National Health Data Dictionary Version 13.3 Volume 1 Data elements A to Co

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Data Elements

Accrued mental health care days

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

A day is measured from midnight to 2359 hours.

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

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

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

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

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

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

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

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

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

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

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

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

Collection methods:

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

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

population.

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Activity and participation life area

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Collection and usage attributes

Guide for use:

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

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

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

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

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

CODE d9 Community, social and civic life

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

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

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

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

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

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

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

Source and reference attributes

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

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

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

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

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

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

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

Activity when injured

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

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

Activity when injured (non-admitted patient)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

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

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

Actual place of birth

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

9	Not stated

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

CODE 4 Home

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

CODE 8 Other

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

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:

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

Implementation in Data Set Specifications:

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

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

Acute coronary syndrome procedure type

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

99	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

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

Source and reference attributes

Submitting organisation:

Acute coronary syndrome data working group

Steward:

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

Relational attributes

Related metadata references:

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

Implementation in Data Set Specifications:

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

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

Acute coronary syndrome stratum

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	with ST elevation (myocardial infarction)
2	with non-ST elevation ACS with high-risk features
3	with non-ST elevation ACS with intermediate-risk features
4	with non-ST elevation ACS with low-risk features

Supplementary values:

9	Not reported

Collection and usage attributes

Guide for use:

CODE 1 With ST elevation (myocardial infarction)

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

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

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

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

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

more contiguous leads,

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

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

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

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

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

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

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

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

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

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

Collection methods: Collected at time of presentation.

Only one code should be recorded.

Must be collected in conjunction with Person—acute coronary

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

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

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

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

Relational attributes

Related metadata references: Supersedes Acute coronary syndrome stratum, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (20.61 KB)

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

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

Additional diagnosis

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

treatment

- Diagnostic procedures
- Increased clinical care and/or monitoring

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

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

Source and reference attributes

Origin: National Centre for Classification in Health

Relational attributes

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

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

Implementation start date: 01/07/2008

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

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

Implementation start date: 01/07/2008

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

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

Implementation start date: 01/07/2008

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

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

Implementation start date: 01/07/2008

Address line (person)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

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

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

- Lot/section number

- Street name

- Street type code

- Street suffix code

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

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

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

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

Multiple Address lines may be recorded as required.

Collection methods:

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

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

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

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

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

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

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

Source and reference attributes

Submitting organisation: Standards Australia

Origin: Health Data Standards Committee

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

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

Relational attributes

Related metadata references:

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

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

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

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

Standard 30/09/2005

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

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

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

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

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

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

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

Implementation in Data Set Specifications:

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

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

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

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

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

Address line (service provider organisation)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

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

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

- Street suffix code

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

Collection methods:

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

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

Source and reference attributes

Submitting organisation: Standards Australia

Origin: Health Data Standards Committee

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

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

Relational attributes

Related metadata references:

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

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

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

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

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

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

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

Address type (person)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

9	Unknown/Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Business

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

CODE 2 Mailing or postal

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

CODE 3 Residential

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

CODE 4 Temporary residential

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

CODE 9 Unknown/Not stated/inadequately described

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

Data element attributes

Collection and usage attributes

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

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

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

Source and reference attributes

Submitting organisation:
Standards Australia
Australian Institute of Health and Welfare

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

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

Relational attributes

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

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

Address type (service provider organisation)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Business
2	Mailing or postal

Supplementary values:

9	Unknown/Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Business

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

CODE 2 Mailing or postal

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

CODE 9 Unknown/Not stated/inadequately described

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

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

Address—country identifier (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—country identifier, code (SACC 1998) NNNN
METeOR identifier:	288091
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The country component of the address of a person, as represented by a code.
Data Element Concept:	Person (address)—country identifier

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

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

Administrative health region name

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	Palliative Care Intergovernmental Forum

Relational attributes

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

Information specific to this data set:
Within the context of this collection, administrative health region boundaries may overlap.

