Relational attributes

Related metadata references:	Supersedes Number of available beds for admitted patients/residents Health, Superseded 03/12/2008
Data Element Concepts implementing this Property:	Available bed—overnight-stay admitted care Health, Standard 03/12/2008

Pacemaker insertion date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359599
Registration status:	Health, Standard 01/10/2008
Definition:	The date when an artificial pacemaker is inserted to regulate the heart beat.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—pacemaker insertion date Health, Standard 01/10/2008

Pacemaker insertion time

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 359657

Registration status: Health, Standard 01/10/2008

Definition: The time when an artificial pacemaker is inserted to regulate the heart beat.

Property group: Service provision event

Relational attributes

Data Element Concepts implementing this Property: Person—pacemaker insertion time Health, Standard 01/10/2008

Palliative care strategic plan indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288321
Registration status:	Health, Standard 05/12/2007
Definition:	An indicator of the existence of a written strategic plan for palliative care.
Property group:	Performance indicators

Relational attributes

Data Element Concepts implementing this Property:	Administrative health region—palliative care strategic plan indicator Health, Standard 05/12/2007

Parity

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	302011
Registration status:	Health, Standard 29/11/2006
Definition:	A count of previous pregnancies resulting in a live birth or stillbirth.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Data Element Concepts implementing this Property:	Female—parity Health, Standard 29/11/2006

Partner organisation type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	290699
Registration status:	Health, Standard 05/12/2007
Definition:	The type of organisation with which an organisation has a formal working partnership in place.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—partner organisation type Health, Standard 05/12/2007

Patient election status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	339067
Registration status:	Health, Standard 28/11/2006
Definition:	An indicator of whether a person has elected to be treated as either a public or private patient.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Elected accommodation status Health, Superseded 28/11/2006
Data Element Concepts implementing this Property:	Episode of admitted patient care—patient election status Health, Standard 28/11/2006

Patient listing status

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Readiness for care
METeOR identifier:	269041
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator a person's readiness to commence an awaited procedure.
Property group:	Service/care urgency

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—patient listing status Health, Standard 01/03/2005

Patient present status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269111
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a patient's presence at a service event.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient service event—patient present status Health, Standard 01/03/2005

Patient/client participation indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	286845
Registration status:	Health, Standard 08/12/2004
Definition:	An indication of participation in a service contact.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Mental health service contact—patient/client participation indicator Health, Standard 08/12/2004

Patients/clients in residence at year end

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269091
Registration status:	Health, Standard 01/03/2005
Definition:	A count of admitted patients/clients in residence at the end of the normal financial year.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—patients/clients in residence at year end Health, Standard 01/03/2005

Percutaneous coronary intervention procedure type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359745
Registration status:	Health, Standard 01/10/2008
Definition:	The type of procedure performed during a percutaneous coronary intervention (PCI).
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—percutaneous coronary intervention procedure type Health, Standard 01/10/2008

Period of residence in Australia

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269092
Registration status:	Health, Standard 01/03/2005
Definition:	The length of time lived in Australia.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—period of residence in Australia Health, Standard 01/03/2005

Peripheral neuropathy indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269164
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of peripheral nerve disorders of any cause.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—peripheral neuropathy indicator Health, Standard 01/03/2005

Peripheral vascular disease indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269093

Registration status: Health, Standard 01/03/2005

Definition: An indicator of the presence of peripheral vascular disease.

Context: Public health, health care and clinical settings.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—peripheral vascular disease indicator (foot) Health, Standard 01/03/2005

Person identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269369
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005 Health, Standard 01/03/2005
Definition:	A sequence of characters which identify a person.
Property group:	Identifier characteristics

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Data Element Concepts implementing this Property:	Person—person identifier Community Services, Standard 25/08/2005 Health, Standard 04/05/2005 Person—person identifier (within establishment/agency) Community Services, Superseded 25/08/2005 Health, Superseded 04/05/2005

Pharmacotherapy type prescribed in hospital

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	344340
Registration status:	Health, Standard 01/10/2008
Definition:	The type of pharmacotherapy prescribed for the treatment of acute coronary syndrome in hospital including the emergency department.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person with acute coronary syndrome—pharmacotherapy type prescribed in hospital Health, Standard 01/10/2008

Pharmacotherapy type taken post discharge from hospital

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	351101
Registration status:	Health, Standard 01/10/2008
Definition:	Pharmacotherapy type taken following discharge from hospital.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person with acute coronary syndrome—pharmacotherapy type taken post discharge from hospital Health, Standard 01/10/2008

Physical activity sufficiency status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269095
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of whether a level of activity is sufficiently vigorous to confer a health benefit.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—physical activity sufficiency status Health, Standard 01/03/2005

Physical departure date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	322593
Registration status:	Health, Standard 24/03/2006 Tasmanian Health, Proposed 28/09/2011
Definition:	The date on which a patient or client physically departs a service or facility.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Data Element Concepts implementing this Property:	Emergency department stay—physical departure date Health, Superseded 17/04/2012 Tasmanian Health, Proposed 28/09/2011 Emergency department stay—physical departure date Health, Standard 22/12/2011

Physical departure time

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 322606

Registration status: Health, Standard 24/03/2006
Tasmanian Health, Proposed 28/09/2011

Definition: The time at which a patient or client physically departs a service or facility.

Property group: Exit/leave from service event

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Data Element Concepts implementing this Property: Emergency department stay—physical departure time Health, Superseded 22/12/2011
Tasmanian Health, Proposed 28/09/2011

Emergency department stay—physical departure time Health, Standard 22/12/2011

Place of occurrence

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269393
Registration status:	Health, Standard 01/03/2005
Definition:	The physical location in which an event occurred.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Injury event—place of occurrence Health, Standard 01/03/2005

Planned hospital transfer indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 402775

Registration status: Health, Standard 25/08/2011

Definition: An indicator of whether the relocation of a person from an establishment to a hospital was planned or unplanned.

Property group: Transport characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Establishment (prison)—planned hospital transfer indicator Health, Standard 25/08/2011

Pneumococcal disease immunisation indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	460012
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of immunisation against pneumococcal disease.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property:	Person—pneumococcal disease immunisation indicator Health, Standard 07/12/2011

Postal delivery point identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269334
Registration status:	Community Services, Standard 01/03/2005 Health, Standard 01/03/2005
Definition:	A sequence of assigned characters which uniquely identify a postal delivery point.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—postal delivery point identifier Community Services, Superseded 06/02/2012 Health, Standard 01/03/2005 Service provider organisation (address)—postal delivery point identifier Community Services, Superseded 06/02/2012 Health, Standard 04/05/2005

Postal delivery service type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269382
Registration status:	Health, Standard 01/03/2005
Definition:	The type of distribution service for mail and packages
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Health Data Standards Committee

Relational attributes

Data Element Concepts implementing this Property:	Person—postal delivery service type Health, Standard 01/03/2005

Postal delivery service type identifier

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269381

Registration status: Community Services, Standard 06/02/2012
Health, Standard 01/03/2005

Definition: The specification of the identification of a postal delivery service such as General Post Office Box, Community Mail Bag, etc. to clearly distinguish it from another when applicable.

Context: Australian addresses.

Property group: Location characteristics

Source and reference attributes

Submitting organisation: Health Data Standards Committee

Relational attributes

Data Element Concepts implementing this Property: Person (address)—postal delivery service type identifier
Health, Standard 01/03/2005

Postpartum perineal status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269054

Registration status: Health, Standard 01/03/2005

Definition: An indicator of the condition of the perineum after birth.

Property group: Birth event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Female (mother)—postpartum perineal status Health, Standard 01/03/2005

Pre-vocational training services grants for non-government organisations

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 288095

Registration status: Health, Standard 08/12/2004

Definition: Grants made to non-government organisations for the provision of pre-vocational training services.

Property group: Funding characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Specialised mental health service organisation—pre-vocational training services grants for non-government organisations Health, Standard 08/12/2004

Preferred language

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269244
Registration status:	Community Services, Standard 10/04/2006 Housing assistance, Standard 13/10/2011 Health, Standard 01/03/2005 Homelessness, Standard 13/10/2011 Tasmanian Health, Proposed 28/09/2011
Definition:	The language most preferred for communication.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—preferred language Community Services, Standard 10/04/2006 Housing assistance, Standard 13/10/2011 Health, Standard 01/03/2005 Homelessness, Standard 13/10/2011 Tasmanian Health, Proposed 28/09/2011

Pregnancy completion date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269257
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a pregnancy was completed.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Pregnancy (last previous)—pregnancy completion date Health, Standard 01/03/2005

Pregnancy indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	303950
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of a developing embryo or fetus within a body.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Dorland’s Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

Related metadata references:	Supersedes Current pregnancy status Health, Superseded 22/09/2005
Data Element Concepts implementing this Property:	Female—pregnancy indicator Health, Standard 21/09/2005

Pregnancy outcome

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269049
Registration status:	Health, Standard 01/03/2005
Definition:	The end result of a period of pregnancy.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Pregnancy (last previous)—pregnancy outcome Health, Standard 01/03/2005

Premature cardiovascular disease family history status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269233
Registration status:	Health, Standard 01/03/2005
Definition:	Indicates whether there is a history of early cardiovascular conditions within the family.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—premature cardiovascular disease family history status Health, Standard 01/03/2005

Presentation date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269321

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: The date on which the patient/client presented for the delivery of a service.

Property group: Entry into service event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Emergency department stay—presentation date Health, Standard 22/12/2011

Health service event—presentation date Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Presentation time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269146
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The time at which a person presents for the delivery of a service.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Emergency department stay—presentation time Health, Standard 22/12/2011 Health service event—presentation time Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011

Previous opioid pharmacotherapy treatment program indicator

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Opioid replacement program
METeOR identifier:	404735
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of previous participation in a drug-based opioid dependence treatment program.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—previous opioid pharmacotherapy treatment program indicator Health, Standard 25/08/2011

Previous specialised treatment

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269308
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the receipt of prior care in the same specialty as the current treatment.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Patient—previous specialised treatment Health, Standard 01/03/2005

Primary body function or structure affected

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	330158
Registration status:	Health, Standard 07/12/2011
Definition:	The primary body function or structure alleged to have been affected.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Patient—primary body function or structure affected Health, Standard 07/12/2011

Primary incident or allegation type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	425722
Registration status:	Health, Standard 07/12/2011
Definition:	A description of the main event or circumstance that led, or may have led, to unintended or unnecessary harm.
Property group:	Legal characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Medical indemnity claim—primary incident or allegation type Health, Standard 07/12/2011

Primary percutaneous coronary intervention date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359179
Registration status:	Health, Standard 01/10/2008
Definition:	The date of the first percutaneous coronary intervention performed for reperfusion therapy of an ST-segment-elevation myocardial infarction.
Property group:	Service provision event

Relational attributes

Related metadata references:	Supersedes First angioplasty balloon inflation or stenting date Health, Superseded 01/10/2008
Data Element Concepts implementing this Property:	Person—primary percutaneous coronary intervention date Health, Standard 01/10/2008

Primary percutaneous coronary intervention time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359212
Registration status:	Health, Standard 01/10/2008
Definition:	The time of the first percutaneous coronary intervention performed for reperfusion therapy of an ST-segment-elevation myocardial infarction.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes First angioplasty balloon inflation or stenting time Health, Superseded 01/10/2008
Data Element Concepts implementing this Property:	Person—primary percutaneous coronary intervention time Health, Standard 01/10/2008

Primary site of cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269180
Registration status:	Health, Standard 01/03/2005
Definition:	The anatomical position of origin of a tumour.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—primary site of cancer Health, Standard 01/03/2005

Primary tumour status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 293238

Registration status: Health, Standard 13/06/2004

Definition: The extent of the primary tumour.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Sobin LH (Editors) (1997) International Union Against Cancer (UICC) TNM classification of malignant tumours, 5th edition. Wiley-Liss, New York

Relational attributes

Data Element Concepts implementing this Property: Person with cancer—primary tumour status Health, Superseded 07/12/2011

Person with cancer—primary tumour status Health, Standard 07/12/2011

Principal clinician specialty involved in health-care incident

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	330125
Registration status:	Health, Standard 07/12/2011
Definition:	The clinical specialty of the health-care provider who played the most prominent role in the health-care incident.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health-care incident—principal clinician specialty involved in health-care incident Health, Standard 07/12/2011

Principal diagnosis

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269186
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The diagnosis chiefly responsible for occasioning a service event or episode.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—principal diagnosis Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011 Patient—principal diagnosis Health, Standard 07/12/2011

Principal field of medicine

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	375490
Registration status:	Health, Standard 10/12/2009
Definition:	The field of medicine in which the most hours were worked in the week prior to registration.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Registered health professional—principal field of medicine Health, Standard 10/12/2009

Principal role

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269351
Registration status:	Community Services, Standard 15/09/2007 Health, Standard 01/03/2005
Definition:	A descriptor of the role to which the most time is devoted.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health professional—principal role Health, Standard 01/03/2005 Registered health professional—principal role Health, Standard 10/12/2009

Principal source of funding

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	339074
Registration status:	Health, Standard 29/11/2006
Definition:	The source from which the majority of funding is anticipated.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Expected principal source of funding Health, Superseded 29/11/2006
Data Element Concepts implementing this Property:	Episode of care—principal source of funding Health, Standard 29/11/2006 Non-admitted patient service event—principal source of funding Health, Standard 01/12/2010

Prison health clinic visit initiator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 376342

Registration status: Health, Standard 25/08/2011

Definition: The party responsible for initiating contact with the prison health clinic.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Health service event—prison health clinic visit initiator Health, Standard 25/08/2011

Prisoner health discharge summary indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	412258
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether a summary of the health-care provided is on the prisoner's medical file at the time of release from prison. The summary may contain information on the prisoner's medical history including current problems, allergies, scheduled appointments, any investigations (i.e. blood tests, current medications, vaccination record) and contact details for further information on the prisoner.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—prisoner health discharge summary indicator Health, Standard 25/08/2011

Prisoner location

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	418449
Registration status:	Health, Standard 25/08/2011
Definition:	The physical location of a prisoner.
Property group:	Accommodation/living characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health service event—prisoner location Health, Standard 25/08/2011

Prisoner location when service provider was needed, but not utilised

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	418811
Registration status:	Health, Standard 25/08/2011
Definition:	The physical location of a prisoner when they needed to, but did not, engage with a professional who provides a service or care.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health service event—prisoner location when service provider was needed, but not utilised Health, Standard 25/08/2011

Procedure

Identifying and definitional attributes

Metadata item type: Property

Synonymous names: Clinical intervention; Surgical operation

METeOR identifier: 269052

Registration status: Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Definition: A series of steps performed by a healthcare professional through which a desired result is intended to be accomplished.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Dorland I & Newman W.A 2003. Dorland's illustrated medical dictionary, 30th ed. Philadelphia: Saunders.

Relational attributes

Data Element Concepts implementing this Property: Episode of admitted patient care—procedure Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Procedure commencement date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269251
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a procedure commenced.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care (procedure)—procedure commencement date Health, Standard 01/03/2005

Proficiency in spoken English

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269192
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005 Health, Standard 01/03/2005
Definition:	An indicator of the level of skill in speaking English.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—proficiency in spoken English Community Services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006 Health, Standard 01/03/2005

Progesterone receptor assay results

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	291334
Registration status:	Health, Standard 13/06/2004
Definition:	The results of a progesterone receptor test.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—progesterone receptor assay results Health, Standard 13/06/2004

Proteinuria status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269290
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the presence of excessive protein in the urine.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—proteinuria status Health, Standard 01/03/2005

Psychosocial support services grants for non-government organisations

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 288670

Registration status: Health, Standard 08/12/2004

Definition: Grants made to non-government organisations for the provision of psychosocial support services.

Property group: Funding characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Specialised mental health service organisation—psychosocial support services grants for non-government organisations
Health, Standard 08/12/2004

Purchase of goods and services

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	360134
Registration status:	Health, Standard 05/12/2007
Definition:	Expenditure incurred for the purchase of goods and services.
Property group:	Financial characteristics

Collection and usage attributes

Collection methods:

Relational attributes

Data Element Concepts implementing this Property:	Organisation—purchase of goods and services Health, Standard 05/12/2007

Quality accreditation/certification standard indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269293

Registration status: Health, Standard 01/03/2005

Definition: An indicator of whether a service provider is accredited or compliant with relevant industry quality standards.

Property group: Organisational characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Establishment—quality accreditation/certification standard indicator Health, Standard 01/03/2005

Radiation dose administered

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 433489

Registration status: Health, Standard 07/12/2011

Definition: The amount of radiation administered.

Radiotherapy is the treatment of disease by means of ionizing radiation.

The amount or dose of radiation administered is measured in grays. The gray (Gy) is the SI (International System of Units) unit of absorbed radiation dose of ionizing radiation (for example, X-rays), and is defined as the absorption of one joule of ionizing radiation by one kilogram of matter (usually human tissue).

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Dorland I, Newman WA 2003. Dorland's illustrated medical dictionary (30th edn). Philadelphia: Saunders p1564

Myers T (Editor) 2009. Mosby's Medical Dictionary , 8th Edition. Missouri: Mosby Elsevier page 820

Relational attributes

Data Element Concepts implementing this Property: Cancer treatment—radiation dose administered Health, Standard 07/12/2011

Radiotherapy completion date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 394467

Registration status: Health, Standard 07/12/2011

Definition: The date on which radiotherapy was completed.

Radiotherapy is the treatment of disease by means of ionizing radiation.

Property group: Exit/leave from service event

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Dorland I, Newman WA 2003. Dorland's illustrated medical dictionary (30th edn). Philadelphia: Saunders p1564

Relational attributes

Data Element Concepts implementing this Property: Cancer treatment—radiotherapy completion date Health, Standard 07/12/2011

Radiotherapy fractions administered

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 393508

Registration status: Health, Standard 07/12/2011

Definition: The number of radiotherapy fractions or treatment sessions administered.

Radiotherapy is the treatment of disease by means of ionizing radiation.

Administration of the total dose of radiation is spread out over time and delivered to the patient in a number of even parts or treatment sessions (fractions). Although a treatment session may include several treatment portals delivered within a confined period of time, usually a few minutes, it is still considered one fraction.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision, Commission on Cancer page 163

Relational attributes

Data Element Concepts implementing this Property: Cancer treatment—radiotherapy fractions administered Health, Standard 07/12/2011

Radiotherapy start date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	393479
Registration status:	Health, Standard 07/12/2011
Definition:	The date on which radiotherapy commenced. Radiotherapy is the treatment of disease by means of ionizing radiation.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Dorland I, Newman WA 2003. Dorland's illustrated medical dictionary (30th edn). Philadelphia: Saunders p1564

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—radiotherapy start date Health, Standard 07/12/2011 Patient—radiotherapy start date Health, Standard 07/12/2011

Radiotherapy target site

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	414605
Registration status:	Health, Standard 07/12/2011
Definition:	The site or region of the body where radiotherapy is administered. Radiotherapy is the treatment of disease by means of ionizing radiation.
Property group:	Service provision event

Collection and usage attributes

Guide for use:	An example is administrating radiotherapy for the treatment of cancer; the primary site, regional or distant sites of cancer may be targeted for treatment.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Dorland I, Newman WA 2003. Dorland's illustrated medical dictionary (30th edn). Philadelphia: Saunders p1564

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—radiotherapy target site Health, Standard 07/12/2011

Radiotherapy treatment type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	291343
Registration status:	Health, Standard 13/06/2004
Definition:	The type of radiation therapy used for treatment.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—radiotherapy treatment type Health, Superseded 07/12/2011 Cancer treatment—radiotherapy treatment type Health, Standard 07/12/2011

Ready-for-care date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	429071
Registration status:	Health, Standard 07/12/2011
Definition:	The first date, in the opinion of the treating clinician, on which treatment can commence.
Property group:	Entry into service event

Relational attributes

Data Element Concepts implementing this Property:	Patient—ready-for-care date Health, Standard 07/12/2011

Reason for health clinic attendance

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 365277

Registration status: Health, Standard 25/08/2011

Definition: The reason or health issue that prompts a visit to a health clinic.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—reason for health clinic attendance Health, Standard 25/08/2011

Reason for non prescription of pharmacotherapy

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	347218
Registration status:	Health, Standard 01/10/2008
Definition:	Whether a pharmacotherapy was not indicated or contraindicated.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—reason for non prescription of pharmacotherapy Health, Standard 01/10/2008

Reason for non-utilisation of health service

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 376298

Registration status: Health, Standard 25/08/2011

Definition: The explanation for not using a health service when it was needed.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Prison entrant—reason for non-utilisation of health service Health, Standard 25/08/2011

Reason for readmission following acute coronary syndrome episode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285161
Registration status:	Health, Standard 04/06/2004
Definition:	Identifies the main reason for the readmission, following a previous discharge from an acute coronary syndrome episode.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—reason for readmission following acute coronary syndrome episode Health, Standard 04/06/2004 Person—reason for readmission following acute coronary syndrome episode Health, Standard 01/10/2008

Reason for removal from a waiting list

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269071
Registration status:	Health, Standard 01/03/2005
Definition:	The reason for removal of an entry from a waiting list.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—reason for removal from a waiting list Health, Standard 01/03/2005

Recreation services grants to non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288692
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of recreation services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—recreation services grants to non-government organisations Health, Standard 08/12/2004

Recurrent expenditure

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269132

Registration status: Housing assistance, Standard 01/03/2005
Health, Standard 13/05/2005

Definition: Expenditure which does not result in the acquisition or enhancement of an asset.

Property group: Financial characteristics

Collection and usage attributes

Guide for use: National Housing Assistance Data Dictionary specific:

Recurrent expenditure on goods and services is expenditure, which does not result in the creation or acquisition of fixed assets (new or second-hand). It consists mainly of expenditure on wages, salaries and supplements, purchases of goods and services and consumption of fixed capital (depreciation).

When fees charged for goods and services are offset against recurrent expenditure, the result equates to final consumption expenditure in the Australian Bureau of Statistics' national accounts framework.

Includes:

- Operating expenses
- Tenancy manager revenue and expense components.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0

Relational attributes

Data Element Concepts implementing this Property: Establishment—recurrent expenditure Health, Standard 08/12/2004

Establishment—recurrent expenditure (administrative expenses) Health, Standard 01/03/2005

Establishment—recurrent expenditure (Department of Veterans' Affairs funded) Health, Standard 02/12/2009

Establishment—recurrent expenditure (Department of Veterans' Affairs funded) Health, Superseded 02/12/2009

Establishment—recurrent expenditure (depreciation) Health, Standard 01/03/2005

Establishment—recurrent expenditure (domestic services)

Health, Standard 01/03/2005

Establishment—recurrent expenditure (drug supplies) Health, Standard 01/03/2005

Establishment—recurrent expenditure (food supplies) Health, Standard 01/03/2005

Establishment—recurrent expenditure (indirect health care) Health, Standard 01/03/2005

Establishment—recurrent expenditure (interest payments) Health, Standard 01/03/2005

Establishment—recurrent expenditure (medical and surgical supplies) Health, Standard 01/03/2005

Establishment—recurrent expenditure (National Mental Health Strategy payments) Health, Standard 08/12/2004

Establishment—recurrent expenditure (non-salary operating costs) Health, Standard 01/03/2005

Establishment—recurrent expenditure (other Commonwealth Government funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (other patient revenue funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (other recurrent expenditure) Health, Standard 01/03/2005

Establishment—recurrent expenditure (other revenue funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (other state or territory funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (patient transport cost) Health, Standard 01/03/2005

Establishment—recurrent expenditure (recoveries funded expenditure) Health, Standard 08/12/2004

Establishment—recurrent expenditure (repairs and maintenance) Health, Standard 01/03/2005

Establishment—recurrent expenditure (salaries and wages) Health, Standard 01/03/2005

Establishment—recurrent expenditure (state or territory health authority funded) Health, Standard 08/12/2004

Establishment—recurrent expenditure (superannuation employer contributions) Health, Standard 01/03/2005

Establishment—recurrent expenditure (visiting medical officer payments) Health, Standard 01/03/2005

Specialised mental health service organisation—recurrent expenditure (residual mental health) Health, Standard 08/12/2004

Referral destination

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269147
Registration status:	Health, Standard 01/03/2005
Definition:	The service provider to which a referral is made.
Property group:	Referral event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—referral destination Health, Standard 01/03/2005 Episode of residential care—referral destination (mental health care) Health, Superseded 07/12/2011 Episode of residential care—referral destination (mental health care) Health, Standard 07/12/2011

Referral source

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269061

Registration status: Community Services, Standard 02/06/2005
Housing assistance, Standard 23/08/2010
Health, Standard 01/03/2005
Homelessness, Standard 23/08/2010

Definition: A person or organisation from which a person or group of people is referred.

Property group: Referral event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Episode of admitted patient care—referral source Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs—referral source Health, Standard 01/03/2005

Referral to ophthalmologist indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	304006
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of whether there was a referral to an ophthalmologist.
Property group:	Referral event

Source and reference attributes

Submitting organisation:	National diabetes data working group

Relational attributes

Related metadata references:	Supersedes Referral to ophthalmologist Health, Superseded 22/09/2005
Data Element Concepts implementing this Property:	Person—referral to ophthalmologist indicator Health, Standard 21/09/2005

Referral to rehabilitation service date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269357
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a referral to a rehabilitation service is made.
Property group:	Referral event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health service event—referral to rehabilitation service date Health, Standard 01/03/2005

Region identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269057
Registration status:	Community Services, Standard 15/09/2007 Health, Standard 01/03/2005 Tasmanian Health, Proposed 05/10/2011
Definition:	An identifier for a defined geographic or administrative area.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—region identifier Health, Standard 01/03/2005

Region name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	352846
Registration status:	Health, Standard 05/12/2007
Definition:	A name for a defined geographic or administrative area.
Property group:	Identifier characteristics

Relational attributes

Data Element Concepts implementing this Property:	Administrative health region—region name Health, Standard 05/12/2007 Establishment—region name Health, Standard 07/12/2011

Region of first recurrence as distant metastasis

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	393850
Registration status:	Health, Standard 07/12/2011
Definition:	The anatomical site of first recurrence as distant metastasis. The term recurrence defines the return, reappearance or metastasis of cancer (of the same histology) after a disease-free intermission or remission. Distant metastasis refers to the spread of cancer of the same histology as the original (primary) tumour to distant organs or distant lymph nodes.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision, Commission on Cancer

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—region of first recurrence as distant metastasis Health, Standard 07/12/2011

Region of first recurrence as locoregional cancer

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 393844

Registration status: Health, Standard 07/12/2011

Definition: The anatomical site of first recurrence as locoregional cancer.

The term recurrence defines the return, reappearance or metastasis of cancer (of the same histology) after a disease free period.

Locoregional recurrence refers to the recurrence of cancer cells at the same site as the original (primary) tumour or the regional lymph nodes after a disease free period.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision, Commission on Cancer

Relational attributes

Data Element Concepts implementing this Property: Person with cancer—region of first recurrence as locoregional cancer Health, Standard 07/12/2011

Region of first recurrence of cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	289045
Registration status:	Health, Standard 04/06/2004
Definition:	The region where there is a return or reappearance of the primary cancer after a disease free period intermission or remission.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—region of first recurrence of cancer Health, Standard 04/06/2004

Regional lymph node metastasis status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 293233

Registration status: Health, Standard 13/06/2004

Definition: The absence or presence and the extent of regional lymph node metastasis.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Sobin LH (Editors) (1997) International Union Against Cancer (UICC) TNM classification of malignant tumours, 5th edition. Wiley-Liss, New York

Relational attributes

Data Element Concepts implementing this Property: Person with cancer—regional lymph node metastasis status Health, Superseded 07/12/2011

Person with cancer—regional lymph node metastasis status Health, Standard 07/12/2011

Regular client indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 436655

Registration status: Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Definition: An indicator of whether a client is a regular client of an organisation or agency.

Property group: Client characteristic

Collection and usage attributes

Comments: The definition of a regular client can vary depending on the context and/or collection in which the term is being applied, but generally involves a minimum number of visits to an organisation or agency or uses of a facility, occurring over a specific period of time. For example, in the primary health care context a regular client may be someone who has visited a particular primary health care provider 3 or more times in the last 2 years.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property: Person—regular client indicator Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Regular tobacco smoking indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	304521
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of current and/or past regular tobacco smoking.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—regular tobacco smoking indicator Health, Standard 21/09/2005

Relationship to health-care service provider

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	330327
Registration status:	Health, Standard 07/12/2011
Definition:	The relationship of the patient to the health-care service provider.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Patient—relationship to health-care service provider Health, Standard 07/12/2011

Renal disease therapy

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269373
Registration status:	Health, Standard 01/03/2005
Definition:	The class of treatment undertaken for renal disease.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Cardiovascular data working group

Relational attributes

Data Element Concepts implementing this Property:	Person—renal disease therapy Health, Standard 01/03/2005

Rescue percutaneous coronary intervention date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359575
Registration status:	Health, Standard 01/10/2008
Definition:	The date when percutaneous coronary intervention is performed following failed fibrinolysis.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—rescue percutaneous coronary intervention date Health, Standard 01/10/2008

Rescue percutaneous coronary intervention time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359564
Registration status:	Health, Standard 01/10/2008
Definition:	The time when percutaneous coronary intervention is performed following failed fibrinolysis.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—rescue percutaneous coronary intervention time Health, Standard 01/10/2008

Reserve placement date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 329684

Registration status: Health, Standard 07/12/2011

Definition: The date on which a **reserve** was first placed against a medical indemnity claim.

Property group: Legal characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Medical indemnity claim management episode—reserve placement date Health, Standard 07/12/2011

Reserve size

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	329849
Registration status:	Health, Standard 07/12/2011
Definition:	An estimate of the likely cost to the health authority of a claim when closed.
Property group:	Financial characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Medical indemnity claim management episode—reserve size Health, Standard 07/12/2011

Residential mental health care

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	373645
Registration status:	Health, Standard 03/12/2008
Definition:	The care provided for the purpose of **specialised residential mental health care**.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Available bed—residential mental health care Health, Standard 03/12/2008

Residential service unit identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	404833
Registration status:	Health, Standard 07/12/2011
Definition:	A sequence of characters which identify a residential service unit.
Property group:	Identifier characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service—residential service unit identifier Health, Standard 07/12/2011

Residential service unit name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	407490
Registration status:	Health, Standard 07/12/2011
Definition:	The appellation by which a residential service unit is known or called.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service—residential service unit name Health, Standard 07/12/2011

Residual expenditure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	295450
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit).
Property group:	Financial characteristics

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Data Element Concepts implementing this Property:

Specialised mental health service—residual expenditure (academic positions) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (education and training) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (insurance) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (Mental Health Act Regulation or related legislation) Health, Standard 02/12/2009

Specialised mental health service—residual expenditure (mental health promotion) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (mental health research) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (other indirect expenditure) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (patient transport services) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (program administration) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (property leasing costs) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (service development) Health, Standard 02/12/2009

Specialised mental health service—residual expenditure (superannuation) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (support services) Health, Standard 08/12/2004

Specialised mental health service—residual expenditure (workers compensation) Health, Standard 08/12/2004

Respite services grants to non-government organisations

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 288749

Registration status: Health, Standard 08/12/2004

Definition: Grants made to non-government organisations for the provision of respite services.

Property group: Funding characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Specialised mental health service organisation—respite services grants to non-government organisations Health, Standard 08/12/2004

Retirement status in registered profession

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	383422
Registration status:	Health, Standard 10/12/2009
Definition:	Whether a person is retired from their position of employment in the registered profession.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Registered health professional—retirement status in registered profession Health, Standard 10/12/2009

Revascularisation percutaneous coronary intervention date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359586
Registration status:	Health, Standard 01/10/2008
Definition:	The date when percutaneous coronary intervention is performed for subsequent restoration of blood flow.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—revascularisation percutaneous coronary intervention date Health, Standard 01/10/2008

Revascularisation percutaneous coronary intervention time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	359733
Registration status:	Health, Standard 01/10/2008
Definition:	The time when percutaneous coronary intervention is performed for subsequent restoration of blood flow.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—revascularisation percutaneous coronary intervention time Health, Standard 01/10/2008

Revenue

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 358088

Registration status: Housing assistance, Standardisation pending 30/11/2007
Health, Standard 05/12/2007

Definition: Revenue is income that arises in the course of ordinary activities of an entity and is referred to by a variety of names including sales, fees, interest, dividends and royalties.

Property group: Financial characteristics

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Origin: ABS 2003. Australian System of Government Finance Statistics: Concepts, Sources and Methods (Cat. no. 5514.0.55.001) EMBARGO: 11:30 AM (CANBERRA TIME) 10/10/2003.

Australian Accounting Standards Board 118, July 2007, <www.aasb.com.au>.

Relational attributes

Related metadata references: Supersedes Revenue Housing assistance, Standard 22/10/2005, Health, Superseded 05/12/2007

Data Element Concepts implementing this Property:

Establishment—revenue (other revenue) Health, Standard 05/12/2007

Establishment—revenue (patient) Health, Standard 05/12/2007

Establishment—revenue (recoveries) Health, Standard 05/12/2007

Organisation—revenue Health, Standard 05/12/2007

Road name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	429740
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	The name given to a road or thoroughfare.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references:	Supersedes Street name Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011
Data Element Concepts implementing this Property:	Address—road name Community Services, Standard 06/02/2012 Health, Standard 07/12/2011

Road number 1

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	429548
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	The number, or start number in a ranged address, of the building/dwelling in the road or thoroughfare.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references:	Supersedes House/property identifier Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011
Data Element Concepts implementing this Property:	Address—road number 1 Community Services, Standard 06/02/2012 Health, Standard 07/12/2011

Road number 2

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 429588

Registration status: Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Definition: The last number for a ranged address in a road or thoroughfare.

Property group: Location characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references: Supersedes House/property identifier Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011

Data Element Concepts implementing this Property: Address—road number 2 Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Road type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	429752
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	An identifier used to distinguish a type of road or thoroughfare.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references:	Supersedes Street type Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011
Data Element Concepts implementing this Property:	Address—road type Community Services, Standard 06/02/2012 Health, Standard 07/12/2011

Same-day admitted care

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 373961

Registration status: Health, Standard 03/12/2008

Definition: The care provided to a same-day patient who is admitted and separated from the hospital on the same date.

Property group: Service provision event

Relational attributes

Data Element Concepts implementing this Property: Available bed—same-day admitted care Health, Standard 03/12/2008

Scheduled admission date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269029

Registration status: Health, Standard 01/03/2005

Definition: The date on which an **admission** is planned.

Property group: Entry into service event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Admitted patient care waiting list episode—scheduled admission date Health, Standard 01/03/2005

Secondary complex name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	429399
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	The name associated with a building or area within a complex site.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Data Element Concepts implementing this Property:	Address—secondary complex name Community Services, Standard 06/02/2012 Health, Standard 07/12/2011

Sector

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269055
Registration status:	Community Services, Standard 27/04/2007 Health, Standard 01/03/2005
Definition:	A categorisation of an organisation based on its funding, management and ownership arrangements.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—sector Health, Standard 01/03/2005

Self-harm ideation in the last 12 months

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Thoughts of self-harm in the last 12 months
METeOR identifier:	358871
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	An indicator of having thoughts, in the last 12 months, of inflicting harm upon one's self.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—self-harm ideation in the last 12 months Community Services, Standard 06/02/2012 Health, Standard 25/08/2011

Self-harm indicator

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 358866

Registration status: Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Definition: An indicator of the deliberate infliction of harm to one's self such as cutting or slashing, blunt force, burning, hanging, strangulation, suffocation, biting, refusing food or water, binge eating or self-poisoning.

Property group: Health and wellbeing

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—self-harm indicator Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Self-help support groups services grants for non-government organisations

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288802
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of self-help services.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service organisation—self-help support groups services grants for non-government organisations Health, Standard 08/12/2004

Separation date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269258
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The date on which an episode of care ceases.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—separation date Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011

Separation mode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269121
Registration status:	Health, Standard 01/03/2005
Definition:	The method by which **separation** is achieved.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—separation mode Health, Standard 01/03/2005

Separation time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269330
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	The time at which an episode of care ceases.
Context:	Admitted patient care.
Property group:	Exit/leave from service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of admitted patient care—separation time Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011

Service commencement date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	313941
Registration status:	Health, Standard 07/12/2005
Definition:	The date on which a service event commences.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—service commencement date Health, Standard 07/12/2005

Service commencement time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269045
Registration status:	Health, Standard 01/03/2005
Definition:	The time at which a service event starts.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health service event—service commencement time Health, Superseded 07/12/2005 Non-admitted patient emergency department service episode—service commencement time Health, Standard 07/12/2005

Service contact date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269137

Registration status: Health, Standard 01/03/2005

Definition: The date on which contact between a service provider and patient/client occurred.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Mental health service contact—service contact date Health, Standard 08/12/2004

Service contact—service contact date Health, Standard 01/03/2005

Service date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 414075

Registration status: Health, Standard 06/10/2010
Tasmanian Health, Proposed 28/09/2011

Definition: The date on which a service occurred.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Non-admitted patient service event—service date Health, Standard 06/10/2010
Tasmanian Health, Proposed 28/09/2011

Service delivery mode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	410944
Registration status:	Health, Standard 06/10/2010
Definition:	The method of communication between a patient/client and a service provider.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient service event—service delivery mode Health, Standard 06/10/2010

Service delivery setting

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269375
Registration status:	Community Services, Standard 02/05/2006 Health, Standard 01/03/2005 Early Childhood, Standard 21/05/2010
Definition:	The setting in which assistance or services are provided.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of treatment for alcohol and other drugs—service delivery setting Health, Standard 01/03/2005 Health-care incident—service delivery setting Health, Standard 07/12/2011 Non-admitted patient service event—service delivery setting Health, Standard 06/10/2010 Service provider organisation—service delivery setting Community Services, Standard 29/04/2006 Health, Standard 05/12/2007 Early Childhood, Standard 21/05/2010 Specialised mental health service—service setting Health, Standard 01/03/2005

Service episode length

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269331
Registration status:	Health, Standard 01/03/2005
Definition:	The length of time between patient presentation and service episode conclusion.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—service episode length Health, Superseded 30/01/2012 Non-admitted patient emergency department service episode—service episode length Health, Standard 30/01/2012 Non-admitted patient emergency department service episode—service episode length Health, Superseded 23/05/2012

Service event type

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269245

Registration status: Health, Standard 01/03/2005

Definition: A descriptor of the class of treatment or care provided during a service event.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Non-admitted patient service event—service event type (clinical) Health, Standard 01/03/2005

Service provider needed but not utilised indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	414711
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether a person who provides a service and/or care needed to be consulted, but was not.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Prison entrant—service provider needed but not utilised indicator Health, Standard 25/08/2011

Service request received date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	400709
Registration status:	Health, Standard 06/10/2010
Definition:	The date on which a service request is formally received.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	NAP NMDS (Phase 1) working group

Relational attributes

Data Element Concepts implementing this Property:	Health service event—service request received date Health, Standard 07/12/2011 Non-admitted patient service request—service request received date Health, Standard 06/10/2010

Service request source

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 400743

Registration status: Health, Standard 06/10/2010

Definition: A person or organisation from which a request for a service is sent.

Property group: Referral event

Relational attributes

Data Element Concepts implementing this Property: Non-admitted patient service request—service request source Health, Standard 06/10/2010

Service unit cluster identifier

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	404853
Registration status:	Health, Standard 07/12/2011
Definition:	A sequence of characters which identify a service unit cluster.
Property group:	Identifier characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—service unit cluster identifier Health, Standard 07/12/2011

Service unit cluster name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	409204
Registration status:	Health, Standard 07/12/2011
Definition:	The appellation by which a service unit cluster is known or called.
Property group:	Name characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—service unit cluster name Health, Standard 07/12/2011

Session type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	286780
Registration status:	Health, Standard 08/12/2004
Definition:	An indicator of whether a person or group of persons is provided with a service.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health of Welfare

Relational attributes

Data Element Concepts implementing this Property:	Mental health service contact—session type Health, Standard 08/12/2004

Setting of birth

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Birth setting
METeOR identifier:	269110
Registration status:	Health, Standard 01/03/2005
Definition:	The type of physical environment where the birth occurred.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth event—setting (intended) Health, Superseded 08/12/2005 Birth event—setting of birth Health, Standard 01/03/2005

Severe hypoglycaemia indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	304017
Registration status:	Health, Standard 22/09/2005
Definition:	An indicator of hypoglycaemia requiring assistance from another party.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Severe hypoglycaemia history Health, Superseded 22/09/2005
Data Element Concepts implementing this Property:	Person—severe hypoglycaemia indicator Health, Standard 21/09/2005

Sex

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269231
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005 Health, Standard 01/03/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010
Definition:	The biological distinction between male and female.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Australian Bureau of Statistics 1999. Standards for Social, Labour and Demographic Variables Demographic Variables, Sex

Relational attributes

Data Element Concepts implementing this Property:	Person—sex Community Services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006 Health, Standard 01/03/2005 Early Childhood, Standard 21/05/2010 Homelessness, Standard 23/08/2010

Smoking status recorded indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	441374
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether smoking status has been recorded.
Property group:	Performance indicators

Relational attributes

Data Element Concepts implementing this Property:	Person—smoking status recorded indicator Health, Standard 07/12/2011

Solid tumour size

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269184
Registration status:	Health, Standard 01/03/2005
Definition:	The diameter of a solid tumour at the widest point.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person with cancer—solid tumour size Health, Standard 01/03/2005

Source of funding

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	472036
Registration status:	Health, Standard 11/04/2012
Definition:	The source of funding.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—source of funding Health, Standard 11/04/2012

Source of revenue

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	352332
Registration status:	Health, Standard 05/12/2007
Definition:	The origin from which revenue is received.
Property group:	Funding characteristics

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Relational attributes

Data Element Concepts implementing this Property:	Health industry relevant organisation—source of revenue Health, Standard 05/12/2007

Specialised mental health service target population group

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288951
Registration status:	Health, Standard 08/12/2004
Definition:	The population group primarily targeted by a specialised mental health service.
Context:	Specialised mental health services.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Specialised mental health service—specialised mental health service target population group Health, Standard 08/12/2004

Specialised service indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269158
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the capacity to provide specialised service.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment—specialised service indicator Health, Standard 01/03/2005

Specialist private sector rehabilitation care indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269325
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator that identifies whether the criteria for specialist private sector rehabilitation care is met.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of care—specialist private sector rehabilitation care indicator Health, Standard 01/03/2005

Specific chronic condition indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	399221
Registration status:	Health, Standard 25/08/2011
Definition:	An indicator of whether a doctor or nurse has ever told a patient that they suffer from a health condition that is long term; has a pattern of recurrence, or deterioration; has a poor prognosis and produces consequences, or sequelae that impact on the individual's quality of life.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—specific chronic condition indicator Health, Standard 25/08/2011

Staging basis of cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	296959
Registration status:	Health, Standard 04/06/2004
Definition:	The type of evidence that confirms a diagnosis of a malignant tumour.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Cancer staging—staging basis of cancer Health, Superseded 07/12/2011 Cancer staging—staging basis of cancer Health, Standard 07/12/2011

Standards assessment indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	356459
Registration status:	Health, Standard 05/12/2007
Definition:	An indicator of whether routine assessment against defined industry standards occurs.
Property group:	Performance indicators

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—standards assessment indicator Health, Standard 05/12/2007

Standards assessment level

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 359010

Registration status: Health, Standard 05/12/2007

Definition: The level of assessment undertaken or undergone by an organisation against defined industry standards

Property group: Performance indicators

Relational attributes

Data Element Concepts implementing this Property: Service provider organisation—standards assessment level Health, Standard 05/12/2007

Standards assessment method

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	287989
Registration status:	Health, Standard 05/12/2007
Definition:	The method used for standards assessment.
Property group:	Performance indicators

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—standards assessment method Health, Standard 05/12/2007

State/territory of birth

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269339
Registration status:	Health, Standard 01/03/2005
Definition:	The state/territory in which the birth occurred.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Birth event—state/territory of birth Health, Standard 01/03/2005 Person—state/territory of birth Health, Standard 10/12/2009

Statistical area

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	457283
Registration status:	Community Services, Standard 06/12/2011 Health, Standard 07/12/2011 Early Childhood, Standard 09/03/2012
Definition:	A designated region with a pre-determined population range primarily for statistical usage. Based on the Australian Statistical Geography Standard (ASGS) structure of six hierarchical statistical area levels comprised in ascending order. Each level directly aggregates to the level above. This principle continues up through the remaining levels of the hierarchy.
Property group:	Location characteristics

Relational attributes

Data Element Concepts implementing this Property:	Address—statistical area Community Services, Standard 06/12/2011 Health, Standard 07/12/2011 Early Childhood, Standard 09/03/2012

Street suffix

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269384
Registration status:	Community Services, Superseded 06/02/2012 Health, Standard 01/03/2005
Definition:	Term used to qualify the street name used for directional references.
Context:	Australian addresses.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Health Data Standards Committee
Origin:	AS4590 Interchange of client information, Australia Post Address Presentation Standard.

Relational attributes

Data Element Concepts implementing this Property:	Person (address)—street suffix Community Services, Superseded 06/02/2012 Health, Standard 01/03/2005 Service provider organisation (address)—street suffix Community Services, Superseded 06/02/2012 Health, Standard 04/05/2005

Stress test intensity

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	344435
Registration status:	Health, Standard 01/10/2008
Definition:	Describes the level of exertion applied in a stress test.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Functional stress test—stress test intensity Health, Standard 01/10/2008

Sub-dwelling unit number

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	429006
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 07/12/2011
Definition:	A number used to distinguish location within a building/sub-complex or marina.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references:	Supersedes Building/complex sub-unit identifier Community Services, Superseded 06/02/2012, Health, Superseded 07/12/2011
Data Element Concepts implementing this Property:	Address—sub-dwelling unit number Community Services, Standard 06/02/2012 Health, Standard 07/12/2011

Substance used illicitly indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	365204
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	An indicator of whether a substance has been possessed illegally, or used in an illegal manner.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—substance used illicitly indicator Community Services, Standard 06/02/2012 Health, Standard 25/08/2011

Suburb/town/locality name

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269335
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 23/08/2010 Health, Standard 01/03/2005 Early Childhood, Standard 21/05/2011 Homelessness, Standard 23/08/2010 Tasmanian Health, Proposed 28/09/2011
Definition:	The full name of the general locality containing the specific address.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Address—suburb/town/locality name Community Services, Standard 06/02/2012 Health, Standard 07/12/2011 Early Childhood, Standard 09/03/2012 Person (address)—suburb/town/locality name Community Services, Superseded 06/02/2012 Housing assistance, Standard 23/08/2010 Health, Superseded 07/12/2011 Early Childhood, Superseded 09/03/2012 Homelessness, Standard 23/08/2010 Tasmanian Health, Proposed 28/09/2011 Service provider organisation (address)—suburb/town/locality name Community Services, Superseded 06/02/2012 Housing assistance, Recorded 13/10/2011 Health, Superseded 07/12/2011 Early Childhood, Superseded 09/03/2012 Tasmanian Health, Proposed 28/09/2011 Workplace (address)—suburb/town/locality name Health, Superseded 07/12/2011 Tasmanian Health, Proposed 30/09/2011

Supported mental health housing places

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	390920
Registration status:	Health, Standard 07/12/2011
Definition:	Housing places targeted to people affected by mental illness or psychiatric disability.
Context:	People affected by mental illness or psychiatric disability.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Number of supported public housing places Health, Superseded 07/12/2011
Data Element Concepts implementing this Property:	Specialised mental health service—supported mental health housing places Health, Standard 07/12/2011

Surgery target site

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	413947
Registration status:	Health, Standard 07/12/2011
Definition:	The anatomical location or site in the body where surgery is performed. Surgery is the treatment of disease, injury and deformity by physical operation or manipulation.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Stedman TL 2006. Stedman's Medical Dictionary, 28th Edition. Maryland: Lippincott Williams & Wilkins page 1877

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—surgery target site Health, Standard 07/12/2011

Surgical procedure date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288620
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which the surgical procedure was performed.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—surgical procedure date Health, Standard 04/06/2004

Surgical procedure for cancer

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	288476
Registration status:	Health, Standard 04/06/2004
Definition:	The surgical procedure(s) used in the treatment of a cancer.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—surgical procedure for cancer Health, Superseded 07/12/2011 Cancer treatment—surgical procedure for cancer Health, Standard 07/12/2011

Surgical specialty

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269155
Registration status:	Health, Standard 01/03/2005
Definition:	A descriptor of an area of clinical expertise in surgery.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—surgical specialty (of scheduled doctor) Health, Standard 01/03/2005

Systemic therapy agent or protocol

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	393613
Registration status:	Health, Standard 07/12/2011
Definition:	The systemic therapy agent or protocol used for treatment. Systemic therapy agents are drugs that travel through the bloodstream and reach and effect cells all over the body. They are administered orally or intravenously. Systemic therapy agents may be administered as single-agent treatments or as a combination of drugs administered according to a prespecified regimen or protocol. A protocol is a precise and detailed plan for therapy that includes the type, quantity, method and length of time of taking the drugs required for any treatment cycle. Systemic therapy agents are encompassed in the treatment modalities **chemotherapy**, **immunotherapy** and **hormone therapy** administered for the treatment of cancer.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer, 28D-28E

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—systemic therapy agent or protocol Health, Standard 07/12/2011

Systemic therapy procedure

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 394647

Registration status: Health, Standard 07/12/2011

Definition: The type of systemic therapy procedure used in treatment.

A systemic therapy procedure is a medical, surgical or radiation procedure that has an effect on the hormonal or immunologic balance of the patient, and refers to haematologic transplant and endocrine procedures. Haematologic transplants are bone marrow or stem cell transplants performed to protect patients from myelosuppression or bone marrow ablation associated with the administration of high-dose chemotherapy or radiotherapy.

Endocrine therapy is cancer therapy that achieves its antitumour effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient (when the cancer occurs at another site) and, therefore, alter or affect the long-term control of the cancer's growth.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer, 28E

Relational attributes

Data Element Concepts implementing this Property: Cancer treatment—systemic therapy procedure Health, Standard 07/12/2011

Systemic therapy procedure date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 394639

Registration status: Health, Standard 07/12/2011

Definition: The date on which a systemic therapy procedure was performed.

A systemic therapy procedure is a medical, surgical or radiation procedure that has an effect on the hormonal or immunologic balance of the patient, and refers to haematologic transplant and endocrine procedures.

Haematologic transplants are bone marrow or stem cell transplants performed to protect patients from myelosuppression or bone marrow ablation associated with the administration of high-dose chemotherapy or radiotherapy. Endocrine therapy is cancer therapy that achieves its antitumour effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient (when the cancer occurs at another site) and, therefore, alter or affect the long-term control of the cancer’s growth.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Commission on Cancer, 28E, American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision

Relational attributes

Data Element Concepts implementing this Property: Cancer treatment—systemic therapy procedure date Health, Standard 07/12/2011

Target site for cancer treatment

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	293145
Registration status:	Health, Standard 13/06/2004
Definition:	The site or region of the cancer that is being targeted at treatment.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Cancer treatment—target site for cancer treatment Health, Standard 13/06/2004

Teaching status

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269156

Registration status: Health, Standard 01/03/2005

Definition: An indicator of engagement in the implementation of an educational program.

Property group: Organisational characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Establishment—teaching status (university affiliation) Health, Standard 01/03/2005

Team Care Arrangement (MBS Item 723) indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	441516
Registration status:	Health, Standard 07/12/2011
Definition:	An indicator of whether a Team Care Arrangement (MBS Item 723) has been received.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)

Relational attributes

Data Element Concepts implementing this Property:	Person—Team Care Arrangement (MBS Item 723) indicator Health, Standard 07/12/2011

Technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	313225
Registration status:	Health, Standard 13/10/2005
Definition:	Procedures and tasks for which specific nursing education is required as well as knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions relating to each.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person—technical nursing care requirement Health, Standard 13/10/2005

Telephone number

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269232

Registration status: Community Services, Standard 01/03/2005
Health, Standard 01/03/2005

Definition: A sequence of digits.

Property group: Location characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—telephone number Community Services, Superseded 06/02/2012
Health, Standard 01/03/2005

Telephone number type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269239
Registration status:	Community Services, Standard 01/03/2005 Health, Standard 01/03/2005
Definition:	The class of telephone number.
Property group:	Location characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person (telephone)—telephone number type Community Services, Standard 01/03/2005 Health, Standard 01/03/2005

Time since quitting tobacco smoking

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269266
Registration status:	Health, Standard 01/03/2005
Definition:	The period of time since quitting tobacco smoking.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—time since quitting tobacco smoking Health, Standard 01/03/2005

Timing of ACE-inhibitor prescription

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	349377
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when an ACE-inhibitor is prescribed.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—timing of ACE-inhibitor prescription Health, Standard 01/10/2008

Timing of angiotensin II receptor blocker prescription

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	350414
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when an angiotensin II receptor blocker is prescribed.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—timing of angiotensin II receptor blocker prescription Health, Standard 01/10/2008

Timing of antithrombin therapy prescription

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	350503
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when antithrombin therapy is prescribed.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—timing of antithrombin therapy prescription Health, Standard 01/10/2008

Timing of aspirin prescription

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 347824

Registration status: Health, Standard 01/10/2008

Definition: The timing of care when aspirin, a medication having antiinflammatory, analgesic, and antipyretic effects, is prescribed.

Property group: Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property: Person—timing of aspirin prescription Health, Standard 01/10/2008

Timing of beta-blocker prescription

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 349369

Registration status: Health, Standard 01/10/2008

Definition: The timing of care when a beta-blocker, a medication to lower heart rate and blood pressure, reduce the risk of heart attack, help control angina symptoms and treat irregular heart rhythms is prescribed.

Property group: Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property: Person—timing of beta-blocker prescription Health, Standard 01/10/2008

Timing of clopidogrel prescription

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	350427
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when clopidogrel, an inhibitor of platelet aggregation, is prescribed.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—timing of clopidogrel prescription Health, Standard 01/10/2008

Timing of glycoprotein IIb/IIIa inhibitor prescription

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	349391
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when a glycoprotein IIb/IIIa inhibitor is prescribed.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—timing of glycoprotein IIb/IIIa inhibitor prescription Health, Standard 01/10/2008

Timing of statin prescription

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	350437
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when a statin is prescribed.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—timing of statin prescription Health, Standard 01/10/2008

Tobacco product smoked

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269276

Registration status: Health, Standard 01/03/2005

Definition: The type of tobacco smoked.

Property group: Lifestyle characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—tobacco product smoked Health, Standard 01/03/2005

Tobacco smoking daily use status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269279
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of whether tobacco has ever been smoked on a daily basis.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—tobacco smoking daily use status Health, Standard 01/03/2005

Tobacco smoking duration

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269280
Registration status:	Health, Standard 01/03/2005
Definition:	The length of time tobacco has been smoked.
Property group:	Lifestyle characteristics

Relational attributes

Data Element Concepts implementing this Property:	Person—tobacco smoking duration Health, Standard 01/03/2005

Tobacco smoking frequency

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269277
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of how frequently tobacco is smoked.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—tobacco smoking frequency Health, Standard 01/03/2005

Tobacco smoking indicator (after twenty weeks of pregnancy)

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	375055
Registration status:	Health, Standard 03/12/2008
Definition:	A self-reported indicator of tobacco smoking after 20 weeks of pregnancy.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Female (pregnant)—tobacco smoking indicator (after twenty weeks of pregnancy) Health, Standard 03/12/2008

Tobacco smoking indicator (first twenty weeks of pregnancy)

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	365394
Registration status:	Health, Standard 03/12/2008
Definition:	A self-reported indicator of tobacco smoking in the first twenty weeks of pregnancy.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Female (pregnant)—tobacco smoking indicator (first twenty weeks of pregnancy) Health, Standard 03/12/2008

Tobacco smoking quit age

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269274
Registration status:	Health, Standard 01/03/2005
Definition:	The age at which tobacco smoking ceased.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—tobacco smoking quit age Health, Standard 01/03/2005

Tobacco smoking start age

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269275
Registration status:	Health, Standard 01/03/2005
Definition:	The age at which tobacco smoking commenced.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—tobacco smoking start age Health, Standard 01/03/2005

Tobacco smoking status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269267
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of current and/or past tobacco smoking.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—tobacco smoking status Health, Standard 01/03/2005 Person—tobacco smoking status (last three months) Health, Superseded 21/09/2005

Transgender indicator

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Transgender status
METeOR identifier:	375981
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	An indicator of whether a person identifies as **transgender**, or is undergoing gender reassignment.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—transgender indicator Community Services, Standard 06/02/2012 Health, Standard 25/08/2011

Transport mode

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269043
Registration status:	Health, Standard 01/03/2005
Definition:	The act or method of moving an object or person.
Property group:	Transport characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Emergency department stay—transport mode Health, Standard 22/12/2011 Non-admitted patient emergency department service episode—transport mode Health, Superseded 22/12/2011

Treatment cessation date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269254
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which the treatment is completed or discontinued; or there has been a change in the principal drug of concern, the main treatment type, or the treatment delivery setting.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of treatment for alcohol and other drugs—treatment cessation date Health, Standard 01/03/2005

Treatment commencement date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269255

Registration status: Health, Standard 01/03/2005

Definition: The date of the first service contact in which an assessment and/or treatment occurred, whichever occurred first.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Episode of treatment for alcohol and other drugs—treatment commencement date Health, Standard 01/03/2005

Treatment type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269107
Registration status:	Health, Standard 01/03/2005
Definition:	The category of health care intervention or therapy.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Episode of treatment for alcohol and other drugs—treatment type Health, Standard 01/03/2005 Episode of treatment for alcohol and other drugs—treatment type (other) Health, Superseded 13/10/2005

Triage category

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269109
Registration status:	Health, Standard 01/03/2005
Definition:	The classification of a patient assigned according to the urgency of their need for medical and/or nursing care.
Context:	Emergency department care
Property group:	Service/care urgency

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—triage category Health, Superseded 29/01/2012 Non-admitted patient emergency department service episode—triage category Health, Superseded 30/01/2012 Non-admitted patient emergency department service episode—triage category Health, Standard 30/01/2012

Triage date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269259
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a patient is assessed to determine the urgency of their problem and priority for care.
Property group:	Service/care urgency

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Non-admitted patient emergency department service episode—triage date Health, Superseded 22/12/2011 Non-admitted patient emergency department service episode—triage date Health, Superseded 30/01/2012 Non-admitted patient emergency department service episode—triage date Health, Standard 30/01/2012 Triage—triage date Health, Superseded 07/12/2005

Triage time

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269360

Registration status: Health, Standard 01/03/2005

Definition: The time on which a patient is assessed to determine the urgency of their problem and priority for care.

Property group: Service/care urgency

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:

Non-admitted patient emergency department service episode—triage time Health, Superseded 22/12/2011

Non-admitted patient emergency department service episode—triage time Health, Superseded 30/01/2012

Non-admitted patient emergency department service episode—triage time Health, Standard 30/01/2012

Triage—triage time Health, Superseded 07/12/2005

Triglyceride level

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	TG; Triacylglycerol
METeOR identifier:	269204
Registration status:	Health, Standard 01/03/2005
Definition:	The amount of triglyceride in the blood.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—triglyceride level Health, Standard 01/03/2005

Troponin assay type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285213
Registration status:	Health, Standard 04/06/2004
Definition:	An indicator of the type of troponin assay.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—troponin assay type Health, Standard 04/06/2004

Troponin level

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285243
Registration status:	Health, Standard 04/06/2004
Definition:	The amount of troponin.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—troponin level Health, Standard 04/06/2004

Troponin level measured date

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 284987

Registration status: Health, Standard 04/06/2004

Definition: The date on which troponin was measured.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—troponin level measured date Health, Standard 04/06/2004

Troponin level measured time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285205
Registration status:	Health, Standard 04/06/2004
Definition:	The time at which troponin was measured.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—troponin level measured time Health, Standard 04/06/2004

Type of acute coronary syndrome related clinical event

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	338250
Registration status:	Health, Standard 01/10/2008
Definition:	Identifies the clinical event which can impact on health outcomes from acute coronary syndrome.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Person with acute coronary syndrome—type of acute coronary syndrome related clinical event Health, Standard 01/10/2008

Type of chronic condition

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	399211
Registration status:	Health, Standard 25/08/2011
Definition:	A type of health condition that is long term; has a pattern of recurrence, or deterioration; has a poor prognosis and produces consequences, or sequelae that impact on the individual's quality of life.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—type of chronic condition Health, Standard 25/08/2011

Type of compensatory payment to other party

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	329784
Registration status:	Health, Standard 07/12/2011
Definition:	A description of the categories of loss for which an other party is compensated.
Property group:	Legal characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Medical indemnity claim—type of compensatory payment to other party Health, Standard 07/12/2011

Type of compensatory payment to patient

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	440487
Registration status:	Health, Standard 07/12/2011
Definition:	A description of the categories of loss for which the patient is compensated.
Property group:	Legal characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Medical indemnity claim—type of compensatory payment to patient Health, Standard 07/12/2011

Type of corrective services facility

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	398991
Registration status:	Health, Standard 25/08/2011
Definition:	A descriptor of the type of legally proclaimed premises in which an offender is held in custody.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Prison entrant—type of corrective services facility Health, Standard 25/08/2011

Type of health or health related function

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	352183
Registration status:	Health, Standard 05/12/2007
Definition:	Type of activity or program provided to prevent or cure disease, care for illness, impairment, disability or handicap, or to support this activity.
Property group:	Organisational characteristics

Relational attributes

Data Element Concepts implementing this Property:	Organisation—type of health or health related function Health, Standard 05/12/2007

Type of opioid pharmacotherapy treatment

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 404783

Registration status: Health, Standard 25/08/2011

Definition: The type of opioid treatment that is based on the administration of drugs.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—type of opioid pharmacotherapy treatment Health, Standard 25/08/2011

Type of service provider consulted

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	376354
Registration status:	Health, Standard 25/08/2011
Definition:	The type of professional who provides a service and/or care in consultation with a patient and/or client.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Health service event—type of service provider consulted Health, Standard 25/08/2011 Prison entrant—type of service provider consulted Health, Standard 25/08/2011

Type of service provider needed but not utilised

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 402816

Registration status: Health, Standard 25/08/2011

Definition: The type of professional who provides a service and/or care whose services were required, but not utilised.

Property group: Service provision event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Prison entrant—type of service provider needed but not utilised Health, Standard 25/08/2011

Type of substance used illicitly

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	365390
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	The type of substance which is possessed illegally, or used in an illegal manner.
Property group:	Lifestyle characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—type of substance used illicitly Community Services, Standard 06/02/2012 Health, Standard 25/08/2011

Type of vaccine administered

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	411902
Registration status:	Health, Standard 25/08/2011
Definition:	The type of vaccine administered for the purpose of inducing immunity in the body.
Property group:	Service provision event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Establishment (prison)—type of vaccine administered Health, Standard 25/08/2011

Type of visit to emergency department

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269300

Registration status: Health, Standard 01/03/2005

Definition: An indicator of the reason for arrival at an emergency department.

Property group: Entry into service event

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Emergency department stay—type of visit to emergency department Health, Standard 22/12/2011

Non-admitted patient emergency department service episode—type of visit to emergency department Health, Superseded 22/12/2011

Underlying cause of acute coronary syndrome

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	338303
Registration status:	Health, Standard 01/10/2008
Definition:	Identifies the condition or acute event, other than the usual risk factors, that precipitated the acute coronary syndrome symptoms.
Property group:	Crisis event

Relational attributes

Data Element Concepts implementing this Property:	Person—underlying cause of acute coronary syndrome Health, Standard 01/10/2008

Underlying cause of death

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	296462
Registration status:	Health, Standard 01/10/2008
Definition:	The disease or injury which initiated the train of events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury. (WHO 2004)
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—underlying cause of death Health, Standard 01/10/2008

Units of blood transfused

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	344792
Registration status:	Health, Standard 01/10/2008
Definition:	The number of blood units transfused.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—units of blood transfused Health, Standard 01/10/2008

Upper limit of normal range for creatine kinase isoenzyme

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	349625
Registration status:	Health, Standard 01/10/2008
Definition:	The value of creatine kinase isoenzyme that is the upper boundary of the normal reference range.
Property group:	Organisational characteristics

Relational attributes

Data Element Concepts implementing this Property:	Laboratory standard—upper limit of normal range for creatine kinase isoenzyme Health, Standard 01/10/2008

Upper limit of normal range for creatine kinase myocardial band isoenzyme

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 284925

Registration status: Health, Standard 04/06/2004

Definition: The value of creatine kinase myocardial band (CK-MB) isoenzyme that is the upper boundary of the normal reference range.

Property group: Organisational characteristics

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Data Element Concepts implementing this Property: Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme Health, Standard 04/06/2004

Upper limit of normal range for microalbumin

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269283

Registration status: Health, Standard 01/03/2005

Definition: The value of microalbumin that is the upper boundary of the normal reference range.

Property group: Organisational characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Laboratory standard—upper limit of normal range for microalbumin Health, Standard 01/03/2005

Upper limit of normal range of glycosylated haemoglobin

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269282
Registration status:	Health, Standard 01/03/2005
Definition:	The value of glycosylated haemoglobin (HbA1c) that is the upper boundary of the normal reference range.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Laboratory standard—upper limit of normal range of glycosylated haemoglobin Health, Standard 01/03/2005

Upper limit of normal range of troponin assay

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	285227
Registration status:	Health, Standard 04/06/2004
Definition:	The value of `troponin T' or `troponin I' that is the upper boundary of the normal reference range.
Property group:	Organisational characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Laboratory standard—upper limit of normal range of troponin assay Health, Standard 04/06/2004

Vascular condition status

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269070
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of conditions of blood vessels of the body.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—vascular condition status Health, Standard 01/03/2005

Vascular procedure

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269072
Registration status:	Health, Standard 01/03/2005
Definition:	Interventions pertaining to the vascular system
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—vascular procedure Health, Standard 01/03/2005

Ventricular ejection fraction test date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	344270
Registration status:	Health, Standard 01/10/2008
Definition:	The date on which the ventricular ejection fraction is measured.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Ventricular ejection fraction test—test date Health, Standard 01/10/2008

Ventricular ejection fraction test performed indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	347667
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether a test was performed to measure the amount of blood pumped out of the ventricles per heart beat.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Person—ventricular ejection fraction test performed indicator Health, Standard 01/10/2008

Ventricular ejection fraction test result

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	346986
Registration status:	Health, Standard 01/10/2008
Definition:	The result from the test to measure ventricular ejection fraction.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Ventricular ejection fraction—test result Health, Standard 01/10/2008

Ventricular ejection fraction test time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	349813
Registration status:	Health, Standard 01/10/2008
Definition:	The time when the ventricular ejection fraction test is performed.
Property group:	Service provision event

Relational attributes

Data Element Concepts implementing this Property:	Ventricular ejection fraction—test time Health, Standard 01/10/2008

Ventricular ejection fraction test type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	344247
Registration status:	Health, Standard 01/10/2008
Definition:	The type of test used to measure the amount of blood pumped out of a ventricle per heart beat.
Property group:	Health and wellbeing

Relational attributes

Data Element Concepts implementing this Property:	Ventricular ejection fraction test—test type Health, Standard 01/10/2008

Visa type

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	375179
Registration status:	Health, Standard 10/12/2009
Definition:	The category of visa (or travel authority) granted by Australia for foreign nationals (excluding New Zealand citizens) to travel to, enter and remain in Australia.
Property group:	Legal characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Further information regarding visas can be obtained from the Australian Department of Immigration and Citizenship or visit their website www.immi.gov.au

Relational attributes

Data Element Concepts implementing this Property:	Registered health professional—visa type Health, Standard 10/12/2009

Visual acuity

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269073
Registration status:	Health, Standard 01/03/2005
Definition:	Sharpness or acuteness of vision.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

Data Element Concepts implementing this Property:	Person—visual acuity Health, Standard 01/03/2005

Waist circumference

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 269145

Registration status: Health, Standard 01/03/2005

Definition: The distance around the human body between the ribs and the hips.

Property group: Physical characteristics

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Person—waist circumference Health, Standard 01/03/2005

Waist circumference risk indicator

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	Abdominal obesity risk indicator
METeOR identifier:	269195
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the level of the risk of metabolic complications associated with excess abdominal adiposity.
Property group:	Health and wellbeing

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Adult—waist circumference risk indicator Health, Standard 01/03/2005

Waist-to-hip ratio

Identifying and definitional attributes

Metadata item type:	Property
Synonymous names:	WHR
METeOR identifier:	269196
Registration status:	Health, Standard 01/03/2005
Definition:	The division of waist circumference by hip circumference.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Adult—waist-to-hip ratio Health, Standard 01/03/2005

Waiting list removal date

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269113
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a person is removed from a waiting list.
Property group:	Entry into service event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—waiting list removal date Health, Standard 01/03/2005

Waiting time

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269063
Registration status:	Health, Standard 01/03/2005
Definition:	The time elapsed between a service request and a subsequent administrative or service event.
Property group:	Performance indicators

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Elective surgery waiting list episode—waiting time Health, Standard 01/03/2005 Emergency department stay—waiting time (to commencement of clinical care) Health, Standard 22/12/2011 Non-admitted patient emergency department service episode—waiting time Health, Superseded 22/12/2011 Non-admitted patient emergency department service episode—waiting time (to hospital admission) Health, Standard 01/03/2005

Weight

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269197
Registration status:	Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011
Definition:	A measurement of body mass.
Property group:	Physical characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Adult—weight Health, Superseded 14/07/2005 Person—weight Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011

Work sector in registered health profession

Identifying and definitional attributes

Metadata item type: Property

METeOR identifier: 375310

Registration status: Health, Standard 10/12/2009

Definition: Whether employment in a registered health profession is in the private or the public sector.

Property group: Labour characteristics

Collection and usage attributes

Comments: This property differentiates between establishments run by the government sector and establishments that receive some government funding but are run by the non-government sector.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property: Registered health professional—work sector in registered health profession Health, Standard 10/12/2009

Work setting

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	375396
Registration status:	Health, Standard 10/12/2009
Definition:	The type of service setting or other organisation arrangement in which the work was undertaken.
Property group:	Labour characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Registered health professional—work setting Health, Standard 10/12/2009

Working partnership indicator

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	290692
Registration status:	Health, Standard 05/12/2007
Definition:	An indicator of whether an agency has formal working partnership(s) with other service provider(s) or organisation(s).
Property group:	Organisational characteristics

Relational attributes

Data Element Concepts implementing this Property:	Service provider organisation—working partnership indicator Health, Standard 05/12/2007

Year of first arrival in Australia

Identifying and definitional attributes

Metadata item type:	Property
METeOR identifier:	269050
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 23/08/2010 Health, Standard 04/05/2005 Homelessness, Standard 23/08/2010
Definition:	The calendar year in which an individual first arrived in Australia.
Property group:	Demographic/social/cultural characteristics

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Property:	Person—year of first arrival in Australia Community Services, Standard 01/03/2005 Housing assistance, Standard 23/08/2010 Health, Standard 04/05/2005 Homelessness, Standard 23/08/2010

Classifications

Australian and New Zealand Standard Classification of Occupations, First edition, 2006

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ANZSCO 1st edition
METeOR identifier:	350882
Registration status:	Community Services, Standard 27/03/2007 Health, Standard 04/07/2007
Definition:	The Australian Bureau of Statistics (ABS) classification for occupations.

Classification structure:

The structure of ANZSCO has five hierarchical levels - major group, sub-major group, minor group, unit group and occupation. The categories at the most detailed level of the classification are termed ‘occupations’. These are grouped together to form ‘unit groups’, which in turn are grouped into ‘minor groups’. Minor groups are aggregated to form ‘sub-major groups’ which in turn are aggregated at the highest level to form ‘major groups’.

These are the same hierarchical levels that are used in ASCO Second Edition and NZSCO 1999.

Conceptual model

ANZSCO is a skill-based classification used to classify all occupations and jobs in the Australian and New Zealand labour markets.

To do this, ANZSCO identifies a set of occupations covering all jobs in the Australian and New Zealand labour markets, defines these occupations according to their attributes and groups them on the basis of their similarity into successively broader categories for statistical and other types of analysis. The individual objects classified in ANZSCO are jobs.

In ANZSCO, occupations are organised into progressively larger groups on the basis of their similarities in terms of both skill level and skill specialisation.

The conceptual model adopted for ANZSCO uses a combination of skill level and skill specialisation as criteria to design major groups which are meaningful and useful for most purposes. The eight major groups are formed by grouping together sub-major groups using aspects of both skill level and skill specialisation. In designing the major groups, intuitive appeal and usefulness in both statistical and administrative applications were also important considerations.

The skill level criterion is applied as rigorously as possible at the second level of the classification, the sub-major group level, together with a finer application of skill specialisation than that applied at the major group level. Each sub-major group is made up of a number of minor groups.

Minor groups are distinguished from each other mainly on the basis of a finer application of skill specialisation than that applied at the sub-major group level. Within minor groups, unit groups are distinguished from each other on the basis of skill specialisation and, where necessary, skill level.

Virtually all unit groups are at one skill level. There are only eight unit groups which contain occupations at more than one skill level. In all but two of these unit groups, the vast majority of jobs classified to the unit group are at one skill level only. Data stored at unit group level can therefore be aggregated by skill level with a high degree of validity.

Within unit groups, the distinction between occupations amounts to differences between tasks performed in occupations. All occupations are at one skill level.

As a result, data classified at the major group level will provide only a broad indication of skill level. Data at the sub-major group level will provide a satisfactory indication of skill level for many analytical purposes. Data classified at the unit group level will provide an accurate indication of skill level. Unit groups can, therefore, be aggregated by skill level to provide an indicative measure of occupations classified by skill level.

Source and reference attributes

Origin:

Australian Bureau of Statistics 2006. Australian and New Zealand Standard Classification of Occupations, First Edition, Cat no. 1220.0 Canberra: ABS. Viewed 13 March 2007.

Relational attributes

Related metadata references:

Supersedes Australian Standard Classification of Occupations 2nd edition Community Services, Superseded 27/03/2007, Housing assistance, Standard 01/03/2005, Health, Superseded 04/07/2007

Value Domains based on this Classification Scheme:

Occupation code (ANZSCO 1st edition) N[NNN]{NN}
Community Services, Standard 27/03/2007
Housing assistance, Standard 10/08/2007
Health, Standard 04/07/2007
Tasmanian Health, Proposed 28/09/2011

Australian Classification of Health Interventions (ACHI) 7th edition

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ACHI 7th edn
METeOR identifier:	391343
Registration status:	Health, Standard 22/12/2009
Definition:	The National Centre for Classification in Health classification of health interventions.
Classification structure:	ACHI is comprised of: • Tabular List of Interventions - contains seven character code in the format xxxxx-xx. Generally, the first five characters represent the MBS item number and the last two characters are allocated for each procedural concept derived from the MBS item description. Two appendices are specified: Mapping table; and ACHI codes listed in numerical order. • Alphabetic Index of Interventions - is an alphabetic index to the ACHI Tabular List of Interventions that contains many more procedural terms than those appearing in the ACHI Tabular List.

Source and reference attributes

Origin:	National Centre for Classification in Health (NCCH) 2010. The Australian Classification of Health Interventions (ACHI) – Seventh Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney. ACHI 7th edition is available for purchase from the National Casemix and Classification Centre (NCCC). Please see the following link for product information http://nccc.uow.edu.au/productservices/icd10am/index.html.
Revision status:	ACHI was developed by the National Centre for Classification in Health (NCCH). During the development, the NCCH was advised by members of the NCCH Coding Standards Advisory Committee (CSAC) and the Clinical Classification and Coding Groups (CCCG), consisting of expert clinical coders and clinicians nominated by the Clinical Casemix Committee of Australia.

Relational attributes

Related metadata references:	Supersedes Australian Classification of Health Interventions (ACHI) 6th edition Health, Superseded 22/12/2009

Value Domains based on this Classification Scheme:	Elective care type code N Health, Standard 13/12/2011 Indicator procedure code NN Health, Standard 13/12/2011 Procedure code (ACHI 7th edn) NNNNN-NN Health, Standard 22/12/2009 Tasmanian Health, Proposed 28/09/2011

Australian Refined Diagnosis Related Groups version 6

Identifying and definitional attributes

Metadata item type: Classification Scheme

Synonymous names: AR-DRG v 6

METeOR identifier: 391288

Registration status: Health, Standard 22/12/2009

Definition: The Commonwealth Department of Health and Ageing classification for the reasons for hospitalisation and the complexity of cases that a hospital treats.

Collection and usage attributes

Comments: The Australian Refined Diagnosis Related Groups are derived from a range of data collected on admitted patients, including diagnosis and procedure information, classified using ICD-10-AM.

Relational attributes

Related metadata references: Supersedes Australian Refined Diagnosis Related Groups version 5.1 Health, Superseded 22/12/2009

Value Domains based on this Classification Scheme: Diagnosis related group code (AR-DRG v 6) ANNA Health, Standard 22/12/2009
Tasmanian Health, Proposed 28/09/2011

Major diagnostic category code (AR-DRG v 6) NN Health, Standard 22/12/2009
Tasmanian Health, Proposed 28/09/2011

Australian Standard Classification of Drugs of Concern 2011

Identifying and definitional attributes

Metadata item type: Classification Scheme

Synonymous names: ASCDC 2011

METeOR identifier: 466899

Registration status: Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Definition: The Australian Bureau of Statistics’ classification for data relating to drugs which are considered to be of concern in Australian society.

Classification structure: The main classification of the ASCEDC has a three level hierarchical structure. It is essentially a classification of type of drug of concern based on the chemical structure, mechanism of action and effect on physiological activity of the drugs of concern.

Collection and usage attributes

Guide for use: Indexes in alphabetical and numerical order are available, see the *Origin:* attribute.

Source and reference attributes

Steward: Australian Bureau of Statistics (ABS)

Origin: The Australian Standard Classification of Drugs of Concern (ASCDC). ABS Cat No. 1248.0 (2011)

Relational attributes

Related metadata references: Supersedes Australian Standard Classification of Drugs of Concern 2000 Health, Superseded 07/12/2011

Value Domains based on this Classification Scheme: Drug of concern (ASCDC 2011 extended) code NNNN
Community Services, Standard 06/02/2012
Health, Standard 07/12/2011

Australian Standard Classification of Languages 2011

Identifying and definitional attributes

Metadata item type: Classification Scheme

Synonymous names: ASCL 2011

METeOR identifier: 460114

Registration status: Community Services, Standard 17/11/2011
Housing assistance, Standard 17/11/2011
Health, Standard 17/11/2011
Homelessness, Standard 17/11/2011

Definition: The Australian Bureau of Statistics (ABS) classification for the languages spoken by Australians.

Classification structure: The Australian Standard Classification of Languages (ASCL) has a three-level hierarchical structure.

Languages are grouped together into progressively broader categories on the basis of their evolution from a common ancestral language, and on the basis of geographic proximity of areas where a particular language originated.

Collection and usage attributes

Guide for use: The ASCL is intended for use in the collection, aggregation and dissemination of data relating to the language use of the Australian population, or subsets of the population.

Indexes in alphabetical and numerical order are available, see the *Origin:* attribute.

Source and reference attributes

Origin: Australian Bureau of Statistics 2005. *Australian Standard Classification of Languages (ASCL) 2011*. Cat No. 1267.0. Canberra: ABS. 16/8/2011.

Revision status: If you require further information about this classification please email: social.classifications@abs.gov.au or telephone the Standards Support Hotline on (02) 6252 5736.

Relational attributes

Related metadata references: Supersedes Australian Standard Classification of Languages 2005 Community Services, Superseded 17/11/2011, Housing assistance, Standard 10/02/2006, Health, Superseded 17/11/2011

Value Domains based on this Classification Scheme: Language code (ASCL 2011) NN{NN} Community Services, Standard 13/10/2011
Housing assistance, Standard 13/10/2011
Health, Standard 13/10/2011

Australian Standard Geographical Classification 2011

Identifying and definitional attributes

Metadata item type: Classification Scheme

Synonymous names: ASGC 2011

METeOR identifier: 455481

Registration status: Community Services, Standard 26/10/2011
Health, Standard 22/11/2011
Early Childhood, Proposed 14/07/2011

Definition: The Australian Bureau of Statistics classification for the classification of geographical locations.

Source and reference attributes

Origin: Australian Bureau of Statistics 2006. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS. Viewed on 14/07/2011

Relational attributes

Related metadata references: Supersedes Australian Standard Geographical Classification 2010 Community Services, Superseded 26/10/2011, Health, Superseded 22/11/2011

Value Domains based on this Classification Scheme: Geographical location code (ASGC 2011) NNNNN
Community Services, Standard 21/02/2012
Health, Standard 22/11/2011
Early Childhood, Standard 09/03/2012

Australian Statistical Geography Standard 2011

Identifying and definitional attributes

Metadata item type: Classification Scheme

Synonymous names: ASGS 2011

METeOR identifier: 437772

Registration status: Community Services, Standard 06/12/2011
Health, Standard 07/12/2011

Definition: The Australian Bureau of Statistics framework for statistical geography. The main purpose of the Australian Statistical Geography Standard (ASGS) is the dissemination of geographically classified statistics. It provides a common framework of statistical geography which enables the publication of statistics that are comparable and spatially integrated.

Context: From July 2011, the ABS will progressively replace the current Australian Standard Geographical Classification (ASGC) with the Australian Statistical Geography Standard (ASGS) as its geographical framework.

Classification structure: The ASGS classification structures are split into two broads groups, the ABS Structures and the Non-ABS Structures.

The ABS Structures are hierarchies of regions defined and maintained by the ABS. The regions that comprise the ABS Structures will remain unchanged until the next Census of Population and Housing in 2016.

The Non-ABS Structures are hierarchies of regions which are not defined or maintained by the ABS, but for which the ABS is committed to providing a range of statistics. They generally represent administrative units such as Postcode and Local Government Areas.

The ABS Structures are built directly from mesh blocks. Non-ABS Structures are approximated by mesh blocks, the Statistical Areas Level 1 (SA1s), or the Statistical Areas Level 2 (SA2s).

The ABS Structures comprise six interrelated hierarchies of regions. They are:

- Main Structure
- Indigenous Structure
- Urban Centres and Localities/Section of State Structure
- Remoteness Area Structure
- Greater Capital City Statistical Area (GCCSA) Structure
- Significant Urban Area Structure.

The Non-ABS Structures comprise eight hierarchies of regions which are not defined or maintained by the ABS, but for which the ABS is committed to providing a range of statistics. They generally represent administrative regions and are approximated by mesh blocks, SA1s or SA2s. They are:

- Local Government Areas (LGAs)
- Postal Areas
- State Suburbs
- Commonwealth Electoral Divisions
- State Electoral Divisions
- Australian Drainage Divisions
- Natural Resource Management Regions
- Tourism Regions.

Source and reference attributes

Origin:

Australian Bureau of Statistics 2011. 1270.0.55.001 - Australian Statistical Geography Standard (ASGS): Volume 1 - Main Structure and Greater Capital City Statistical Areas, July 2011 http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1270.0.55.001July%202011?OpenDocument

Canberra: ABS. Viewed on 15/07/2011.

Relational attributes

Value Domains based on this Classification Scheme:

Statistical area level 2 (SA2) code (ASGS 2011) N(9) Community Services, Standard 06/12/2011
Health, Standard 07/12/2011

British Paediatric Association Classification of Diseases 1979

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	BPA 1979
METeOR identifier:	270559
Registration status:	Health, Standard 01/03/2005
Definition:	The British Paediatric Association classification system for the classification of diseases.

Relational attributes

Value Domains based on this Classification Scheme:	Congenital malformations code (BPA 1979) ANN.N[N] Health, Standard 01/03/2005

International Classification of Diseases for Oncology 3rd edition

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ICDO-3
METeOR identifier:	270553
Registration status:	Health, Standard 01/03/2005
Definition:	The World Health Organization's classification for coding the topography and the morphology of the neoplasm.

Source and reference attributes

Origin:	International Classification of Diseases for Oncology, Third Edition

Relational attributes

Value Domains based on this Classification Scheme:	Morphology of cancer code (ICD-O-3) NNNN/N Health, Standard 07/12/2011 Morphology of cancer code (ICDO-3) NNNN/N Health, Superseded 07/12/2011 Primary site of cancer code (ICDO-3) ANN{.N[N]} Health, Superseded 07/12/2011 Topography code (ICD-O-3) ANN.N Health, Standard 07/12/2011 Topography code (ICD0-3) ANN Health, Standard 13/06/2004

International Classification of Functioning, Disability and Health 2001

Identifying and definitional attributes

Metadata item type: Classification Scheme

Synonymous names: ICF 2001

METeOR identifier: 270548

Registration status: Community Services, Standard 01/12/2004
Health, Standard 23/02/2005

Definition: The World Health Organization's (WHO) system for classifying functioning, disability and health.

Collection and usage attributes

Comments: The International Classification of Functioning, Disability and Health (ICF) was endorsed by the World Health Assembly in 2001 and is a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

Source and reference attributes

Origin: World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health. Geneva: WHO

Reference documents: Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide Version 1.0 (AIHW 2003), at the following websites:

- WHO ICF website: http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website: http://www.aihw.gov.au/disability/icf/index.cfm

Relational attributes

Value Domains based on this Classification Scheme: Activities and participation code (ICF 2001) AN[NNN] Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Activity difficulty level code (ICF 2001) N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Activity need for assistance code N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Body function code (ICF 2001) AN[NNNN] Community Services, Standard 16/10/2006

Health, Standard 29/11/2006

Body structure code (ICF 2001) AN[NNNN] Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Environmental factor code (ICF 2001) AN[NNN] Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Extent of environmental factors influence code (ICF 2001) [X]N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Impairment extent code (ICF 2001) N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Impairment location code (ICF 2001) N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Impairment nature code (ICF 2001) N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Participation extent code (ICF 2001) N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, (2nd edition)

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ICD-10
METeOR identifier:	352607
Registration status:	Health, Standard 01/10/2008
Definition:	The World Health Organisation classification for diseases and related health problems
Classification structure:	ICD-10 is comprised of three volumes: • Tabular List of Diseases • Instruction manual • Alphabetical index

Source and reference attributes

Origin:	World Health Organisation 2004. The International statistical classification of diseases and related health problems, Tenth revision, (2nd edn). Geneva: World Health Organisation. (viewed 16/05/2007)

Relational attributes

Value Domains based on this Classification Scheme:	Underlying cause of death code (ICD-10 2nd edn) ANN-ANN Health, Standard 01/10/2008

International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition

Identifying and definitional attributes

Metadata item type: Classification Scheme

Synonymous names: ICD-10-AM 7th edn

METeOR identifier: 391301

Registration status: Health, Standard 22/12/2009

Definition: The National Centre for Classification in Health classification of diseases and related health problems

Classification structure: ICD-10-AM is comprised of:

- Tabular List of Diseases - contains core three character codes with some expansion to four and five character codes. Two appendices are specified: Morphology of neoplasms; and Special tabulation lists for mortality and morbidity.
- Alphabetic Index of Diseases - consists of three sections: Section I is the index of diseases, syndromes, pathological conditions, injuries, signs, symptoms, problems and other reasons for contact with health services. Section II is the index of external causes of injury. The terms included here are not medical diagnoses but descriptions of the circumstances in which the violence occurred. Section III is the index of drugs and other chemical substances giving rise to poisoning or other adverse effects (also known as the Table of drugs and chemicals).

Source and reference attributes

Origin: National Centre for Classification in Health (NCCH) 2010. The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) – Seventh Edition - Tabular list of diseases and Alphabetic index of diseases. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.

Revision status: ICD-10-AM was developed by the National Centre for Classification in Health (NCCH). During the development, the NCCH was advised by members of the NCCH Coding Standards Advisory Committee (CSAC) and the Clinical Classification and Coding Groups (CCCG), consisting of expert clinical coders and clinicians nominated by the Clinical Casemix Committee of Australia.

Relational attributes

Related metadata references:

Supersedes International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition Health, Superseded 22/12/2009

Value Domains based on this Classification Scheme:

Activity type code (ICD-10-AM 7th edn) ANNNN Health, Standard 22/12/2009

Congenital malformations code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

Diagnosis code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009
Tasmanian Health, Proposed 28/09/2011

External cause code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

Neonatal morbidity code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

Place of occurrence (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

Pregnancy/childbirth and puerperium code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

Primary site of cancer code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

International Union against Cancer (UICC) TNM Classification of Malignant Tumours 7th edition

Identifying and definitional attributes

Metadata item type: Classification Scheme

METeOR identifier: 403583

Registration status: Health, Standard 07/12/2011

Definition: The International Union Against Cancer classification for malignant tumours.

Source and reference attributes

Submitting organisation: Cancer Australia.

Reference documents: Sobin LH, Gospodarowicz M, Wittekind C, (editors), International Union Against Cancer (UICC). TNM Classification of Malignant Tumours. 7th ed. Hoboken, NJ: Wiley-Blackwell; 2010.

Relational attributes

Related metadata references:

Supersedes International Union against Cancer (UICC) TNM Classification of Malignant Tumours 6th edition Health, Superseded 07/12/2011

Supersedes International Union against Cancer TNM Classification of Malignant Tumours 5th edition Health, Superseded 06/03/2009

Value Domains based on this Classification Scheme:

M stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011

N stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011

T stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XXX] Health, Standard 07/12/2011

TNM stage (UICC TNM Classification of Malignant Tumours, 7th ed) code X[XX] Health, Standard 07/12/2011

North American Nursing Diagnosis Association (NANDA) Taxonomy 1997-1998

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	NANDA 1997-98
METeOR identifier:	270555
Registration status:	Health, Standard 01/03/2005
Definition:	The North American Nursing Diagnosis Association's (NANDA) 1997-1998 classification for nursing diagnoses.

Source and reference attributes

Origin:	North American Nursing Diagnosis Association (NANDA) Nursing Diagnoses: Definitions and Classification 1997-1998. (1997) NANDA

Relational attributes

Value Domains based on this Classification Scheme:	Nursing diagnosis code (NANDA 1997-98) N.N[{.N}{.N}{.N}{.N}] Health, Standard 01/03/2005

Postcode datafile

Identifying and definitional attributes

Metadata item type:	Classification Scheme
METeOR identifier:	270561
Registration status:	Community Services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006 Health, Standard 01/03/2005
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a party (person or organisation), as defined by Australia Post.
Context:	Postcode is an important part of a persons or organisations postal address and facilitates written communication. It is one of a number of geographic identifiers that can be used to determine a geographic location. Postcode may assist with uniquely identifying a person or organisation.

Collection and usage attributes

Guide for use:	The postcode book is updated more than once annually as postcodes are dynamic entities and are constantly changing.

Source and reference attributes

Origin:	Australia Post Postcode book. Reference through: http://www1.auspost.com.au/postcodes/

Relational attributes

Value Domains based on this Classification Scheme:	Australian postcode code (Postcode datafile) NNN[N] Community Services, Superseded 25/08/2005 Health, Superseded 04/05/2005 Australian postcode code (Postcode datafile) {NNNN} Community Services, Superseded 06/02/2012 Housing assistance, Standard 10/02/2006 Health, Superseded 07/12/2011 Early Childhood, Superseded 09/03/2012 Homelessness, Standard 23/08/2010 Tasmanian Health, Proposed 28/09/2011 Australian postcode code (Postcode datafile) {NNNN} Community Services, Standard 06/02/2012 Health, Standard 07/12/2011 Early Childhood, Standard 09/03/2012

Standard Australian Classification of Countries 2011

Identifying and definitional attributes

Metadata item type: Classification Scheme

Synonymous names: SACC 2011

METeOR identifier: 459967

Registration status: Community Services, Standard 17/11/2011
Housing assistance, Standard 17/11/2011
Health, Standard 17/11/2011
Homelessness, Standard 17/11/2011

Definition: The Australian Bureau of Statistics classification for countries.

Collection and usage attributes

Comments: The Standard Australian Classification of Countries 2011 (SACC) Edition 1 supersedes the Australian Standard Australian Classification of Countries 2008 (SACC) Edition 2.

Source and reference attributes

Origin: Australian Bureau of Statistics 2011. Standard Australian Classification of Countries 2011 (SACC). Cat No. 1269.0. Canberra: ABS (last viewed 22 August 2011)

Relational attributes

Related metadata references: Supersedes Standard Australian Classification of Countries 2008 Community Services, Superseded 22/11/2011, Housing assistance, Superseded 22/11/2011, Health, Superseded 22/11/2011

Value Domains based on this Classification Scheme: Country code (SACC 2011) NNNN Community Services, Standard 13/10/2011
Housing assistance, Standard 13/10/2011
Health, Standard 13/10/2011
Homelessness, Standard 13/10/2011

The Anatomical, Therapeutic, Chemical Classification System with Defined Daily Doses (ATC/DDD)

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	The ATC/DDD system
METeOR identifier:	334667
Registration status:	Health, Standard 07/12/2005
Definition:	The ATC/DDD system classifies therapeutic drug utilisation. The purpose of the ATC/DDD system is to serve as a tool for drug utilization research in order to improve quality of therapeutic drug use.
Classification structure:	In the ATC/DDD classification system, drugs are divided into different groups according to the organ or system on which they act and their chemical, pharmacological and therapeutic properties. Drugs are classified into five different levels. Drug consumption statistics (international and other levels) can be presented for each of these five levels.

Collection and usage attributes

Comments:	The Anatomical therapeutic classification (AT) was developed by the European Pharmaceutical Market Research Association (EPhMRA). The ATC/DDD system and the AT classification have the same origin, but are developed for different purposes. Comparative tables are available. The ATC classification used the International Nonproprietary Name (INN) whenever possible.

Source and reference attributes

Reference documents:	The Guidelines for ATC classification and DDD assignment were published for the first time in the current format in 1990. The Guidelines are published in all 3 languages in paper format only. The Index was published as a paper copy in the current format in 1990 for the first time. The Index is published in the following languages and formats: English (all available indexes), German (paper version only), Spanish (paper version only). An online searchable database is also available at http://www.whocc.no/atcddd/.
Revision status:	The system has been used for statistics since 1975.

Years between revisions - 1

Year of last revision - 2004

Latest revision number - 6 for the Guidelines in the current format, 13 for the Index in the current format.

Relational attributes

Value Domains based on this Classification Scheme:	Medication type (ATC/DDD) code A[{NN}AA{NN}] Health, Standard 25/08/2011

Glossary items

Activity—functioning, disability and health

Identifying and definitional attributes

Metadata item type: Glossary Item

Synonymous names: Activity

METeOR identifier: 327296

Registration status: Community Services, Standard 01/03/2005
Health, Standard 29/11/2006

Definition: In the context of health, an activity is the execution of a task or action by an individual.

Context: 'Activities and participation' is one of three components that define the concept 'Disability', along with 'Body functions and structures' and 'Environmental factors'. 'Activities and participation' is also encompassed within the concept 'Functioning'.

The concept 'Activity', as defined here and as measured in the metadata item Activity difficulty level code (ICF) N, may be relevant to people and human services not related to disability.

Collection and usage attributes

Comments: Activity limitations are difficulties an individual has in the execution of an activity.

The performance of an activity is what the individual does in his or her current environment. The environment includes all aspects of the physical, social and attitudinal world. Activity limitation varies with the environment and is assessed in relation to a particular environment and in the absence or presence of assistance, including aids and equipment.

In time, a related and more generic data element may be developed. In the meantime, the addition of 'functioning, disability and health' to the concept of 'ability' indicates that the current concept is based on the concept and framework developed by World Health Organization to assist in the classification and description of functioning and disability, as contained in the ICF.

The ICF recognises two constructs that can be used with 'Activities and Participation': performance and capacity. 'Performance' is what the person does in their usual environment. 'Capacity' describes 'an individual's ability to execute a task or an action in a standardised environment, where a standardised environment may be:

- an actual environment commonly used for assessment in test settings; or
- in cases where this is not possible, an assumed environment which can be thought to have a uniform impact' (WHO 2001).

The standardised environment has not been generally operationalised. However, the recognition of these two constructs in the ICF underscores the importance of recording the environment in which activities are being performed.

This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002). The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd Ed) ANN{.N[N} and Episode of care additional diagnosis, code (ICD-10-AM 3rd Ed) ANN{.N[N}.

Source and reference attributes

Origin:

World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites
• WHO ICF website
http://www.who.int/classifications/icf/en
• Australian Collaborating Centre ICF website
http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Related metadata references:

Supersedes Activity - functioning, disability and health, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (17.9 KB)

Metadata items which use this glossary item:

Activities and participation code (ICF 2001) AN[NNN] Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Activity difficulty level code (ICF 2001) N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Disability Community Services, Standard 01/03/2005
Housing assistance, Standard 01/03/2005
Health, Standard 29/11/2006

Extent of environmental factors influence code (ICF 2001) [X]N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Functioning and Disability DSS Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Address

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327278

Registration status: Community Services, Standard 08/05/2006
Housing assistance, Recorded 13/10/2011
Health, Standard 01/03/2005

Definition: The referential description of a location where an entity is located or can be otherwise reached or found.

Collection and usage attributes

Comments: The following attributes are commonly used in the formation of a full address:

- Address line; (address line is a composite data element containing many attributes of the specific location of a full address - see the current version of the Address line metadata item for further description and a list of its components for addresses located in Australia)
- Address type
- Australian state/territory identifier
- Country identifier
- Non-Australian State/province
- Postal delivery point identifier
- Postcode - Australian
- Postcode - international
- Suburb/town/locality

Some attributes of an address, located within Australia, also provide the elements to determine the **Statistical Local Are**a (SLA). This enables:

- comparison of the use of services by persons residing in different geographical areas,
- characterisation of catchment areas and populations for facilities for planning purposes, and
- documentation of provision of services to clients who reside in other states or territories. The address is also a relevant element in the unambiguous identification of a Health Care Client and a Health Care Provider.

Source and reference attributes

Submitting organisation: Health Data Standards Committee

Reference documents: AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2004, Sydney:

Standards Australia

Relational attributes

Related metadata references:

Supersedes Address, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.3 KB)

Metadata items which use this glossary item:

Person (address)—address line, text [X(180)] Community Services, Standard 30/09/2005
Health, Standard 04/05/2005

Service provider organisation (address)—address line, text [X(180)] Community Services, Standard 30/09/2005
Housing assistance, Recorded 13/10/2011
Health, Standard 04/05/2005
Early Childhood, Standard 21/05/2010

Administrative and clerical staff

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327166

Registration status: Health, Standard 01/03/2005

Definition: Staff engaged in administrative and clerical duties. Medical staff and nursing staff, diagnostic and health professionals and any domestic staff primarily or partly engaged in administrative and clerical duties are excluded. Civil engineers and computing staff are included in this category.

Relational attributes

Metadata items which use this glossary item:

Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (administrative and clerical staff) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (administrative and clerical staff), average N[NNN{.N}] Health, Standard 01/03/2005

Establishment—recurrent expenditure (salaries and wages) (administrative and clerical staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Admission

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327206

Registration status: Health, Standard 01/03/2005

Definition: Admission is the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical.

Formal admission:

The administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient.

Statistical admission:

The administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within one hospital stay.

Context: Admitted patient care

Collection and usage attributes

Comments: This treatment and/or care provided to a patient following admission occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

Source and reference attributes

Submitting organisation: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Admission, version 3, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)

Metadata items which use this glossary item: Accommodation type prior to admission code N Health, Standard 01/03/2005

Acute hospital and private psychiatric hospital admission labour force status code N Health, Standard 01/03/2005

Admission urgency status Health, Standard 01/03/2005

Admission urgency status code N Health, Standard 01/03/2005

Admitted patient Health, Standard 01/03/2005

Admitted patient care NMDS Health, Superseded 07/12/2005

Admitted patient care NMDS 2006-2007 Health,

Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Admitted patient care NMDS 2010-2011 Health, Superseded 18/01/2011

Admitted patient care NMDS 2011-2012 Health, Superseded 11/04/2012

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Admitted patient hospital stay Health, Standard 01/03/2005

Tasmanian Health, Proposed 28/09/2011

Clinical urgency code N Health, Standard 01/03/2005

Episode of admitted patient care—admission urgency status Health, Standard 01/03/2005

Episode of admitted patient care—admission urgency status, code N Health, Standard 01/03/2005

Episode of admitted patient care—elected accommodation status Health, Superseded 28/11/2006

Episode of admitted patient care—elected accommodation status, code N Health, Superseded 23/10/2006

Episode of admitted patient care—intended length of hospital stay Health, Standard 01/03/2005

Episode of admitted patient care—intended length of hospital stay, code N Health, Standard 01/03/2005

Episode of admitted patient care—patient election status Health, Standard 28/11/2006

Episode of admitted patient care—patient election status, code N Health, Standard 23/10/2006

Episode of care—funding eligibility indicator (Department of Veterans Affairs), code N Health, Standard 01/03/2005

Establishment—specialised service indicator (geriatric assessment unit), yes/no code N Health, Standard 01/03/2005

Health or health related function code NNN Health, Standard 05/12/2007

Non-admitted patient Health, Standard 01/03/2005

Non-admitted patient emergency department service episode—waiting time (to hospital admission) Health, Standard 01/03/2005

Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005

Nursing diagnosis Health, Standard 01/03/2005

Patient—previous specialised treatment Health, Standard 01/03/2005

Patient—previous specialised treatment, code N Health, Standard 01/03/2005

Person—accommodation type (prior to admission), code N Health, Standard 01/03/2005

Person—labour force status, acute hospital and private psychiatric hospital admission code N Health, Standard 01/03/2005

Person—labour force status, public psychiatric hospital admission code N Health, Standard 01/03/2005

Person—reason for readmission following acute coronary syndrome episode Health, Standard 04/06/2004

Person—reason for readmission following acute coronary syndrome episode Health, Standard 01/10/2008

Person—reason for readmission following acute coronary syndrome episode, code N[N] Health, Superseded 01/10/2008

Person—reason for readmission following acute coronary syndrome episode, code N[N] Health, Standard 01/10/2008

Previous specialised treatment code N Health, Standard 01/03/2005

Public psychiatric hospital admission labour force status code N Health, Standard 01/03/2005

Reason for readmission following acute coronary syndrome episode code N[N] Health, Standard 01/10/2008

Reason for readmission following acute coronary syndrome episode code N[N] Health, Superseded 01/10/2008

Scheduled admission date Health, Standard 01/03/2005

Admitted patient mental health care service

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	409067
Registration status:	Health, Standard 07/12/2011
Definition:	An admitted patient mental health care service is a specialised mental health service that provides overnight care in a psychiatric hospital or a specialised mental health unit in an acute hospital. Psychiatric hospitals and specialised mental health units in acute hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. These services are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder/illness.
Context:	Specialised admitted patient mental health services.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Metadata items which use this glossary item:	Specialised mental health service—admitted patient service unit identifier, XXXXXX Health, Standard 07/12/2011 Specialised mental health service—admitted patient service unit name, text XXX[X(97)] Health, Standard 07/12/2011 Specialised mental health service—ambulatory service unit identifier, XXXXXX Health, Standard 07/12/2011

Adoption

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327208

Registration status: Community Services, Standard 01/03/2005
Health, Standard 01/03/2005

Definition: Adoption is the legal process by which a person legally becomes a child of the adoptive parents and legally ceases to be a child of his/her existing parents.

Context: Children and family services.

Collection and usage attributes

Comments: The adoption order severs the legal relationship between the biological parents and the child. A new birth certificate is issued to the child bearing the name(s) of his/her adoptive parent(s) as the natural parent(s) and the new name of the child, where a change has occurred.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW)

Origin: Adoptions Australia (AIHW). *Data collection standards, tables and counting rules*, 1998-99.

Relational attributes

Related metadata references: Supersedes Adoption, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (12.3 KB)

Metadata items which use this glossary item:

Person (name)—family name, text X[X(39)] Community Services, Superseded 25/08/2005
Health, Superseded 04/05/2005

Person (name)—family name, text X[X(39)] Community Services, Superseded 06/02/2012
Housing assistance, Standard 20/06/2005
Health, Standard 04/05/2005
Tasmanian Health, Proposed 28/09/2011

Ambulatory care

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 354366

Registration status: Health, Standard 05/12/2007

Definition: Care provided to hospital patients who are not admitted to the hospital, such as patients of **emergency departments** and **outpatient clinics**. The term is also used to refer to care provided to patients of community-based (non-hospital) health care services.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Origin: AIHW 2007. Mental health services in Australia 2004–05. AIHW cat. no. HSE 47. Canberra: AIHW (Mental Health Series no. 9).

Relational attributes

Metadata items which use this glossary item:

Ambulatory service unit name Health, Standard 07/12/2011

Health industry relevant organisation type code NNN Health, Superseded 01/04/2009

Health industry relevant organisation type code NNN Health, Standard 01/04/2009

Health or health related function code NNN Health, Standard 05/12/2007

Ambulatory mental health care service

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 409081

Registration status: Health, Standard 07/12/2011

Definition: An ambulatory mental health care service is a specialised mental health service that provides services to people who are not currently admitted to a mental health admitted or residential service. Services are delivered by health professionals with specialist mental health qualifications or training. Ambulatory mental health services include:

- community-based crisis assessment and treatment teams,
- day programs,
- mental health outpatient clinics provided by either hospital or community-based services,
- child and adolescent outpatient and community teams,
- social and living skills programs,
- psychogeriatric assessment services,
- hospital-based consultation-liaison and in-reach services to admitted patients in non-psychiatric and hospital emergency settings,
- ambulatory-equivalent same day separations,
- home based treatment services,
- hospital based outreach services.

Context: Specialised ambulatory mental health services.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Metadata items which use this glossary item:

Specialised mental health service—admitted patient service unit identifier, XXXXXX Health, Standard 07/12/2011

Specialised mental health service—ambulatory service unit identifier, XXXXXX Health, Standard 07/12/2011

Specialised mental health service—ambulatory service unit name, text XXX[X(97)] Health, Standard 07/12/2011

Specialised mental health service—number of clients receiving services, total NNNNNN Health, Standard 07/12/2011

Specialised mental health service—number of service contacts, total NNNNNN Health, Standard 07/12/2011

Antenatal care visit

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 461257

Registration status: Health, Standard 12/10/2011

Definition: An intentional encounter between a pregnant woman and a midwife or doctor to assess and improve maternal and fetal well-being throughout pregnancy and prior to labour.

Context: An antenatal care visit may occur in the following clinical settings:

- antenatal outpatients clinic
- specialist outpatient clinic
- general practitioner surgery
- obstetrician private room
- community health centre
- rural and remote health clinic
- independent midwife practice setting including home of pregnant female

Source and reference attributes

Submitting organisation: National Perinatal Epidemiology and Statistics Unit

Reference documents: CPIU (Clinical Practice Improvement Unit) 2006. 3Centre consensus guidelines on antenatal care. Melbourne:3Centres Collaboration.

Relational attributes

Metadata items which use this glossary item:

Female—number of antenatal care visits Health, Standard 12/10/2011

Female—number of antenatal care visits, total N[N] Health, Standard 12/10/2011

Indigenous primary health care: PI13a-Number of regular clients who had their first antenatal care visit within specified periods, 2013 Health, Standard 07/12/2011

Indigenous primary health care: PI13b-Proportion of regular clients who had their first antenatal care visit within specified periods, 2013 Health, Standard 07/12/2011

Number of antenatal care visits Health, Standard 12/10/2011

Assistance with activities and participation

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327298
Registration status:	Community Services, Standard 01/03/2005 Health, Standard 29/11/2006
Definition:	The help that a person receives or needs from another person, because of their difficulty in performing an activity or in participating in an area of life.

Context:

'Assistance' is an important subset of Environmental factors that may facilitate (or hinder) the activities or participation of people with disability. Assistance is a key policy and service component in the disability and aged care services field in Australia. Further, it is recognised in the ICF as a crucial factor whose presence (or absence) must be noted when recording measures of functioning and disability.

Recording measures of assistance needed or provided will provide further information about activity limitations.

Collection and usage attributes

Comments:

The concept can be used to describe aspects of the environment. Depending on which environment is present or being considered, the measure of assistance indicates what assistance is currently received (in the current or usual environment) and what would be needed (in an optimum environment). 'Need' more generally relates to environmental factors (including personal assistance, equipment and environmental modifications) that are present in an optimum environment but not in the person's current environment. That is, changes may be needed to environmental factors in order to improve a person's functioning and reduce their disability. While these ideas apply generally to 'Environmental Factors' and the related metadata item, Extent of environmental factors influence code [X]N, the concept of 'Assistance' focuses solely on the factor of personal assistance.

Measures of assistance and need for assistance are under active development in a number of disciplines and service programs. Assistance may be measured in various ways, for instance in relation to duration, frequency and intensity of assistance. Related data elements are therefore likely to emerge in the future.

This glossary item is based on the International Classification of Functioning, Disability and Health (ICF).

The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd Ed) ANN{.N[N} and Episode of care additional diagnosis, code (ICD-10-AM 3rd Ed) ANN{.N[N}.

Source and reference attributes

Origin:

World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites

- WHO ICF website http://www.who.int/classifications/icf/en
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Related metadata references: Supersedes Assistance with activities and participation, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (17.4 KB)

Metadata items which use this glossary item: Activity difficulty level code (ICF 2001) N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Average for the counting period

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	373642
Registration status:	Health, Standard 03/12/2008
Definition:	The average for the counting period is calculated by summing all the individual counts and dividing it by the number of periods for which a count was taken. For the reporting year, if a count was taken n times, the average is calculated as the SUM (Count1 + Count2 + ...Countn) DIVIDED by n. A reporting year is a financial year. It begins on 1 July and ends on 30 June of the following year.

Relational attributes

Metadata items which use this glossary item:	Available bed—neonatal admitted care (Non-special-care), average number of beds N[NNN.N] Health, Standard 03/12/2008 Available bed—overnight-stay admitted care, average number of beds N[NNN.N] Health, Standard 03/12/2008 Available bed—residential mental health care, average number of beds N[NNN.N] Health, Standard 03/12/2008 Available bed—same-day admitted care, average number of beds N[NNN.N] Health, Standard 03/12/2008

Birthweight

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327212

Registration status: Health, Standard 01/03/2005

Definition: The first weight of the fetus or baby obtained after birth. The World Health Organization further defines the following categories:

- extremely low birthweight: less than 1,000 grams (up to and including 999 grams),
- very low birthweight: less than 1,500 grams (up to and including 1,499 grams),
- low birthweight: less than 2,500 grams (up to and including 2,499 grams).

Context: Perinatal

Collection and usage attributes

Comments: The definitions of low, very low, and extremely low birthweight do not constitute mutually exclusive categories. Below the set limits they are all-inclusive and therefore overlap (i.e. low includes very low and extremely low, while very low includes extremely low).

For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 gram groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Origin: International Classification of Diseases and Related Health Problems, 10th Revision, WHO, 1992

Relational attributes

Related metadata references: Supersedes Birthweight, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005 .pdf (14.0 KB)

Metadata items which use this glossary item: Birth Health, Standard 01/03/2005

Birth event—birth plurality, code N Health, Standard 01/03/2005

Birth order Health, Standard 01/03/2005

Birth status code N Health, Standard 01/03/2005

Birth weight recorded indicator Health, Standard 07/12/2011

Birth—birth weight, total grams NNNN Health, Standard 01/03/2005

Female—number of previous pregnancies (spontaneous abortion), total NN Health, Standard 01/03/2005

Female—number of previous pregnancies (stillbirth), total N[N] Health, Standard 01/03/2005

Pregnancy (last previous)—pregnancy completion date, DDMMYYYY Health, Standard 01/03/2005

Blood pressure

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327210

Registration status: Health, Standard 01/03/2005

Definition: The pressure exerted by blood against the walls of the blood vessels - i.e. arteries, capillaries or veins.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: Australian Institute of Health and Welfare (AIHW) 2001.

Heart, stroke and vascular diseases-Australian facts 2001. Canberra: AIHW.

National Heart Foundation of Australia.

National Stroke Foundation of Australia.

Relational attributes

Related metadata references: Supersedes Blood pressure - concept, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005 .pdf (12.3 KB)

Metadata items which use this glossary item:

Adult—body mass index Health, Standard 01/03/2005

Blood pressure measurement result less than or equal to 130/80 mmHg indicator Health, Standard 07/12/2011

Blood pressure measurement result recorded indicator Health, Standard 07/12/2011

Person—blood pressure (diastolic) Health, Standard 01/03/2005

Person—blood pressure (diastolic) (measured), millimetres of mercury NN[N] Health, Standard 01/03/2005

Person—blood pressure (systolic) Health, Standard 01/03/2005

Person—blood pressure (systolic) (measured), millimetres of mercury NN[N] Health, Standard 01/03/2005

Person—blood pressure measurement result less than or equal to 130/80 mmHg indicator, yes/no code N Health, Standard 07/12/2011

Person—blood pressure measurement result recorded indicator, yes/no code N Health, Standard 07/12/2011

Person—hypertension treatment status (antihypertensive medication) Health, Superseded 21/09/2005

Person—hypertension treatment with antihypertensive medication indicator Health, Standard 21/09/2005

Body functions

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327294

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Definition: Body functions are the physiological functions of body systems (including psychological functions).

Collection and usage attributes

Guide for use: Body functions are organised according to body systems. The term 'body' refers to the human organism as a whole and includes mental or psychological functions.
Body functions are classified in neutral terms. To indicate that there is a problem with a body function requires the use of the impairment extent code to denote the extent or magnitude of the problem together with the body functions code.

Comments: This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of the ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]}.

Source and reference attributes

Origin: World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites:

- WHO ICF website
http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website
http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Metadata items which use this glossary item:	Body function code (ICF 2001) AN[NNNN] Community Services, Standard 16/10/2006 Health, Standard 29/11/2006 Functioning and Disability DSS Community Services, Standard 16/10/2006 Health, Standard 29/11/2006

Body structures

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327300
Registration status:	Community Services, Standard 16/10/2006 Health, Standard 29/11/2006
Definition:	Body structures are anatomical parts of the body such as organs, limbs and their components.

Collection and usage attributes

Guide for use:

Body structures are classified according to body systems. **Impairments of body structure** can involve anomaly, defect, loss and significant deviation. These are identified by use of the impairment extent, impairment location and impairment nature codes.

Comments:

This glossary term is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]}.

Source and reference attributes

Origin:

World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites
• WHO ICF website
http://www.who.int/classifications/icf/en

- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Metadata items which use this glossary item:	Functioning and Disability DSS Community Services, Standard 16/10/2006 Health, Standard 29/11/2006

Carer consultant

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327330

Registration status: Health, Standard 08/12/2004

Definition: Carer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of carers and advocate for their needs.

Relational attributes

Metadata items which use this glossary item:

Establishment—full-time equivalent staff (paid) (carer consultants) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (carer consultants), average N[NNN{.N}] Health, Standard 08/12/2004

Establishment—recurrent expenditure (salaries and wages) (carer consultants) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Cessation of treatment episode for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327302
Registration status:	Health, Standard 01/03/2005
Definition:	Cessation of a treatment episode occurs when treatment is completed or discontinued; or there has been a change in the principal drug of concern, the main treatment type, or the treatment delivery setting.
Context:	Alcohol and other drug treatment services

Collection and usage attributes

Guide for use:

A client is identified as ceasing a treatment episode if one or more of the following apply:

- their treatment plan is completed,
- they have had no contact with the treatment provider for a period of three months, nor is there a plan in place for further contact,
- their principal drug of concern for alcohol and other drugs has changed,
- their main treatment type for alcohol and other drugs has changed,
- their treatment delivery setting for alcohol and other drugs has changed,
- their treatment has ceased for other reasons (e.g. imprisoned, ceased treatment against advice, transferred to another service provider, died, etc.).

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set working group
Origin:	

Relational attributes

Related metadata references:	Supersedes Cessation of treatment episode for alcohol and other drugs, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB)
Metadata items which use this glossary item:	Episode of treatment for alcohol and other drugs—treatment cessation date, DDMMYYYY Health, Standard 01/03/2005

Chemotherapy

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 436811

Registration status: Health, Standard 07/12/2011

Definition: The treatment of disease by means of chemical substances or drugs, usually used in reference to neoplastic disease.

Chemotherapy for the treatment of cancer achieves its antitumour effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Stedman TL 2006. Stedman's Medical Dictionary, 28th Edition. Maryland: Lippincott Williams & Wilkins page 358.

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2011 revision. Commission on Cancer page 26.

Relational attributes

Metadata items which use this glossary item: Cancer treatment—chemotherapy completion date, DDMMYYYY Health, Standard 07/12/2011

Cancer treatment—chemotherapy cycles administered Health, Standard 07/12/2011

Cancer treatment—chemotherapy cycles administered, number of cycles N[NN] Health, Standard 07/12/2011

Cancer treatment—chemotherapy start date, DDMMYYYY Health, Standard 07/12/2011

Cancer treatment—systemic therapy agent or protocol, eviQ protocol identifier, NNNNNN Health, Standard 07/12/2011

Cancer treatment—systemic therapy agent or protocol, text X[(149)] Health, Standard 07/12/2011

Class action

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	466681
Registration status:	Health, Standard 07/12/2011
Definition:	A lawsuit brought by one or more plaintiffs on behalf of a large group of others who have a common legal claim.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	Houghton Mifflin 2000. The American Heritage. Dictionary of the English Language, Fourth Edition. America: Houghton Mifflin Company

Relational attributes

Metadata items which use this glossary item:	Class action indicator Health, Standard 07/12/2011 Medical indemnity claim management episode—class action indicator Health, Standard 07/12/2011 Medical indemnity claim management episode—class action indicator, yes/no code N Health, Standard 07/12/2011

Clinical intervention

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327220
Registration status:	Health, Standard 01/03/2005
Definition:	An intervention carried out to improve, maintain or assess the health of a person, in a clinical situation.
Context:	Health services: Information about the surgical and non-surgical interventions provides the basis for analysis of health service usage, especially in relation to specialised resources, for example theatres and equipment or human resources.

Collection and usage attributes

Comments:

Clinical interventions include invasive and non-invasive procedures, and cognitive interventions.

Invasive:

(a) Therapeutic interventions where there is a disruption of the epithelial lining generally, but not exclusively, with an implied closure of an incision (e.g. operations such as cholecystectomy or administration of a chemotherapeutic drug through a vascular access device);

(b) Diagnostic interventions where an incision is required and/or a body cavity is entered (e.g. laparoscopy with/without biopsy, bone marrow aspiration).

Non-invasive:

Therapeutic or diagnostic interventions undertaken without disruption of an epithelial lining (e.g. lithotripsy, hyperbaric oxygenation; allied health interventions such as hydrotherapy; diagnostic interventions not requiring an incision or entry into a body part such as pelvic ultrasound, diagnostic imaging).

Cognitive:

An intervention which requires cognitive skills such as evaluating, advising, planning (e.g. dietary education, physiotherapy assessment, crisis intervention, bereavement counselling).

Source and reference attributes

Submitting organisation: National Health Data Committee.

Relational attributes

Related metadata references:	Supersedes Clinical intervention, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)
Metadata items which use this glossary item:	Episode of admitted patient care—procedure Health, Standard 01/03/2005 Tasmanian Health, Proposed 28/09/2011

Clinical review

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327214

Registration status: Health, Standard 01/03/2005

Definition: The examination of a patient by a clinician after the patient has been added to the elective care waiting list. This examination may result in the patient being assigned a different urgency rating from the initial classification. The need for clinical review varies with a patient's condition and is therefore at the discretion of the treating clinician.

Context: Admitted patient care.

Source and reference attributes

Submitting organisation: Hospital Access Program Waiting List Working Group

National Health Data Committee

Relational attributes

Related metadata references: Supersedes Clinical review, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.0 KB)

Metadata items which use this glossary item: Elective care waiting list episode—category reassignment date Health, Standard 01/03/2005

Elective care waiting list episode—category reassignment date, DDMMYYYY Health, Standard 01/03/2005

Elective surgery waiting list episode—clinical urgency, code N Health, Standard 01/03/2005

Elective surgery waiting list episode—patient listing status, readiness for care code N Health, Standard 01/03/2005

Compensable patient

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327420

Registration status: Health, Standard 01/03/2005

Definition: A compensable patient is a person who:

- is entitled to claim damages under Motor Vehicle Third Party insurance or
- is entitled to claim damages under worker's compensation or
- has an entitlement to claim under public liability or common law damages.

Relational attributes

Metadata items which use this glossary item: Patient—compensable status, code N Health, Standard 01/03/2005

Consultant psychiatrist

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327332

Registration status: Health, Standard 08/12/2004

Definition: Medical officers who are registered to practice psychiatry under the relevant state or territory Medical Registration Board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.

Relational attributes

Metadata items which use this glossary item:

Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists), average N[NNN{.N}] Health, Standard 08/12/2004

Establishment—recurrent expenditure (salaries and wages) (consultant psychiatrists and psychiatrists) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Consumer consultant

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327336

Registration status: Health, Standard 08/12/2004

Definition: Consumer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of consumers and advocate for their needs.

Relational attributes

Metadata items which use this glossary item:

Establishment—full-time equivalent staff (paid) (consumer consultants) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (consumer consultants), average N[NNN{.N}] Health, Standard 08/12/2004

Establishment—recurrent expenditure (salaries and wages) (consumer consultants) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Course of radiotherapy treatment

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	448151
Registration status:	Health, Standard 07/12/2011
Definition:	A series of one or more **radiotherapy** treatments prescribed by a radiation oncologist.

Collection and usage attributes

Comments:

A course of radiotherapy treatment should have an associated ready-for-care date and, when treatment starts, a radiotherapy start date.

A patient can receive more than one course of radiotherapy treatment at the same time (i.e. courses which are simultaneous or which overlap). These courses may have the same or different ready-for-care dates and the same or different radiotherapy start dates.

Only a radiation oncologist can prescribe a course of radiotherapy treatment. A prescription is not equal to a course of radiotherapy treatment. A prescription may be for one or more courses of radiotherapy treatment. A prescription outlines the anatomical region/sites to be treated and is for a prescribed dose at a defined volume (fractionation) over a defined period of time.

One course of radiotherapy treatment may cover multiple phases and multiple treatment plans.

The completion of a course of radiotherapy treatment is not relevant to the definition of a course of radiotherapy treatment.

Relational attributes

Metadata items which use this glossary item:

Patient—radiotherapy start date Health, Standard 07/12/2011

Patient—radiotherapy start date, DDMMYYYY Health, Standard 07/12/2011

Radiotherapy waiting times DSS 2012- Health, Standard 07/12/2011

Diagnosis

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327224

Registration status: Health, Standard 01/03/2005

Definition: A diagnosis is the decision reached, after assessment, of the nature and identity of the disease or condition of a patient or recipient of residential care (resident).

Context: Health services:

Diagnostic information provides the basis for analysis of health service usage, epidemiological studies and monitoring of specific disease entities.

Collection and usage attributes

Comments: Classification systems which enable the allocation of a code to the diagnostic information:

- International Classification of Diseases, Tenth Revision, Australian Modification (ICD-10-AM),
- British Paediatric Association Classification of Diseases,
- North America Nursing Diagnosis Association,
- International Classification of Primary Care International,
- Classification of Impairments, Disabilities and Handicaps,
- International Classification of Functioning.

Source and reference attributes

Submitting organisation: National Data Standards Committee

Origin:

Relational attributes

Related metadata references: Supersedes Diagnosis, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Metadata items which use this glossary item:

Admitted patient care NMDS Health, Superseded 07/12/2005

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Admitted patient care NMDS 2010-2011 Health, Superseded 18/01/2011

Admitted patient care NMDS 2011-2012 Health, Superseded 11/04/2012

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Person—visual acuity (left eye), code NN Health, Standard 01/03/2005

Person—visual acuity (right eye), code NN Health, Standard 01/03/2005

Diagnostic and health professional

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327164
Registration status:	Health, Standard 01/03/2005
Definition:	Qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature (but also including diagnostic and health professionals whose duties are primarily or partly of an administrative nature). This category includes all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff).

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (diagnostic and health professionals) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (diagnostic and health professionals), average N[NNN{.N}] Health, Standard 01/03/2005 Establishment—recurrent expenditure (salaries and wages) (diagnostic and health professionals) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Disability

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327304

Registration status: Community Services, Standard 01/03/2005
Housing assistance, Standard 01/03/2005
Health, Standard 29/11/2006

Definition: Disability is the umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation.

Disability is a multi-dimensional and complex concept and is conceived as a dynamic interaction between health conditions and environmental and personal factors (WHO 2001:6).

Collection and usage attributes

Comments: Many different 'definitions' of disability are used in Australia, both in administrative data collections and in Acts of Parliament. The consistent identification of disability in national data collections has been recommended in a number of reports, for instance to enable:

- the monitoring of access to generic services by people with disability;
- the collection of more consistent data on disability support and related services, including data on service use by different groups;
- population data and service data to be related, thereby improving the nation's analytical capacity in relation to the need for and supply of services; and
- improved understanding of the relationship between disability, health conditions and other health outcomes.

Defining disability makes it possible to determine the number of people who are accessing services, both disability specific and generic, and also those with a disability in the general population with unmet need. Better definition of disability will aid better targeting of resources to those in need.

Disability arises from the interaction between health conditions and environmental and personal factors. A health condition may be a disease (acute or chronic), disorder, injury or trauma. Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives. Personal factors relate to the individual, such as age, sex and Indigenous status.

The concept 'Disability' can be described using a combination of related metadata items as building blocks.

The metadata items selected may vary depending on the definition of disability used. For example, in hospital rehabilitation, the focus may be on the impairment and **activity** dimensions and in community-based care the focus may be primarily on participation. Some applications may require a broad scope for inclusion (e.g. discrimination legislation). Data collections relating to services will select combinations of the data elements, which best reflect the eligibility criteria for the service.

This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd Edn) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd Edn) ANN{.N[N]}.

Source and reference attributes

Origin:

World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites
• WHO ICF website
http://www.who.int/classifications/icf/en
• Australian Collaborating Centre ICF website
http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Metadata items which use this

Activities and participation code (ICF 2001) AN[NNN]
Community Services, Standard 16/10/2006

glossary item:

Health, Standard 29/11/2006

Activity difficulty level code (ICF 2001) N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Activity need for assistance code N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Body function code (ICF 2001) AN[NNNN] Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Body structure code (ICF 2001) AN[NNNN] Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Environmental factor code (ICF 2001) AN[NNN] Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Extent of environmental factors influence code (ICF 2001) [X]N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Functioning and Disability DSS Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Goal of care code NN Health, Standard 01/03/2005

Impairment extent code (ICF 2001) N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Impairment location code (ICF 2001) N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Impairment nature code (ICF 2001) N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Participation extent code (ICF 2001) N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Participation satisfaction level code N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Domestic and other staff

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327168

Registration status: Health, Standard 01/03/2005

Definition: Domestic staff are staff engaged in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded. This category also includes all staff not elsewhere included (primarily maintenance staff, trades people and gardening staff).

Relational attributes

Metadata items which use this glossary item:

Establishment—full-time equivalent staff (paid) (domestic and other staff) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (domestic and other staff), average N[NNN{.N}] Health, Standard 01/03/2005

Establishment—recurrent expenditure (salaries and wages) (domestic and other staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Elective surgery

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327226
Registration status:	Health, Standard 01/03/2005
Definition:	Elective care where the procedures required by patients are listed in the surgical operations section of the Medicare benefits schedule book, with the exclusion of specific procedures frequently done by non-surgical clinicians.
Context:	Admitted patient care.

Source and reference attributes

Submitting organisation:	Hospital access program waiting list working group
Origin:	The National Health Data Committee.

Relational attributes

Related metadata references:	Supersedes Elective surgery, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (11.7 KB)
Metadata items which use this glossary item:	Coronary artery disease intervention code N Health, Standard 01/03/2005 Elective surgery code NN Health, Standard 01/03/2005

Emergency department

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327158

Registration status: Health, Standard 01/03/2005

Definition: An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical condition/s and/or injury.

Relational attributes

Metadata items which use this glossary item:

Emergency department visit type code N Health, Superseded 30/01/2012

Emergency department visit type code N Health, Standard 30/01/2012

Emergency department visit type code N Health, Superseded 22/12/2011

Establishment (public psychiatric or alcohol and drug hospital)—number of group session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN] Health, Standard 01/03/2005

Establishment (public psychiatric or alcohol and drug hospital)—number of individual session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN] Health, Standard 01/03/2005

Health or health related function code NNN Health, Standard 05/12/2007

Health service event—presentation date, DDMMYYYY Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Health service event—presentation time, hhmm Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Health service event—service commencement date, DDMMYYYY Health, Superseded 07/12/2005

Non-admitted patient emergency department service episode Health, Superseded 30/01/2012

Non-admitted patient emergency department service episode Health, Standard 30/01/2012

Non-admitted patient emergency department service episode Health, Superseded 22/12/2011

Non-admitted patient service event Health, Superseded 06/10/2010

Triage Health, Retired 07/12/2005

Emergency department - public hospital

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327228

Registration status: Health, Standard 01/03/2005

Definition: The dedicated area in a public hospital that is organised and administered to provide emergency care to those in the community who perceive the need for or are in need of acute or urgent care.

The emergency department must be part of a hospital and be licensed or otherwise recognised as an emergency department by the appropriate state or territory authority.

An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical condition(s) and/or injury.

Context: Emergency department care.

Collection and usage attributes

Comments: This glossary term has been defined to support the National Minimum Data Set - Non-admitted patient emergency department care. It is not intended as a definitive statement of the role or purpose of an emergency department.

The national definition of an emergency department and the care that is provided in an emergency department is characterised by jurisdictional and local differences. For example, there is no national agreement on the identification and classification of emergency department-related settings such as observation units, short stays units, or the use of 'admitted patient beds' located in an emergency department setting.
Emergency department is therefore defined as a concept, and not necessarily as a physical premises, setting or site.

Source and reference attributes

Submitting organisation: National reference group for non-admitted patient data development, 2001/02.

Relational attributes

Related metadata references: Supersedes Emergency department - public hospital, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Metadata items which use this glossary item: Health or health related function code NNN Health, Standard 05/12/2007

Enrolled nurse

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327160
Registration status:	Health, Standard 01/03/2005
Definition:	Enrolled nurses are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states).

Relational attributes

Related metadata references:	See also Establishment—full-time equivalent staff (paid) (nurses), average NNNN.NN Health, Standard 07/12/2011
Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (enrolled nurses) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (enrolled nurses), average N[NNN{.N}] Health, Standard 01/03/2005 Establishment—recurrent expenditure (salaries and wages) (enrolled nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Environmental factors

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327286

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Definition: Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives.

Context: Environmental factors are external to the individual and can have a positive or negative influence on a person's participation as a member of society, on performance of activities, or on a person's body function or structure.

Collection and usage attributes

Guide for use: In the ICF classification scheme Environmental factors are organised to focus on two different levels, individual and societal. Environmental factors interact with the Body structures/Body functions and Activities and participation components.
A person's functioning and disability is conceived as the dynamic interaction between health conditions and environmental and personal factors.

Comments: This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]}.

Source and reference attributes

Origin: World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health.

Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites
- WHO ICF website
http://www.who.int/classifications/icf/en
- Australian Collaborating Centre ICF website
http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Metadata items which use this glossary item:

Extent of environmental factors influence code (ICF 2001) [X]N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Functioning and Disability DSS Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—extent of environmental factor influence, code (ICF 2001) [X]N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Episode of acute care

Identifying and definitional attributes

Metadata item type: Glossary Item

Synonymous names: Acute care episode for admitted patients

METeOR identifier: 327230

Registration status: Health, Standard 01/03/2005

Definition: An episode of acute care for an admitted patient is one in which the principal clinical intent is to do one or more of the following:

- manage labour (obstetric),
- cure illness or provide definitive treatment of injury,
- perform surgery,
- relieve symptoms of illness or injury (excluding palliative care),
- reduce severity of illness or injury,
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions,
- perform diagnostic or therapeutic procedures.

Context: Admitted patient care.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Acute care episode for admitted patients, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.2 KB)

Metadata items which use this glossary item: Admitted patient care NMDS Health, Superseded 07/12/2005

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Admitted patient care NMDS 2010-2011 Health, Superseded 18/01/2011

Admitted patient care NMDS 2011-2012 Health,

Superseded 11/04/2012

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Episode of residential care end

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 376427

Registration status: Health, Standard 07/12/2011

Definition: Episode of residential care end is the administrative process by which a residential care service either records:

Formal episode of residential care end:

- the formal end of residential care and accommodation of a resident, or;

Statistical episode of residential care end:

- the end of the reference period.

Context: Specialised mental health services (Residential mental health care).

Relational attributes

Related metadata references: Supersedes Episode of residential care end Health, Superseded 07/12/2011

Metadata items which use this glossary item: Episode of residential care—episode end date Health, Standard 07/12/2011

Episode of residential care—episode end date, DDMMYYYY Health, Standard 07/12/2011

Episode of residential care—episode end mode Health, Standard 07/12/2011

Episode of residential care—episode end mode, code N Health, Standard 07/12/2011

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Episode of residential care start

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	376510
Registration status:	Health, Standard 07/12/2011
Definition:	The process whereby the residential care service accepts responsibility for the resident's residential care and accommodation. Episode of residential care start is the administrative process by which a residential care service records either: Formal episode of residential care start: • the start of residential care and accommodation of a resident, or; Statistical episode of residential care start: • the start of a reference period for a resident continuing their residential care and accommodation, from the previous reference period.
Context:	Specialised mental health services (Residential mental health care).

Relational attributes

Related metadata references:	Supersedes Episode of residential care start Health, Superseded 07/12/2011
Metadata items which use this glossary item:	Episode of residential care—episode start date, DDMMYYYY Health, Standard 07/12/2011 Episode of residential care—episode start mode Health, Standard 07/12/2011 Episode of residential care—episode start mode, code N Health, Standard 07/12/2011 Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011 Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Establishment based student nurse

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327186
Registration status:	Health, Standard 01/03/2005
Definition:	Student nurses are persons employed by the establishment currently studying in years one to three of a three year certificate course. This includes any person commencing or undertaking a three year course of training leading to registration as a nurse by the state or territory registration board. This includes full time general student nurse and specialist student nurse, such as mental deficiency nurse, but excludes practising nurses enrolled in post basic training courses.

Relational attributes

Metadata items which use this glossary item:	Establishment—recurrent expenditure (salaries and wages) (student nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Family

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 351499

Registration status: Community Services, Standard 31/08/2007
Health, Standard 31/08/2007

Definition: Two or more people related by blood, marriage (registered or de facto), adoption, step or fostering who may or may not live together.

Source and reference attributes

Reference documents: Australian Bureau of Statistics. Family, household and income unit variables. Cat No. 1286.0. Canberra: ABS. Viewed on 01/03/2007.

Relational attributes

Metadata items which use this glossary item:

Establishment—number of group session occasions of service for non-admitted patients Health, Standard 01/03/2005

Informal carer Community Services, Standard 03/05/2007
Health, Standard 04/07/2007

Person (name)—family name, text X[X(39)] Community Services, Superseded 25/08/2005
Health, Superseded 04/05/2005

Person (name)—family name, text X[X(39)] Community Services, Superseded 06/02/2012
Housing assistance, Standard 20/06/2005
Health, Standard 04/05/2005
Tasmanian Health, Proposed 28/09/2011

Person (name)—given name Community Services, Standard 01/03/2005
Housing assistance, Standard 01/08/2005
Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Person (name)—given name, text [X(40)] Community Services, Superseded 06/02/2012
Housing assistance, Standard 20/06/2005
Health, Standard 04/05/2005
Tasmanian Health, Proposed 28/09/2011

Person—informal carer existence indicator, code N Community Services, Standard 29/04/2006
Health, Standard 04/07/2007

Functioning

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327292

Registration status: Community Services, Standard 01/03/2005
Health, Standard 29/11/2006

Definition: Functioning is the umbrella term for any or all of: body functions, body structures, activities and participation. Functioning is a multidimensional concept denoting the neutral aspects of the interaction between an individual (with a health condition) and that individual's environmental and personal factors.

Context: An individual's functioning in a specific domain is an interaction or complex relationship between health conditions and environmental and personal factors.

Functioning and disability are dual concepts in a broad framework, with disability focussing on the more negative aspects of this interaction.

Collection and usage attributes

Comments: This glossary term is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]}.

Source and reference attributes

Origin: World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites
• WHO ICF website
http://www.who.int/classifications/icf/en
• Australian Collaborating Centre ICF website
http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Related metadata references:

Supersedes Functioning, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (15.4 KB)

Metadata items which use this glossary item:

Functioning and Disability DSS Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Geographic indicator

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327306

Registration status:
Community Services, Standard 01/03/2005
Housing assistance, Standard 22/10/2005
Health, Standard 01/03/2005
Homelessness, Standard 22/10/2005

Definition: A classification scheme that divides an area into mutually exclusive sub-areas based on geographic location.

Some geographic indicators are:

- Australian Standard Geographical Classification (ASGC, ABS Cat No. 1216.0),
- administrative regions,
- electorates,
- Accessibility/Remoteness Index of Australia (ARIA),
- Rural, Remote and Metropolitan Area Classification (RRMA), and
- country.

Context: To enable the analysis of data on a geographical basis. Facilitates analysis of service provision in relation to demographic and other characteristics of the population of a geographic area.

Collection and usage attributes

Comments: Person (address)—Australian postcode (Postcode datafile), code [NNNN] is not included in the above listing, as it is, strictly speaking, not a geographic indicator. Sometimes postcodes are used in the analysis of data on a geographical basis, which involves a conversion to Statistical Local Area (an Australian Bureau of Statistics geographical structure). This conversion results in some inaccuracy of information. However, in some data sets Person (address)—Australian postcode (Postcode datafile), code [NNNN]; is the only geographic identifier, therefore the use of other more accurate indicators (for example, conversion from address line to Statistical Local Area) is not always possible.

Source and reference attributes

Origin: Australian Institute of Health and Welfare.

Relational attributes

Related metadata references: Supersedes Geographic indicator, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (14.0 KB)

Metadata items which use this glossary item:

Australian state/territory identifier Community Services, Standard 01/03/2005
Housing assistance, Standard 22/10/2005
Health, Standard 01/03/2005
Early Childhood, Standard 21/05/2010
Tasmanian Health, Proposed 30/09/2011

Female—number of antenatal care visits, total N[N] Health, Standard 12/10/2011

Hormone therapy

Identifying and definitional attributes

Metadata item type: Glossary Item

Synonymous names: Endocrine therapy, hormonal therapy

METeOR identifier: 439580

Registration status: Health, Standard 07/12/2011

Definition: The treatment of disease with hormones obtained from endocrine glands or substances that stimulate hormonal effects.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Myers T (Editor) 2009. Mosby's Medical Dictionary , 8th Edition. Missouri: Mosby Elsevier page 890

Relational attributes

Metadata items which use this glossary item: Cancer treatment—systemic therapy agent or protocol, eviQ protocol identifier, NNNNNN Health, Standard 07/12/2011

Hormone therapy start date Health, Standard 07/12/2011

Hospital boarder

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	Boarder
METeOR identifier:	327242
Registration status:	Health, Standard 01/03/2005
Definition:	A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.
Context:	Admitted patient care.

Collection and usage attributes

Guide for use:	A boarder thus defined is not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either a qualified or unqualified day.

Source and reference attributes

Submitting organisation:	National Health Data Committee.

Relational attributes

Related metadata references:	Supersedes Hospital boarder, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.1 KB)
Metadata items which use this glossary item:	Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009 Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009 Admitted patient care NMDS 2010-2011 Health, Superseded 18/01/2011 Admitted patient care NMDS 2011-2012 Health, Superseded 11/04/2012 Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012 Hospital service Health, Standard 01/03/2005

Hospital-in-the-home care

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327308
Registration status:	Health, Standard 01/03/2005
Definition:	Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.
Context:	Admitted patient care.

Collection and usage attributes

Comments:

The criteria for inclusion as hospital-in-the-home include but are not limited to:

- without hospital in the home care being available patients would be accommodated in the hospital,
- the treatment forms all or part of an episode of care for an admitted patient (as defined in the metadata item Admitted patient),
- the hospital medical record is maintained for the patient,
- there is adequate provision for crisis care.

Selection criteria for the assessment of suitable patients include but are not limited to:

- the hospital deems the patient requires health care professionals funded by the hospital to take an active part in their treatment,
- the patient does not require continuous 24 hour assessment, treatment or observation,
- the patient agrees to this form of treatment,
- the patient's place of residence is safe and has carer support available,
- the patient's place of residence is accessible for crisis care,
- the patient's place of residence has adequate communication facilities and access to transportation.

Source and reference attributes

Origin:	National Health Data Committee.

Relational attributes

Related metadata references:	Supersedes Hospital-in-the-home care, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Metadata items which use this glossary item:

Admitted patient Health, Standard 01/03/2005

Admitted patient care NMDS Health, Superseded 07/12/2005

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Admitted patient care NMDS 2010-2011 Health, Superseded 18/01/2011

Admitted patient care NMDS 2011-2012 Health, Superseded 11/04/2012

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Available bed—overnight-stay admitted care, average number of beds N[NNN.N] Health, Standard 03/12/2008

Episode of admitted patient care Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of admitted patient care—number of days of hospital-in-the-home care Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of admitted patient care—number of days of hospital-in-the-home care, total {N[NN]} Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of care (community setting)—first service delivery date, DDMMYYYY Health, Standard 01/03/2005

Health or health related function code NNN Health, Standard 05/12/2007

Number of days of hospital-in-the-home care Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Occupied bed—hospital in the home care, average number of beds N[NNN.N] Health, Standard 24/03/2009

Illicit drug

Identifying and definitional attributes

Metadata item type: Glossary Item

Synonymous names: Illegal drug

METeOR identifier: 413485

Registration status: Community Services, Standard 06/02/2012
Health, Recorded 15/09/2010

Definition: An illicit drug is defined as any drug which is illegal to possess or use or any legal drug used in an illegal manner, for example:

- a drug obtained on prescription but given or sold to another person to use
- glue or petrol which is sold legally, but is used in a manner that is not intended, such as inhaling fumes
- stolen pharmaceuticals sold on the black market (e.g. Pethidine)

Collection and usage attributes

Comments: The 2007 National Drug Strategy Household Survey report defines illicit drugs as illegal drugs (such as marijuana/cannabis), prescription or over-the-counter pharmaceuticals (such as analgesics/pain-killers or tranquillisers/sleeping pills) used for illicit purposes, and other substances used inappropriately (such as naturally occurring hallucinogens and inhalants).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: AIHW (Australian Institute of Health and Welfare) 2008. 2007 National Drug Strategy Household Survey: first results. Drug Statistics Series number 20.Cat. no. PHE 98. Canberra: AIHW.

Relational attributes

Metadata items which use this glossary item: Person—substance used illicitly indicator, yes/no/not stated/inadequately described code N Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Immunotherapy

Identifying and definitional attributes

Metadata item type: Glossary Item

Synonymous names: Biological therapy, biotherapy, biological response modifier therapy

METeOR identifier: 437322

Registration status: Health, Standard 07/12/2011

Definition: The application of immunologic knowledge and techniques to prevent and treat disease.

Collection and usage attributes

Guide for use: Examples include the administration of increasing doses of allergens in the treatment of allergies, the use of immunostimulants and immunosuppressants, the transfer of immunocompetent cells and tissues from one person to another, and the use of interferon for its antiviral and antitumor properties.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Myers T (Editor) 2009. Mosby's Medical Dictionary , 8th Edition. Missouri: Mosby Elsevier page 945

Relational attributes

Metadata items which use this glossary item:

Cancer treatment—immunotherapy completion date, DDMMYYYY Health, Standard 07/12/2011

Cancer treatment—immunotherapy start date, DDMMYYYY Health, Standard 07/12/2011

Cancer treatment—systemic therapy agent or protocol, eviQ protocol identifier, NNNNNN Health, Standard 07/12/2011

Cancer treatment—systemic therapy agent or protocol, text X[(149)] Health, Standard 07/12/2011

Immunotherapy completion date Health, Standard 07/12/2011

Immunotherapy start date Health, Standard 07/12/2011

Impairment of body structure

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327288

Registration status: Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Definition: Impairments of body structure are problems in body structure such as a loss or significant departure from population standards or averages.

Context: Body structures are classified in ICF in neutral terms. To indicate that there is a problem with a body structure requires the use of the body structures code for the structure affected and the impairment extent code to denote the extent or magnitude of the problem.
The impairment nature and impairment location codes can be used to expand the description of a problem with a body structure.

Source and reference attributes

Origin: World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Comments

This glossary term is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).
The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an ‘umbrella term for disease (acute or chronic), disorder, injury or trauma’ (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]}.
Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and

the following websites
• WHO ICF website
http://www.who.int/classifications/icf/en
• Australian Collaborating Centre ICF website
http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Metadata items which use this glossary item:

Body structures Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Impairment nature code (ICF 2001) N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Person—body structure, code (ICF 2001) AN[NNNN] Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Informal carer

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	353420
Registration status:	Community Services, Standard 03/05/2007 Health, Standard 04/07/2007
Definition:	An informal carer includes any person, such as a **family** member, friend or neighbour, who is giving regular, ongoing assistance to another person.

Relational attributes

Metadata items which use this glossary item:	Person—informal carer existence indicator Community Services, Standard 02/05/2006 Health, Standard 04/07/2007 Person—informal carer existence indicator, code N Community Services, Standard 29/04/2006 Health, Standard 04/07/2007

Intensive care unit

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327234

Registration status: Health, Standard 01/03/2005

Definition: An intensive care unit (ICU) is a designated ward of a hospital which is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems.

Context: Admitted patient care.

Collection and usage attributes

Comments: There are five different types and levels of ICU defined according to three main criteria: the nature of the facility, the care process and the clinical standards and staffing requirements. All levels and types of ICU must be separate and self-contained facilities in hospitals and, for clinical standards and staffing requirements, substantially conform to relevant guidelines of the Australian Council on Healthcare Standards (ACHS). The five types of ICU are briefly described below:

- Adult intensive care unit, level 3: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for patients in need of intensive care services and have extensive backup laboratory and clinical service facilities to support the tertiary referral role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period; or care of a similar nature.
- Adult intensive care unit, level 2: must be capable of providing complex, multisystem life support and be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for a period of at least several days, or for longer periods in remote areas or care of a similar nature (see ACHS guidelines).
- Adult intensive care unit, level 1: must be capable of providing basic multisystem life support usually for

less than a 24-hour period. It must be capable of providing mechanical ventilation and simple invasive cardiovascular monitoring for a period of at least several hours; or care of a similar nature.

- Paediatric intensive care unit: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for children needing intensive care; and have extensive backup laboratory and clinical service facilities to support this tertiary role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period to infants and children less than 16 years of age; or care of a similar nature.
- Neonatal intensive care unit, level 3: must be capable of providing complex, multisystem life support for an indefinite period. It must be capable of providing mechanical ventilation and invasive cardiovascular monitoring; or care of a similar nature. Definitions for high-dependency unit and coronary care unit are under development.

Source and reference attributes

Submitting organisation: National Intensive Care Working Group.

Relational attributes

Related metadata references: Supersedes Intensive care unit, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.9 KB)

Metadata items which use this glossary item:

Episode of admitted patient care—length of stay (special/neonatal intensive care), total days N[NN] Health, Standard 01/03/2005

Establishment—gross capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005

Establishment—gross capital expenditure (major medical equipment) Health, Standard 01/03/2005

Establishment—net capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005

Health establishment accrual accounting capital expenditure code N Health, Standard 01/03/2005

Juvenile detention centre

Identifying and definitional attributes

Metadata item type: Glossary Item

Synonymous names: Youth detention centre, juvenile justice centre, juvenile holding centre, youth residential centre

METeOR identifier: 398978

Registration status: Health, Standard 25/08/2011

Definition: A place administered and operated by a department responsible for juvenile justice, where young people under the age of 18 years are detained while under the supervision of the department on a pre-sentence or sentenced detention episode.

Collection and usage attributes

Comments: In Australia juvenile justice is the responsibility of the states and territories. There are differences in the legislation relating to juvenile justice in each state and territory.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: AIHW (Australian Institute of Health and Welfare) 2010. The health of Australia's prisoners 2009. Cat. no. PHE 123. Canberra: AIHW.

Reference documents: AIHW 2009. Juvenile justice in Australia 2007-08. Juvenile justice series no. 5. Cat. no. JUV 5. Canberra: AIHW.

Relational attributes

Metadata items which use this glossary item:

Age at first detention Health, Standard 25/08/2011

Incarceration history cluster Health, Standard 25/08/2011

Number of times in prison or juvenile detention Health, Standard 25/08/2011

Prison entrant—number of times in prison or juvenile detention Health, Standard 25/08/2011

Prison entrant—number of times in prison or juvenile detention, total number N[N] Health, Standard 25/08/2011

Leave period

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327156

Registration status: Health, Standard 01/03/2005

Definition: Leave period is a temporary absence from hospital, with medical approval for a period no greater than seven consecutive days.

Relational attributes

Metadata items which use this glossary item: Episode of admitted patient care—number of leave periods Health, Standard 01/03/2005

Live birth

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327248
Registration status:	Health, Standard 01/03/2005
Definition:	A live birth is defined by the World Health Organization to be the complete expulsion or extraction from the mother of a baby, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.
Context:	Perinatal Source document: *International Classification of Diseases and Related Health Problems,* 10th Revision, Vol 1, World Health Organization, 1992.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee National Perinatal Data Advisory Committee.
Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Live birth, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.8 KB)
Metadata items which use this glossary item:	Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009 Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009 Admitted patient care NMDS 2010-2011 Health, Superseded 18/01/2011 Admitted patient care NMDS 2011-2012 Health, Superseded 11/04/2012 Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012 Birth event—birth plurality, code N Health, Standard

01/03/2005

Birth—birth weight, total grams NNNN Health, Standard 01/03/2005

Female—number of previous pregnancies (live birth), total NN Health, Standard 01/03/2005

Mental health disorder

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	Mental disorder
METeOR identifier:	403575
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 25/08/2011
Definition:	A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classifications systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	DoHA (Department of Health and Ageing) 2009. Fourth national mental health plan: An agenda for collaborative government action in mental health 2009–2014. DoHA, Canberra. Viewed March 8 2011.

Relational attributes

Metadata items which use this glossary item:	Medication for mental health disorder indicator Community Services, Standard 06/02/2012 Health, Standard 25/08/2011 Mental health disorder indicator Community Services, Standard 06/02/2012 Health, Standard 25/08/2011 Person—medication for mental health disorder indicator Community Services, Standard 06/02/2012 Health, Standard 25/08/2011 Person—medication for mental health disorder indicator, yes/no code N Community Services, Standard 06/02/2012 Health, Standard 25/08/2011 Person—mental health disorder indicator Community Services, Standard 06/02/2012 Health, Standard 25/08/2011 Person—mental health disorder indicator, yes/no code N Community Services, Standard 06/02/2012 Health, Standard 25/08/2011

Mental health-funded non-government organisation

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327446

Registration status: Health, Standard 07/12/2005

Definition: A private organisation that receives Australian Government and/or State/Territory funding specifically for the provision of community health and related support and information services for people with a mental disorder or psychiatric disability, their carers or the broader community. These include accommodation, advocacy, community awareness, health promotion, counselling, independent living skills, psychosocial, recreation, residential, respite and self-help services.

Collection and usage attributes

Comments: Mental health funded non-government organisations may also provide other services that are not related to mental health programs or activities, and/or undertake mental health research.

Mental health-funded non-government organisations are usually not-for-profit, but can include for-profit organisations.

Relational attributes

Metadata items which use this glossary item: Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Mental health establishments NMDS 2010-2011 Health, Superseded 01/12/2010

Mental health establishments NMDS 2011-2012 Health, Superseded 07/12/2011

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Neonate

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327284

Registration status: Health, Standard 01/03/2005

Definition: A live birth who is less than 28 days old.

Context: Perinatal.

Collection and usage attributes

Comments: The neonatal period is exactly four weeks or 28 completed days, commencing on the date of birth (day 0) and ending on the completion of day 27. For example, a baby born on 1 October remains a neonate until completion of the four weeks on 28 October and is no longer a neonate on 29 October.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

National Perinatal Data Advisory Committee

Origin: National Health Data Committee

International Classification of Diseases and Related Health Problems, 10th Revision, WHO, 1992

Relational attributes

Related metadata references: Supersedes Neonate, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.1 KB)

Metadata items which use this glossary item: Admitted patient care NMDS Health, Superseded 07/12/2005

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Admitted patient care NMDS 2010-2011 Health, Superseded 18/01/2011

Admitted patient care NMDS 2011-2012 Health, Superseded 11/04/2012

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Newborn qualification status

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327254

Registration status: Health, Standard 01/03/2005

Definition: Qualification status indicates whether the patient day within a newborn episode of care is either qualified or unqualified.

Context: Admitted patient care: To provide accurate information on care provided in newborn episodes of care through exclusion of unqualified patient days.

Collection and usage attributes

Guide for use: A newborn qualification status is assigned to each patient day within a newborn episode of care.

A newborn patient day is qualified if the infant meets at least one of the following criteria:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient,
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care,
- is admitted to, or remains in hospital without its mother.

A newborn patient day is unqualified if the infant does not meet any of the above criteria.

The day on which a change in qualification status occurs is counted as a day of the new qualification status.

If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day.

Comments: All babies born in hospital are admitted patients.

The newborn baby's qualified days are eligible for health insurance benefits purposes and the patient day count under the Australian Health Care Agreements. In this context, newborn qualified days are equivalent to acute days and may be denoted as such.

The days when a newborn baby does not meet these criteria are classified as unqualified (if they are nine days old or less) and should not be counted as patient days under the Australian Health Care Agreements and are not eligible for health insurance benefit purposes.

Relational attributes

Related metadata references:

Supersedes Newborn qualification status, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Metadata items which use this glossary item:

Admitted patient care NMDS Health, Superseded 07/12/2005

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Admitted patient care NMDS 2010-2011 Health, Superseded 18/01/2011

Admitted patient care NMDS 2011-2012 Health, Superseded 11/04/2012

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Date of change to qualification status Health, Standard 01/03/2005

Episode of admitted patient care (newborn)—date of change to qualification status Health, Standard 01/03/2005

Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY Health, Standard 01/03/2005

Hospital care type code N[N].N Health, Standard 01/03/2005

Number of qualified days Health, Standard 01/03/2005

Non-financial asset

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327196
Registration status:	Housing assistance, Standard 10/02/2006 Health, Standard 01/03/2005
Definition:	A non-financial asset is an entity functioning as a store of value, over which ownership may be derived over a period of time, and which is not a financial asset.

Relational attributes

Metadata items which use this glossary item:	Gross capital expenditure Housing assistance, Standard 10/02/2006 Health, Standard 01/03/2005

Occupational Therapist

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327340
Registration status:	Health, Standard 08/12/2004
Definition:	Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Occupational Therapists.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (occupational therapists) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (occupational therapists), average N[NNN{.N}] Health, Standard 08/12/2004 Establishment—recurrent expenditure (salaries and wages) (occupational therapists) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Ophthalmologist

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327364

Registration status: Health, Standard 21/09/2005

Definition: An ophthalmologist is a physician specialising in diagnosing and prescribing treatment for defects, injuries and diseases of the eye, and who is skilled at delicate eye surgery.

Relational attributes

Metadata items which use this glossary item:

Person—referral to ophthalmologist indicator Health, Standard 21/09/2005

Person—referral to ophthalmologist indicator (last 12 months), code N Health, Standard 21/09/2005

Organ procurement - posthumous

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327258
Registration status:	Health, Standard 01/03/2005
Definition:	Organ procurement - posthumous is an activity undertaken by hospitals in which human tissue is procured for the purpose of transplantation from a donor who has been declared brain dead.
Context:	Hospital activity.

Collection and usage attributes

Comments:

This activity is not regarded as care or treatment of an admitted patient, but is registered by the hospital. Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, are recorded in accordance with the Australian coding standards.

Declarations of brain death are made in accordance with relevant state/territory legislation.

Relational attributes

Related metadata references:

Supersedes Organ procurement - posthumous, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.1 KB)

Metadata items which use this glossary item:

Admitted patient care NMDS Health, Superseded 07/12/2005

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Admitted patient care NMDS 2010-2011 Health, Superseded 18/01/2011

Admitted patient care NMDS 2011-2012 Health, Superseded 11/04/2012

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Hospital service—care type Health, Standard 01/03/2005

Hospital service—care type, code N[N].N Health, Standard

Other diagnostic and health professional

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327338

Registration status: Health, Standard 08/12/2004

Definition: Includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff).

Relational attributes

Metadata items which use this glossary item:

Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals), average N[NNN{.N}] Health, Standard 08/12/2004

Establishment—recurrent expenditure (salaries and wages) (other diagnostic and health professionals) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Other medical officer

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327342

Registration status: Health, Standard 08/12/2004

Definition: A person who is a medical officer employed or engaged by the organisation who is not registered as a psychiatrist within the state or territory nor is a formal trainee within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.

Relational attributes

Metadata items which use this glossary item:

Establishment—full-time equivalent staff (paid) (other medical officers) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (other medical officers), average N[NNN{.N}] Health, Standard 08/12/2004

Establishment—recurrent expenditure (salaries and wages) (other medical officers) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Other personal care staff

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327162
Registration status:	Health, Standard 01/03/2005
Definition:	This category includes attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (other personal care staff) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (other personal care staff), average N[NNN{.N}] Health, Standard 01/03/2005 Establishment—recurrent expenditure (salaries and wages) (other personal care staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Outpatient clinic service

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 336980

Registration status: Health, Standard 04/07/2007

Definition: An examination, consultation, treatment or other service provided in an outpatient setting in a specialty unit or under an organisational arrangement administered by a hospital.

Context: Non-admitted patient service activity, excluding emergency department. Does not include services provided through community health settings (such as community and child health centre).

Collection and usage attributes

Guide for use: This glossary item relates to activity of a clinic. See the Outpatient care National Minimum Data Set Scope statement for observations about use of the term 'clinic' in hospitals.

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Party, 2006

Origin: NCCH consultants report to Outpatients NMDS Development Working Group, September 2004.

Relational attributes

Related metadata references: Supersedes Outpatient clinic service Health, Superseded 04/07/2007

Metadata items which use this glossary item:

Health or health related function code NNN Health, Standard 05/12/2007

Outpatient care NMDS Health, Standard 04/07/2007

Outpatient clinic type Health, Standard 04/05/2005

Overnight-stay patient

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327256

Registration status: Health, Standard 01/03/2005

Definition: A patient who, following a clinical decision, receives hospital treatment for a minimum of one night, i.e. who is admitted to and separated from the hospital on different dates.

Context: Admitted patient care

Collection and usage attributes

Comments: An overnight-stay patient in one hospital cannot be concurrently an overnight-stay patient in another hospital, unless they are receiving contracted care. If not under a hospital contract, a patient must be separated from one hospital and admitted to the other hospital on each occasion of transfer.

An overnight-stay patient of a hospital (originating hospital) who attends another hospital (the destination hospital) on a contracted basis is to be regarded by the originating hospital as an overnight-stay patient, as if the patient had not left for contracted hospital care.

Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient is regarded as part of the overnight episode.

A non-admitted (emergency/outpatient) service provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care.

Patients who leave of their own accord, die or are transferred on their first day in hospital are not overnight-stay patients.

Source and reference attributes

Origin: National Health Data Committee.

Relational attributes

Related metadata references: Supersedes Overnight-stay patient, version 3, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Metadata items which use this glossary item: Episode of admitted patient care—length of stay (excluding leave days) Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Palliative care agency

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 356474

Registration status: Health, Standard 05/12/2007

Definition: A palliative care agency is an organisation or organisational sub-unit that provides specialist palliative care and receives Australian or state/territory government funding (including Australian Health Care Agreement funding), or does not provide specialist palliative care but receives Australian Health Care Agreement funding to provide care incorporating a palliative approach or palliative care-related services.

Collection and usage attributes

Guide for use: 'Specialist palliative care' services work substantively in the area of palliative care they would usually provide consultative and ongoing care for people with a life-limiting illness and provide support for primary carers and family members, provide multi-disciplinary healthcare and employ healthcare professionals who have qualifications or experience in palliative care.

Care may be provided in admitted patient and/or community settings. Community settings include outpatient facilities.

A palliative care agency represents the level of an organisation that is responsible for the care provided to clients (i.e. care coordination) regardless of whether the agency provides this care directly or purchases the care on behalf of clients.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Metadata items which use this glossary item: Palliative care performance indicators DSS Health, Standard 05/12/2007

Service provider organisation—level of service delivery, palliative care code N Health, Standard 05/12/2007

Service provider organisation—service delivery setting, palliative care agency code N Health, Standard 05/12/2007

Participation - functioning, disability and health

Identifying and definitional attributes

Metadata item type: Glossary Item

Synonymous names: Participation

METeOR identifier: 327312

Registration status: Community Services, Standard 06/06/2005
Health, Standard 29/11/2006

Definition: In the context of health, participation is involvement in a life situation.

Context: Involvement refers to the lived experience of people in the actual context in which they live. This context includes 'Environmental Factors' - all aspects of the physical, social and attitudinal world.

The individual's degree of involvement can be reflected by this glossary item when combined with Participation extent code (ICF 2001) X and Participation satisfaction level code X.

'Activities and participation' is one of three components that define the concept 'Disability', along with 'Body functions and structures' and 'Environmental factors'. 'Activities and participation' is also encompassed within the concept 'Functioning'.

The concept 'Participation', as defined here and as measured in the metadata items Participation extent code (ICF 2001) X and Participation satisfaction level code X, may be relevant to people and human services not related to disability.

Collection and usage attributes

Comments: Participation restrictions are problems an individual may experience in involvement in life situations.

In time, a related and more generic data element may be developed. In the meantime, the addition of 'functioning, disability and health' to the name of this glossary item indicates that the current concept is based on the concept and framework developed by World Health Organization to assist in the classification and description of functioning and disability, as contained in the International Classification of Functioning, Disability and Health (ICF).

This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an ‘umbrella term for disease (acute or chronic), disorder, injury or trauma’ (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]}.

Source and reference attributes

Origin:

World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health. Geneva: WHO
Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites
• WHO ICF website
http://www.who.int/classifications/icf/en
• Australian Collaborating Centre ICF website
http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Related metadata references:

Supersedes Participation - functioning, disability and health, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (17.2 KB)

Metadata items which use this glossary item:

Activities and participation code (ICF 2001) AN[NNN] Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Extent of environmental factors influence code (ICF 2001) [X]N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Functioning and Disability DSS Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Participation extent code (ICF 2001) N Community Services, Standard 16/10/2006
Health, Standard 29/11/2006

Participation satisfaction level code N Community Services,

Standard 16/10/2006
Health, Standard 29/11/2006

Prison

Identifying and definitional attributes

Metadata item type: Glossary Item

Synonymous names: Correctional Complex; Correctional Centre; Remand Centre; Prison Farm; Pre-Release Centre

METeOR identifier: 398976

Registration status: Health, Recorded 15/09/2010

Definition: A legally proclaimed correctional facility or remand centre which holds adult prisoners, excluding police prisons or juvenile detention facilities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Australian Institute of Health and Welfare 2006.Towards a national prisoner health information system. Cat. no. PHE 79. Canberra: AIHW.

Relational attributes

Metadata items which use this glossary item: Prisoner health DSS Health, Standard 25/08/2011

Prisoner

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 399172

Registration status: Health, Standard 25/08/2011

Definition: An adult (aged at least 18 years) who is held in custody and whose confinement is the responsibility of a correctional services agency. It includes sentenced prisoners and prisoners held in custody awaiting trial or sentencing (remandees). Juvenile offenders, persons in psychiatric custody, police cell detainees, those in periodic detention, asylum seekers or Australians held in overseas prisons are not included.

Source and reference attributes

Reference documents: AIHW (Australian Institute of Health and Welfare) 2010. The health of Australia's prisoners 2009. Cat. no. PHE 123. Canberra: AIHW.

Relational attributes

Metadata items which use this glossary item: Person—prisoner health discharge summary indicator, yes/no code N Health, Standard 25/08/2011

Psychiatrist

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327334
Registration status:	Health, Standard 08/12/2004
Definition:	Medical officers who are registered to practice psychiatry under the relevant state or territory Medical Registration Board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.

Relational attributes

Metadata items which use this glossary item:	Establishment—recurrent expenditure (salaries and wages) (consultant psychiatrists and psychiatrists) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Psychiatry registrar or trainee

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327344

Registration status: Health, Standard 08/12/2004

Definition: A medical officer who is a formal trainee within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.

Relational attributes

Metadata items which use this glossary item:

Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees) Health, Standard 08/12/2004

Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees), average N[NNN{.N}] Health, Standard 08/12/2004

Establishment—recurrent expenditure (salaries and wages) (psychiatry registrars and trainees)(financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Psychologist

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327346
Registration status:	Health, Standard 08/12/2004
Definition:	A person who is registered to practice psychology with the relevant state and territory registration board.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (psychologists) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (psychologists), average N[NNN{.N}] Health, Standard 08/12/2004 Establishment—recurrent expenditure (salaries and wages) (psychologists) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Public health

Identifying and definitional attributes

Metadata item type: Glossary Item

Synonymous names: Public health

METeOR identifier: 352234

Registration status: Health, Standard 05/12/2007

Definition: Organised response by society to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions is the population as a whole, or population subgroups (NPHP 1998).

Context: Public health functions

Collection and usage attributes

Guide for use: To be used for collecting information on public health expenditure and activities.

Collection methods: Collected through the National Public Health Expenditure Project and the Government Health Expenditure NMDS.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare.

Origin: National Public Health Partnership 1998.

Reference documents: (NPHP) National Public Health Partnership 1998. Public Health in Australia: the public health landscape: person, society, environment. Melbourne: NPHP.

Relational attributes

Metadata items which use this glossary item: Health or health related function code NNN Health, Standard 05/12/2007

Radiotherapy

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	437265
Registration status:	Health, Standard 07/12/2011
Definition:	Radiotherapy is the treatment of disease by means of ionizing radiation.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Dorland I, Newman WA 2003. Dorland's illustrated medical dictionary (30th edn). Philadelphia: Saunders p1564

Relational attributes

Metadata items which use this glossary item:	Cancer treatment—radiation dose administered, total Gray N[NN.NN] Health, Standard 07/12/2011 Cancer treatment—radiotherapy completion date, DDMMYYYY Health, Standard 07/12/2011 Cancer treatment—radiotherapy fractions administered Health, Standard 07/12/2011 Cancer treatment—radiotherapy fractions administered, total fractions N[N] Health, Standard 07/12/2011 Cancer treatment—radiotherapy start date Health, Standard 07/12/2011 Cancer treatment—radiotherapy start date, DDMMYYYY Health, Standard 07/12/2011 Cancer treatment—radiotherapy target site, code N[N] Health, Standard 07/12/2011 Cancer treatment—radiotherapy treatment type, code N[N] Health, Standard 07/12/2011 Course of radiotherapy treatment Health, Standard 07/12/2011 Radiotherapy completion date Health, Standard 07/12/2011 Radiotherapy fractions administered Health, Standard 07/12/2011 Radiotherapy start date Health, Standard 07/12/2011 Radiotherapy target site Health, Standard 07/12/2011 Radiotherapy target site code N[N] Health, Standard 07/12/2011 Radiotherapy treatment type code N[N] Health, Standard 07/12/2011

Record linkage

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327264

Registration status: Community Services, Standard 01/03/2005
Health, Standard 01/03/2005

Definition: A process, technique or method that enables the bringing together of two or more records that are believed to belong to the same individual.

Context: Record linkage may facilitate improved service provision, treatment or case management to individual clients.

Collection and usage attributes

Comments: Linkage can occur across data systems or within data systems and may be done by using a range of identifiers.

For statistical purposes, including planning, research or the measurement of service or program outcomes, record linkage facilitates separating multiple items clustered around individuals from total counts (for example, double counting of clients can be reduced when calculating total numbers of clients across several agencies).

The proposed use of a linkage key in the Home and Community Care program (HACC) Minimum Data Set is intended to make it possible to count the number of HACC clients (without counting clients more than once) and the services which they receive. The Commonwealth-State Territory Disability Agreement National Minimum Data Set is using the statistical linkage key based on that for the HACC Minimum Data Set.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Commonwealth Department of Health and Family Services 1998 Home and Community Care (HACC) Data Dictionary Version 1.0 Canberra: DHFS

Relational attributes

Related metadata references: Supersedes Record linkage, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (13.6 KB)

Metadata items which use this glossary item: Person (name)—family name, text X[X(39)] Community Services, Superseded 25/08/2005
Health, Superseded 04/05/2005

Person (name)—given name, text [X(40)] Community Services, Superseded 25/08/2005

Health, Superseded 04/05/2005

Person (name)—given name, text [X(40)] Community Services, Superseded 06/02/2012
Housing assistance, Standard 20/06/2005
Health, Standard 04/05/2005
Tasmanian Health, Proposed 28/09/2011

Registered nurse

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327182
Registration status:	Health, Standard 01/03/2005
Definition:	Registered nurses include persons with at least a three year training certificate and nurses holding post graduate qualifications. Registered nurses must be registered with the state/territory registration board. This is a comprehensive category and includes community mental health, general nurse, intellectual disability nurse, midwife (including pupil midwife), psychiatric nurse, senior nurse, charge nurse (now unit manager), supervisory nurse and nurse educator. This category also includes nurses engaged in administrative duties no matter what the extent of their engagement, for example, directors of nursing and assistant directors of nursing.

Relational attributes

Related metadata references:	See also Establishment—full-time equivalent staff (paid) (nurses), average NNNN.NN Health, Standard 07/12/2011
Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (registered nurses) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (registered nurses), average N[NNN{.N}] Health, Standard 01/03/2005 Establishment—recurrent expenditure (salaries and wages) (registered nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005 Female—number of antenatal care visits, total N[N] Health, Standard 12/10/2011 Non-admitted patient emergency department service episode—triage category, code N Health, Superseded 29/01/2012 Non-admitted patient emergency department service episode—triage category, code N Health, Standard 30/01/2012 Non-admitted patient emergency department service episode—triage category, code N Health, Superseded 30/01/2012 Non-admitted patient emergency department service episode—triage category, code N Health, Superseded 22/12/2009

Reserve

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 460218

Registration status: Health, Standard 07/12/2011

Definition: The dollar amount that is the best current estimate of the likely cost of a claim when closed.

Context: The reserve allows an insurer or self-insurer to monitor its potential financial liability with respect to a claim. The setting of a reserve marks an acknowledgement by an insurer or self-insurer that it may incur costs in closing a claim.

Collection and usage attributes

Comments: An insurer or self-insurer can obtain an estimate of its potential liability for finalising claims that are still open by adding up the outstanding reserve amounts for its claims that are still open. Accordingly, the reserve amounts set against open claims are important for an insurer or self-insurer in its budgeting and funds management.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Origin: Australian Institute of Health and Welfare 2005. Medical Indemnity National Collection (Public sector) Data Guide, Data items and definitions 2003–04. Canberra: AIHW

Relational attributes

Metadata items which use this glossary item:

Medical indemnity claim management episode—reserve placement date Health, Standard 07/12/2011

Medical indemnity claim management episode—reserve placement date, DDMMYYYY Health, Standard 07/12/2011

Medical indemnity claim management episode—reserve size, range code N[N] Health, Standard 07/12/2011

Reserve placement date Health, Standard 07/12/2011

Resident

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327198
Registration status:	Health, Standard 01/03/2005
Definition:	A person who receives residential care intended to be for a minimum of one night.
Context:	Specialised mental health services (Residential mental health care).

Collection and usage attributes

Comments:	A resident in one residential mental health service cannot be concurrently a resident in another residential mental health service. A resident in a residential mental health service can be concurrently a patient admitted to a hospital.

Relational attributes

Related metadata references:	Supersedes Resident, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (11.9 KB)
Metadata items which use this glossary item:	Admitted patient mental health care NMDS Health, Superseded 07/12/2005 Admitted patient mental health care NMDS Health, Superseded 23/10/2006 Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009 Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010 Admitted patient mental health care NMDS 2010-2011 Health, Superseded 18/01/2011 Admitted patient mental health care NMDS 2011-2012 Health, Superseded 07/12/2011 Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011 Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005 Episode of care—mental health legal status, code N Health, Standard 07/12/2011 Episode of care—mental health legal status, code N Health, Superseded 07/12/2011 Episode of care—number of psychiatric care days Health, Standard 01/03/2005

Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005

Episode of residential care Health, Standard 07/12/2011

Episode of residential care Health, Superseded 07/12/2011

Episode of residential care—episode end date Health, Standard 07/12/2011

Episode of residential care—episode end date Health, Superseded 07/12/2011

Episode of residential care—episode end date, DDMMYYYY Health, Superseded 07/12/2011

Episode of residential care—episode end date, DDMMYYYY Health, Standard 07/12/2011

Episode of residential care—episode start date Health, Standard 07/12/2011

Episode of residential care—episode start date Health, Superseded 07/12/2011

Episode of residential care—episode start date, DDMMYYYY Health, Standard 07/12/2011

Episode of residential care—episode start date, DDMMYYYY Health, Superseded 07/12/2011

Episode of residential care—number of leave days, total N[NN] Health, Superseded 07/12/2011

Episode of residential care—number of leave days, total N[NN] Health, Standard 07/12/2011

Episode of residential care—referral destination (mental health care) Health, Standard 07/12/2011

Episode of residential care—referral destination (mental health care) Health, Superseded 07/12/2011

Episode of residential care—referral destination (mental health care), code N Health, Standard 07/12/2011

Episode of residential care—referral destination (mental health care), code N Health, Superseded 07/12/2011

Establishment—number of available beds for admitted patients/residents Health, Superseded 03/12/2008

Establishment—number of available beds for admitted patients/residents, average N[NNN] Health, Superseded 03/12/2008

Health industry relevant organisation type code NNN Health, Superseded 01/04/2009

Health or health related function code NNN Health, Standard 05/12/2007

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Residential mental health care NMDS 2007-2008 Health,

Superseded 05/02/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Residential mental health care NMDS 2010-2011 Health, Superseded 21/12/2010

Residential mental health care NMDS 2011-2012 Health, Superseded 07/03/2012

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Residential stay—episode start date Health, Standard 01/03/2005

Residential stay—episode start date, DDMMYYYY Health, Standard 01/03/2005

Residential mental health care service

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 373049

Registration status: Health, Standard 02/12/2009

Definition: A residential mental health service is a service that is considered by the state, territory or commonwealth funding authorities as a service that:

- has the workforce capacity to provide specialised mental health services; and
- employs suitably trained mental health staff to provide rehabilitation, treatment or extended care on-site:

    to consumers residing on an overnight basis;

    in a domestic-like environment; and
- encourages the consumer to take responsibility for their daily living activities.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing (but the trained staff must be on site for a minimum of 6 hours a day and at least 50 hours per week).

Suitably trained residential mental health care staff may include:

- individuals with Vocational Education and Training (VET) qualifications in community services, mental health or disability sectors;
- individuals with tertiary qualifications in medicine, social work, psychology, occupational therapy, counselling, nursing or social sciences; and
- individuals with experience in mental health or disability relevant to providing mental health consumers with appropriate services.

Context: Specialised residential mental health services.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Residential mental health care service Health, Superseded 02/12/2009

Metadata items which use this glossary item: Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Admitted patient mental health care NMDS 2010-2011

Health, Superseded 18/01/2011

Admitted patient mental health care NMDS 2011-2012 Health, Superseded 07/12/2011

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Available bed—residential mental health care Health, Standard 03/12/2008

Available bed—residential mental health care, average number of beds N[NNN.N] Health, Standard 03/12/2008

Episode of care—mental health legal status, code N Health, Superseded 07/12/2011

Episode of care—mental health legal status, code N Health, Standard 07/12/2011

Health or health related function code NNN Health, Standard 05/12/2007

Mental health establishments NMDS 2010-2011 Health, Superseded 01/12/2010

Mental health establishments NMDS 2011-2012 Health, Superseded 07/12/2011

Mental health establishments NMDS 2012-2013 Health, Standard 07/12/2011

Residential mental health care Health, Standard 03/12/2008

Residential mental health care NMDS 2010-2011 Health, Superseded 21/12/2010

Residential mental health care NMDS 2011-2012 Health, Superseded 07/03/2012

Residential mental health care NMDS 2012-2013 Health, Standard 07/03/2012

Specialised mental health service organisation—accommodation services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 01/12/2010

Specialised mental health service setting code N Health, Standard 08/12/2004

Specialised mental health service—residential service unit identifier, XXXXXX Health, Standard 07/12/2011

Specialised mental health service—residential service unit name, text XXX[X(97)] Health, Standard 07/12/2011

Revenue (other revenue)

Identifying and definitional attributes

Metadata item type: Glossary Item

Synonymous names: Other revenue

METeOR identifier: 357543

Registration status: Health, Standard 05/12/2007

Definition: All other revenue received by the establishment that is not included under patient revenue or recoveries (but not including revenue payments received from state or territory governments). This would include revenue such as investment income from temporarily surplus funds and income from charities, bequests and accommodation provided to visitors.

See text relating to offsetting practices. Gross revenue should be reported (except in relation to payments for inter-hospital transfers of goods and services).

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Origin: Establishment—revenue (other revenue), METeOR Identification 269591, NHIG, Standard 01/03/2005

Relational attributes

Metadata items which use this glossary item:

Organisation—revenue Health, Standard 05/12/2007

Organisation—revenue, total Australian currency NNNNN.N Health, Standard 05/12/2007

Revenue (patient)

Identifying and definitional attributes

Metadata item type: Glossary Item

Synonymous names: Patient revenue

METeOR identifier: 357539

Registration status: Health, Standard 05/12/2007

Definition: Patient revenue comprises all revenue received by, and due to, an establishment in respect of individual patient liability for accommodation and other establishment charges. All patient revenue is to be grouped together regardless of source of payment (Commonwealth, health fund, insurance company, direct from patient) or status of patient (whether inpatient or non-inpatient, private or compensable). Gross revenue should be reported.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Origin: Establishment—revenue (patient) METeOR Identifier 269518 NHIG, Standard 01/03/2005

Relational attributes

Metadata items which use this glossary item:

Organisation—revenue Health, Standard 05/12/2007

Organisation—revenue, total Australian currency NNNNN.N Health, Standard 05/12/2007

Revenue (recoveries)

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 357541

Registration status: Health, Standard 05/12/2007

Definition: All revenue received that is in the nature of a recovery of expenditure incurred. This would include:

- income received from the provision of meals and accommodation to members of staff of the hospital (assuming it is possible to separate this from income from the provision of meals and accommodation to visitors);
- income received from the use of hospital facilities by salaried medical officers exercising their rights of private practice and by private practitioners treating private patients in hospital; and
- other recoveries such as those relating to inter-hospital services where the revenue relates to a range of different costs and cannot be clearly offset against any particular cost.

Generally, gross revenues should be reported but, where inter-hospital payments for transfers of goods and services are made, offsetting practices are acceptable to avoid double counting. Where a range of inter-hospital transfers of goods and services is involved and it is not possible to allocate the offsetting revenue against particular expenditure categories, then it is acceptable to bring that revenue in through recoveries.

Source and reference attributes

Origin: Establishment—revenue (recoveries) METeOR Identifier 269417, NHIG, Standard 01/03/2005

Relational attributes

Metadata items which use this glossary item: Organisation—revenue Health, Standard 05/12/2007

Organisation—revenue, total Australian currency NNNNN.N Health, Standard 05/12/2007

Salaried medical officer

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327188
Registration status:	Health, Standard 01/03/2005
Definition:	Medical officers employed by the hospital on a full time or part time salaried basis. This excludes visiting medical offices engaged on an honorary, sessional or fee for service basis. This category includes salaried medical officers who are engaged in administrative duties regardless of the extent of that engagement (for example, clinical superintendent and medical superintendent)

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (salaried medical officers) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (salaried medical officers), average N[NNN{.N}] Health, Standard 01/03/2005 Establishment—recurrent expenditure (salaries and wages) (salaried medical officers) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005 Establishment—recurrent expenditure (visiting medical officer payments) Health, Standard 01/03/2005

Same-day patient

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327270

Registration status: Health, Standard 01/03/2005

Definition: A same-day patient is a patient who is admitted and separates on the same date, and who meets one of the following minimum criteria:

- that the patient receive same-day surgical and diagnostic services as specified in bands 1A, 1B, 2, 3, and 4 but excluding uncertified type C Professional Attention Procedures within the Health Insurance Basic Table as defined in s.4 (1) of the *National Health Act 1953* (Commonwealth),
- that the patient receive type C Professional Attention Procedures as specified in the Health Insurance Basic Table as defined in s.4 (1) of the *National Health Act 1953* (Commonwealth) with accompanying certification from a medical practitioner that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.

Context: Admitted patient care.

Collection and usage attributes

Comments: Same-day patients may be either intended to be separated on the same day, or intended overnight-stay patients who left of their own accord, died or were transferred on their first day in the hospital.

Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient shall be regarded as part of the overnight episode.

Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care.

Data on same-day patients are derived by a review of admission and separation dates.

Source and reference attributes

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Same-day patient, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005 .pdf (14.5 KB)

Metadata items which use this glossary item:

Admitted patient care NMDS Health, Superseded 07/12/2005

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Admitted patient care NMDS 2010-2011 Health, Superseded 18/01/2011

Admitted patient care NMDS 2011-2012 Health, Superseded 11/04/2012

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Admitted patient mental health care NMDS 2010-2011 Health, Superseded 18/01/2011

Admitted patient mental health care NMDS 2011-2012 Health, Superseded 07/12/2011

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Episode of admitted patient care—intended length of hospital stay Health, Standard 01/03/2005

Episode of admitted patient care—length of stay (excluding leave days) Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Standard 04/07/2007

Episode of admitted patient care—number of leave days,

total N[NN] Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Establishment—number of patient days, total N[N(7)]
Health, Standard 01/03/2005

Separation

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327268

Registration status: Health, Standard 01/03/2005

Definition: Separation is the process by which an episode of care for an admitted patient ceases. A separation may be formal or statistical.

Formal separation:

The administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient.

Statistical separation:

The administrative process by which a hospital records the cessation of an episode of care for a patient within the one hospital stay.

Context: Admitted patient care.

Collection and usage attributes

Comments: This treatment and/or care provided to a patient prior to separation occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

While this concept is also applicable to non-Admitted patient care and welfare services, different terminology to 'separation' is often used in these other care settings.

Source and reference attributes

Submitting organisation: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Separation, version 3, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Metadata items which use this glossary item: Admitted patient care NMDS Health, Superseded 07/12/2005

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Admitted patient care NMDS 2010-2011 Health, Superseded 18/01/2011

Admitted patient care NMDS 2011-2012 Health, Superseded 11/04/2012

Admitted patient care NMDS 2012-2013 Health, Standard 11/04/2012

Admitted patient hospital stay Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Admitted patient mental health care NMDS 2010-2011 Health, Superseded 18/01/2011

Admitted patient mental health care NMDS 2011-2012 Health, Superseded 07/12/2011

Admitted patient mental health care NMDS 2012-2013 Health, Standard 07/12/2011

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Episode of admitted patient care Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of admitted patient care—number of leave days Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of admitted patient care—number of leave periods, total N[N] Health, Standard 01/03/2005

Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005
Tasmanian Health, Proposed 28/09/2011

Episode of admitted patient care—separation mode Health, Standard 01/03/2005

Episode of admitted patient care—separation mode, code N Health, Standard 01/03/2005

Episode of care—principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]} Health, Superseded 28/06/2004

Episode of care—principal diagnosis, code (ICD-10-AM 4th edn) ANN{.N[N]} Health, Superseded 07/12/2005

Episode of care—principal diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Episode of care—principal diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Episode of care—principal diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009
Tasmanian Health, Proposed 28/09/2011

Establishment—number of individual session occasions of service for non-admitted patients (alcohol and drug), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (community health services), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (district nursing services), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (emergency services), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (endoscopy and related procedures), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (mental health), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (other medical/surgical/diagnostic), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (other outreach services), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (pathology), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (pharmacy), total N[NNNNNN] Health, Standard 01/03/2005

Establishment—number of separations Health, Standard 01/03/2005

Establishment—number of separations (financial year), total N[NNNNN] Health, Standard 01/03/2005

Person—congenital malformation Health, Standard 01/03/2005

Person—congenital malformation, code (BPA 1979) ANN.N[N] Health, Standard 01/03/2005

Person—congenital malformation, code (ICD-10-AM 3rd edn) ANN{.N[N]} Health, Superseded 28/06/2004

Person—congenital malformation, code (ICD-10-AM 4th edn) ANN{.N[N]} Health, Superseded 07/12/2005

Person—congenital malformation, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Person—congenital malformation, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Person—congenital malformation, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

Separation mode Health, Standard 01/03/2005

Separation mode code N Health, Standard 01/03/2005

Severe hypoglycaemia

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327322

Registration status: Health, Standard 01/03/2005

Definition: **Hypoglycaemia** requiring assistance from another party.

Relational attributes

Metadata items which use this glossary item:

Person—severe hypoglycaemia history Health, Superseded 21/09/2005

Person—severe hypoglycaemia indicator Health, Standard 21/09/2005

Person—severe hypoglycaemia indicator, code N Health, Standard 21/09/2005

Social Worker

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327348
Registration status:	Health, Standard 08/12/2004
Definition:	Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (social workers) Health, Standard 08/12/2004 Establishment—full-time equivalent staff (paid) (social workers), average N[NNN{.N}] Health, Standard 08/12/2004 Establishment—recurrent expenditure (salaries and wages) (social workers) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Student nurse

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327328
Registration status:	Health, Standard 01/03/2005
Definition:	A person employed by a health establishment who is currently studying in years one to three of a three-year certificate course. This includes any person commencing or undertaking a three-year course of training leading to registration as a nurse by the State or Territory registration board. This includes full-time general student nurse and specialist student nurse, such as mental deficiency nurse, but excludes practising nurses enrolled in post-basic training courses.

Relational attributes

Metadata items which use this glossary item:	Establishment—full-time equivalent staff (paid) (student nurses) Health, Standard 01/03/2005 Establishment—full-time equivalent staff (paid) (student nurses), average N[NNN{.N}] Health, Standard 01/03/2005

Systemic therapy procedure

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 439586

Registration status: Health, Standard 07/12/2011

Definition: A systemic therapy procedure is a medical procedure that affects the hormonal or immunologic balance of the patient. It includes endocrine therapy and haematologic transplants and is used to treat cancer.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2011 revision. Commission on Cancer page 25-26

Relational attributes

Related metadata references: See also Cancer treatment—systemic therapy procedure date, DDMMYYYY Health, Standard 07/12/2011

Metadata items which use this glossary item: Cancer treatment—systemic therapy procedure date, DDMMYYYY Health, Standard 07/12/2011

Cancer treatment—systemic therapy procedure, code N[N] Health, Standard 07/12/2011

Trainee/pupil nurse

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327190

Registration status: Health, Standard 01/03/2005

Definition: Trainee/pupil nurse includes any person commencing or undertaking a 1-year course of training leading to registration as an enrolled nurse on the state/territory registration board (includes all trainee nurses).

Relational attributes

Metadata items which use this glossary item:

Establishment—full-time equivalent staff (paid) (trainee/pupil nurses) Health, Standard 01/03/2005

Establishment—full-time equivalent staff (paid) (trainee/pupil nurses), average N[NNN{.N}] Health, Standard 01/03/2005

Establishment—recurrent expenditure (salaries and wages) (trainee/pupil nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Transgender

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 398610

Registration status: Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Definition: A transgender person is a person who:

(a) identifies as a member of a different sex by living, or seeking to live, as a member of that sex; or

(b) has identified as a member of a different sex by living as a member of that sex; whether or not the person is a recognised transgender person.

Collection and usage attributes

Comments: A person's sex may change during their lifetime as a result of surgical procedures known alternatively as sex change, gender reassignment, transsexual surgery, transgender reassignment or sexual reassignment. Throughout this process, which may be over a considerable period of time, sex could be recorded as either male or female.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Australian Capital Territory Legislation (Gay, Lesbian and Transgender) Amendment Act 2003

Relational attributes

Metadata items which use this glossary item: Person—transgender indicator Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Person—transgender indicator, code N Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Transgender indicator Community Services, Standard 06/02/2012
Health, Standard 25/08/2011

Triage

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 334003

Registration status: Health, Standard 24/03/2006

Definition: Process by which a patient is briefly assessed upon arrival in the **emergency department** to determine the urgency of their problem and priority for care.

Context: Emergency department care

Source and reference attributes

Reference documents: Hospital Demand Management Group, Metropolitan Health and Aged Care Services Division, State Government Department of Human Services, Victoria.
http://www.health.vic.gov.au/hdms/triage.htm

Relational attributes

Metadata items which use this glossary item:

Non-admitted patient emergency department service episode—triage category, code N Health, Standard 30/01/2012

Non-admitted patient emergency department service episode—triage date, DDMMYYYY Health, Superseded 30/01/2012

Non-admitted patient emergency department service episode—triage date, DDMMYYYY Health, Superseded 22/12/2011

Non-admitted patient emergency department service episode—triage date, DDMMYYYY Health, Standard 30/01/2012

Non-admitted patient emergency department service episode—triage time, hhmm Health, Superseded 22/12/2011

Non-admitted patient emergency department service episode—triage time, hhmm Health, Superseded 30/01/2012

Non-admitted patient emergency department service episode—triage time, hhmm Health, Standard 30/01/2012

Triage category code N Health, Standard 01/03/2005

Urban Centre

Identifying and definitional attributes

Metadata item type: Glossary Item

Synonymous names: UC

METeOR identifier: 467399

Registration status: Health, Standard 07/12/2011

Definition: A population cluster of 1,000 or more people.

Context: Urban Centres, together with Localities, make up the Urban Centre/Locality (UC/L) structure maintained by the Australian Bureau of Statistics (ABS) as part of the Australian Standard Geographical Classification (ASGC).

A **Locality** is a population cluster of between 200 and 999 people. For statistical purposes, people living in Urban Centres are classified as urban while those in Localities are classified as rural.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: ABS cat. no. 2909.0. Statistical Geography: Volume 3 - Australian Standard Geographical Classification (ASGC) Urban Centres/Localities, Australia, 2006. Canberra: Australian Bureau of Statistics

Relational attributes

Metadata items which use this glossary item: Admitted patient care remoteness classification (ASGC-RA) N Health, Standard 07/12/2011

Health-care incident—geographic remoteness Health, Standard 07/12/2011

Locality Health, Standard 07/12/2011

Remoteness classification (ASGC-RA) N Health, Standard 07/12/2011

Visiting medical officer

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327170

Registration status: Health, Standard 01/03/2005

Definition: A visiting medical officer is a medical practitioner appointed by the hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee for service basis. This category includes the same Australian Standard Classification of Occupations codes as the salaried medical officers category.

Relational attributes

Metadata items which use this glossary item:

Establishment—recurrent expenditure (visiting medical officer payments) Health, Standard 01/03/2005

Establishment—recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Companion guide

What are the national data dictionaries?

The national data dictionaries contain standard data definitions and data elements for use in any Australian community services, health, or housing and homelessness data collection. The National Community Services Data Dictionary, the National Health Data Dictionary, and the National Housing Assistance Data Dictionary are the authoritative source of information about endorsed national metadata standards and provide the basis for consistent national collection and reporting. The national metadata standards are approved by the Australian Government and all state and territory relevant community services and health departments, as well as the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW). This work is funded under the auspices of the Community and Disability Services Ministers' Advisory Council (CDSMAC), the Australian Health Ministers' Advisory Council (AHMAC), and the Housing Ministers' Advisory Committee (HMAC).

Where possible, metadata standards in the dictionary are consistent with other national standard classifications to ensure overall comparability of national data. The ABS is the source of many key socioeconomic classifications used in data collections, for example, the Australian Standard Classification of Languages (ASCL), the Australian Standard Geographical Classification (ASGC) and the Australian and New Zealand Standard Classification of Occupations (ANZSCO).

The data dictionaries have been downloaded from METeOR, which is an online metadata registry for developing, registering and disseminating metadata based on the second edition of the international standard ISO/IEC 11179 Information Technology-Metadata registries in 2003 (ISO/IEC 11179:2003). For more information about METeOR, see the METeOR section on page 3566. The national community services and health data dictionaries are also available online at <http://meteor.aihw.gov.au>.

Governance

The national community services, health, and housing data dictionaries are, respectively, initiatives under the National Community Services Information Infrastructure Agreement; the National Health Information Agreement; and the National Housing and Homelessness Information Infrastructure Agreement.

Under these agreements, all parties agree to ensure that the collection, compilation and interpretation of national information are appropriate and carried out efficiently. This requires agreement on definitions, standards and rules for collecting information, and on guidelines for coordinating the access, interpretation and publication of national community services and health information.

Why use metadata standards?

Making data count

Metadata standards promote the quality, accuracy, interpretability, reliability, relevance, interchange ability, transparency, currency, accessibility, coherence and comparability of data and information.

Without metadata standards there is the potential for data to fail to measure what it is supposed to measure, or not be comparable across collections or over time.

Metadata standards enable consistent and comparable reporting of information about services, including describing what services are available, where they are located and how much they cost. Such standards also achieve consistency when reporting about people, for instance, who delivered a service and when, who received the service, and what happened to them as a result.

By making endorsed metadata standards readily available, users are assured that they can use these standards with confidence and that they will enable the maximum reuse of their data for future research: 'create once, use often'.

How are metadata standards developed?

Creating metadata standards is part of data development**.** Data development is the process of building a data set for a specific purpose. For example, one might wish to build a data set that supports research into cancer diagnoses, treatment and outcomes, or one that supports statistical reporting about the functioning of hospital emergency departments.

Data development demands a clear understanding of why the data are needed; for example, to underpin the design and evaluation of community services policy, or to assess the performance of services, or to support research into social inclusion.

It also requires an assessment of the practicalities of collecting the data. Building almost any data set will demand the assembly of data from multiple sources. Thus there must be an understanding of the diverse information systems from which data are drawn, and there must be an effort to apply or develop common standards for concepts, classifications, terminologies, data values and so on.

The quality of data, including its consistency and comparability, is enhanced when metadata standards are used to support the collection and use of a data set.

Metadata standards development process

Stage 1: Project proposal

A submission is made to the relevant data committee outlining:

- the purpose and scope of the project
- a business case for adoption
- details of national consultation, including the composition of the data working group, (comprising members with expertise in the subject area of the data development project)

- the nominated project manager responsible for managing the data development project
- expected time frames for completion of the data development project.

Stage 2: Data development

The project manager works with the AIHW's METeOR and Metadata Unit and the data working group to develop the metadata items that will be stored in the national metadata registry system, METeOR.

Data collected for national reporting purposes must be defined in a standardised way. The standard adopted for community services data is the International Standards Organisation's metadata registry standard (ISO/IEC 11179:2003).

For more information about the data development process, see the AIHW publication *A guide to data development*, available at: <http://www.aihw.gov.au/publications/index.cfm/title/10422>.

Stage 3: Metadata standards review

The AIHW's METeOR and Metadata Unit undertakes a quality assurance review of the proposed metadata standards. This involves assessing all metadata standards for issues such as technical integrity, compliance with ISO/IEC 11179 and consistency with other standards, and the clarity of the content.

During this stage, the project manager receives feedback, makes adjustments and reports back to the data working group if required.

Stage 4: Endorsement of metadata standards

Once a final metadata assessment has been conducted, and the METeOR and Metadata Unit has provided a certification of the quality of the metadata standards, the metadata is submitted to the relevant endorsing body for final endorsement as a national standard.

Registration status progression

The registration status is the value assigned to a metadata item as it progresses through the standards development and review process. The registration statuses in METeOR are:

Proposed

- A developer has submitted this item for consideration by the METeOR registrar.

Recorded

- The METeOR registrar has conducted an initial technical review and determined that the item meets basic quality criteria.

Candidate

- The item has been compliance checked by the METeOR registrar and is ready for further development or review by the data developer.

Standardisation pending

- The item has undergone a final compliance check by the METeOR registrar and the data working group has recommended the item to a registration authority for approval as a standard.

Standard

- The item has been endorsed by a registration authority as a national data standard.

Superseded

- A registration authority has superseded this item with another standard.

Retired

- The item has been nominated by registration authority as retired.

Not progressed

- The item will no longer be considered by the registrar, a data committee or a registration authority.

Who benefits from using metadata standards?

Information managers use standard formats and definitions to support the receipt, transfer, storage and management of data.

Program managers use data standards as the basis for describing information requests (that is, data required under formal service or funding agreements, and contracts); measuring service activity, client flows, client characteristics and service usage; understanding demand; better planning of services; describing unmet need (need comparability of population and survey data); and understanding ways to integrate service delivery, resulting in better targeting and usage of services and ultimately cost savings.

Researchers use data standards as the common language to support survey work, as well as to integrate data from other sources.

Policy makers need aggregated information for future policy, management and funding decisions, that is, information to support comparisons across jurisdictions, programs and sectors.

Statisticians use data standards for interpreting and analysing data, analysing results, linking data sets for statistical purposes, and carrying out time series analysis (over a period of time) and longitudinal studies (over a period of time within groups).

Metadata structure

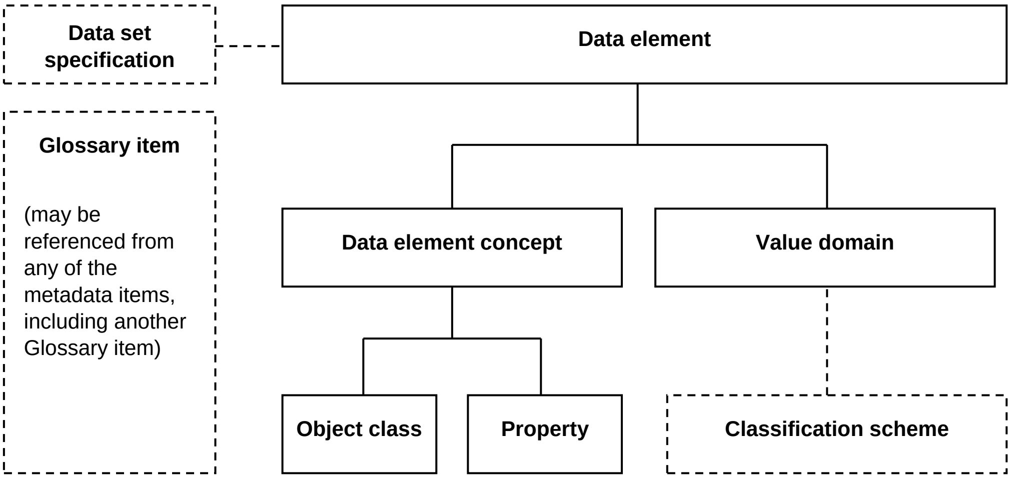
The metadata standards are based on the 2003 version of the ISO/IEC 11179 international standard for metadata registries. Part three of the standard is a model for a metadata registry and the formulation of metadata items.

There are six types of metadata defined by ISO/IEC 11179 that have been applied to METeOR and the data dictionaries:

- Object class
- Property
- Data element concept
- Data element
- Value domain
- Classification scheme.

The structure underlying a data element in the dictionary is illustrated in Figure 1.

Types of metadata


Data set specification
Data element
Glossary item
(may be referenced from any of the metadata items, including another Glossary item)
Data element concept
Value domain
Object class
Property
Classification scheme

Note: Dashed lines show metadata types that are additional to, or different from, the ISO/IEC standard.

Figure 1: The ISO/IEC 11179 model of metadata representation

Components of data elements

The things that we want to know about include ideas (knowledge), persons, organisations, the environment and events. These things are termed *Object classes*. Some examples of Object classes are ‘Person’, ‘Dwelling’ and ‘Service provider organisation’. A characteristic of the Object class is known as a *Property*. It is normally the item of interest. For example, the Object class ‘Person’ can have properties such as ‘Sex’ and ‘Date of birth’.

A *Data element concept* is defined as a concept created by the union of an Object class and a Property. Only one Object class and one Property can be joined for each Data element concept, for example, ‘Person—date of birth’.

As can be seen from Figure 1, a *Data element* is formed when a Data element concept is represented in the real world by a set of values (a *Value domain*).

A Value domain specifies how something is to be represented. A Value domain can specify:

- the range of permitted values, for example, a measure of weight in grams represented by three numeric characters
- all permissible values as a set of codes, for example, ‘Code 1 Female’, ‘Code 2 Male’
- the values referenced from a nationally or internationally endorsed classification, such as all codes in the Australian Standard Classification of Languages 2011, or all activity

codes listed in the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification, 7th edition.

A *Glossary item* defines the meaning of a term within a specific context. Examples of Glossary items include 'Adoption' and 'Family'. These are not currently defined as Object classes but their meaning must be clarified as part of the data development process.

Data set specifications

A data set specification (DSS) is a grouping of a number of Data elements and the conditions under which they are collected. A DSS defines:

- the scope of the collection, that is, the population that is the target of the data development
- the level at which the data will be collected and reported
- whether the inclusion of each Data element is mandatory, optional or conditional, and the sequence in which Data elements are included.

National minimum data sets

A national minimum data set (NMDS) is a type of DSS, made up of a minimum set of Data elements agreed by the national community services or health information groups for mandatory collection and reporting at a national level. An NMDS may include data elements that are also included in another NMDS.

An NMDS is contingent upon a national agreement to collect uniform data and to supply it as part of the national collection, but does not preclude agencies and service providers from collecting additional data to meet their own specific needs.

An example of an NMDS is the Juvenile Justice NMDS, which is used to obtain information about young people under juvenile justice supervision in Australia.

Non-mandatory data set specifications

DSSs are data sets that are not mandated for national collection and reporting, but are recommended as best practice.

For example, the Diabetes (clinical) Data Set Specification is a non-mandatory data set that aims to ensure national consistency in relation to defining, monitoring and recording information on patients diagnosed with diabetes.

Integration of data elements in data dictionaries

The national community services and health data dictionaries contain about 100 integrated data items that can be used consistently across the community services and health sectors. This is especially important for services that straddle sector boundaries, such as aged care, mental health, drug and alcohol services, and services for people with a disability.

Examples of integrated data items are:

Accuracy indicator, code AAA

Activity and participation life area, code (ICF 2001) AN[NNN]

Address line, text [X(180)]

Informal carer existence indicator, code N

Interpreter service required, yes/no code N

Labour force status, code N

Organisation name, text [X(200)]

Formulation of good data standards

1. **A metadata item must have, at least, a name and a definition.**
2. **A metadata item can have an explicitly stated context within which the definition has meaning.**
3. **The name of the standard version of the metadata item must follow certain criteria:**
   - the name must be unique within the context of the metadata item
   - the name must be stated in the singular
   - the name must reflect the concept being defined
   - the name must avoid the use of abbreviations or acronyms other than those widely accepted (for example radar, laser, pH)
   - the name should avoid the use of words that imply a preselected single instance.
4. **Definition rules and guidelines**

   A definition must:

   - be stated in the singular
   - state what the concept is, not only what it is not
   - be stated as a descriptive phrase or sentence(s)
   - contain only commonly understood abbreviations
   - be expressed without embedding definitions of other data or underlying concepts.

   A data definition should:

   - be expressed without embedding rationale, functional usage, domain information or procedural information
   - state the essential meaning of the concept
   - be precise and unambiguous
   - be concise
   - be able to stand alone
   - avoid circular reasoning
   - use the same terminology and consistent logical structure for related definitions
   - contain information appropriate for the type of metadata item being defined
   - use a preferred term to represent the definition of a concept specified elsewhere in the document
   - pass the substitution test.
5. **Context should be closely linked to definition.**

6. **Information must be included in a metadata item attribute only if it is appropriate for that attribute or metadata item.**

   - Context
     - Metadata can exist within a specific context.
     - Only information that is relevant to the environment or framework within which the definition for the metadata item is valid must be included in the Context attribute.
     - The contexts of two metadata items must be compatible when the definition of one metadata item references a term defined in another.
   - Guide for use information must be included in any metadata item only if it is intended to provide advice or interpretation on how to use the particular metadata item or data collected using the metadata item.
     - In metadata items other than Data elements, Guide for use information should be about how to use the item itself and not about any data that can be collected or used.
     - Data elements can also include information about how to use or interpret the data in the Guide for use.
   - The Collection methods attribute must only include information about how data is to be collected. The following metadata items must not have a metadata attribute of Collection methods:
     - Object class
     - Property
     - Data element concept
     - Value domain
     - Glossary item.
   - Permissible values in a Value domain must:
     - be exhaustive within the set
     - be made into an exhaustive set of values by adding an ‘Other’ to aggregate all other possibilities not covered by the stated set of values
     - be mutually exclusive within the set
     - be a true representation of the concept defined in the Data element.
   - When allocating code values:
     - avoid the use of a code value for ‘Other’ that is contiguous with the last code in the sequence of permissible values or that, in any other way, does not provide for inclusions in the future
     - wherever possible, avoid the use of a coded value for ‘Other’ that may be commonly used as a Supplementary value.
   - Supplementary values
     - Supplementary values must not be included in a Value domain unless it is necessary.
     - Do not include valid permissible values in the Supplementary values attribute of a Value domain.
     - Avoid the use of values that are contiguous with the last code in the permissible value sequence.

- To limit variations in the meaning within a specific data collection, use a default Supplementary value meaning of 'Not stated/inadequately described'.
- When using more than one Supplementary value, use a logical set.
- It is appropriate that the Supplementary value field size is the same number of characters as the permissible value.
- Consistent use of Supplementary codes/values across the Data elements in a data set should be applied.
- In non-enumerated Value domains (that is, those without defined value meanings, such as in a measurement) the Supplementary value used should not be a valid permissible value.

7. **Always use a standard format for referencing publications and not a mixture of referencing methods.**

METeOR

METeOR is the AIHW's online metadata registry.

It integrates and presents information about:

- the National Community Services Data Dictionary
- the National Health Data Dictionary
- the National Housing Assistance Data Dictionary
- national minimum data sets
- data set specifications
- performance indicator specifications.

It includes:

- data search and browse tools that allow navigation of data standards of varying levels of endorsement and across the community services, health and housing assistance sectors
- data view, collation and download tools
- data development tools, including areas in which multiple data developers may collaborate on the development of data standards
- data submission tools that enable data developers to submit draft metadata standards for consideration as national standards
- data management tools that allow the registrar to change the registration status of metadata standards under authorisation of one or more registration authorities
- comprehensive guidelines for developing and reviewing metadata.

METeOR is based on the 2003 version of the ISO/IEC 11179, Information Technology—Metadata registries. This standard was applied to provide a detailed registry architecture in which metadata standards can be better defined, navigated and managed throughout the data development lifecycle. METeOR is an internet-based application accessible through the web address <http://meteor.aihw.gov.au>.

Data Element Technical Names

Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service service provider type, occupation code (ANZSCO 1st edition) N[NNN]{NN} 85

Establishment (prison)—Aboriginal community controlled health organisation or Aboriginal medical service visitation frequency, code N 87

Establishment—accrued mental health care days, total N[N(7)] 89

Person—activity and participation life area, code (ICF 2001) AN[NNN] 92

Injury event—activity type, code (ICD-10-AM 7th edn) ANNNN 96

Injury event—activity type, non-admitted patient code N[N] 98

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Feedback and contact details

The development of the data dictionaries is an ongoing process, reliant on the support and input of a range of data development groups to expand its scope and utility.

The data committees welcome feedback on existing metadata standards in the data dictionaries, and also submissions (either for new data items, modifications to existing items, or information on your data development activities).

Please feel free to contact the AIHW by any of the means listed below.

METeOR and Metadata Unit

For further information about the data dictionaries and for any comments and suggestions about national standards development processes, please contact the METeOR and Metadata Unit at the AIHW.

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Further information can also be obtained from the Committees page on the AIHW website: <http://www.aihw.gov.au/committees/index.cfm>.

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The National Health Data Dictionary provides national standards for the broader health sector. This update reflects changes to data standards between 1 July 2010 and 30 April 2012. During this time 10 data set specifications, 23 data element clusters, 177 data elements, one classification and 20 glossary items have been added. Twelve national minimum data sets, two data set specifications, 96 data elements, five classifications and three glossary items have been superseded, and three national standards have been retired since Version 15 of the NHDD was published.

National Health Data Dictionary Version 16, 2012

AIHW