Administrative health region palliative care strategic plan indicator

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

A strategic plan typically has a mission statement, outlines a

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

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

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

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

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

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

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

Admission date

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:

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

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

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

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

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

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

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

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

Is used in the formation of Episode of admitted patient care

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

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

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

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Information specific to this data set:

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

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Information specific to this data set:
Right justified and zero filled.
admission date ≤ separation date
admission date ≥ date of birth

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Information specific to this data set:
Right justified and zero filled.
admission date <= separation date
admission date >= date of birth

Admission time

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

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

Admitted patient election status

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Public
2	Private

Collection and usage attributes

Guide for use:

Public patient:

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

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

Private patient:

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

Clause 49 states that:

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

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

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

- a public patient or
- a private patient

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

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

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

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

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

Source and reference attributes

Submitting organisation:

Admitted patient care NMDS Technical Reference Group

Relational attributes

Related metadata references:

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

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Age

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

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

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

Source and reference attributes

Submitting organisation: National Public Health Information Working Group

Origin: Australian Bureau of Statistics, *Standards for Social, Labour and Demographic Variables*. Reference through: www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary

Relational attributes

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

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

Information specific to this data set:

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

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

Age range

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

99	Not stated

Data element attributes

Collection and usage attributes

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

the standard 10 year ranges recommended by the ABS.

Source and reference attributes

Submitting organisation: National Public Health Information Working Group

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

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

Relational attributes

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

Information specific to this data set:
For some data collection settings, using Computer Assisted Telephone Interviewing (CATI), the suggested question is :

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

0-4

5-14

15-24

25-34

35-44

45-54

55-64

65-74

75 years or older

Refused

Alcohol consumption frequency (self reported)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

Value	Meaning
99	Not reported

Data element attributes

Collection and usage attributes

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

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

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

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

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

Relational attributes

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

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

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

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

Information specific to this data set:

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

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

Alcohol can also be a contributor to acute health problems.

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

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

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

The table below outlines those patterns.

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

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

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

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

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

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

Alcohol consumption in standard drinks per day (self reported)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
99	Consumption not reported

Unit of measure: Standard drink

Collection and usage attributes

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

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

Data element attributes

Collection and usage attributes

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

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

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

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

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

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

Collection methods:

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

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

Origin:

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

Relational attributes

Related metadata references:

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

Implementation in Data Set Specifications:

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

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

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

Information specific to this data set:

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

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

Evidence from prospective studies indicates that heavy alcohol consumption is associated with increased mortality and morbidity from coronary heart disease and stroke (Hanna et al. 1992). However, there is some evidence to suggest that alcohol appears to provide some protection against heart disease (both illness and death) for both men and women from middle age onwards. Most if not all of this benefit is achieved with 1-2 standard

drinks per day for men and less than 1 standard drink for women (the National Health and Medical Research Council's Australian Alcohol Guidelines, October 2001).

Anaesthesia administered for operative delivery of the baby

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

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

Analgesia administered for labour

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	None
2	Nitrous oxide
4	Epidural or caudal
5	Spinal
6	Systemic opioids
7	Combined spinal-epidural
8	Other

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Systemic opioids include both intra-muscular and intravenous opioids. Code 7: this code is used when this technique has been selected for the administration of analgesia for labour.
Collection methods:	More than one agent or technique can be recorded, except where 1=none applies. This item is to be recorded for first and second stage labour, but not third stage labour e.g. removal of placenta.
Comments:	Analgesia use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

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

Angiotensin converting enzyme (ACE) inhibitors therapy status

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

Value	Meaning
90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 21 - 29 Not given

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

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

Relational attributes

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

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

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

Information specific to this data set:

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

Anticipated patient election status

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Public
2	Private

Collection and usage attributes

Guide for use:

CODE 1 Public patient:

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

CODE 2 Private patient:

An eligible person who elects to be treated as a private patient; and elects to be responsible for paying fees of the type referred to in clause 57 (clause 58 of the Northern Territory Agreement) of the Australian Health Care Agreements.

Clause 57 states that 'Private patients and ineligible persons may be charged an amount for public hospital services as determined by the State'.

Data element attributes

Collection and usage attributes

Guide for use:

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

- a public patient; or
- a private patient

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

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

Comments:

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

Relational attributes

Related metadata references:

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

Apgar score at 1 minute

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

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

Apgar score at 5 minutes

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

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

Implementation start date: 01/07/2008

Information specific to this data set:

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

Area of usual residence

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

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

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

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

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

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

Collection methods:

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

Comments:

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

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

Source and reference attributes

Origin:

Health Data Standards Committee

Relational attributes

Related metadata references:

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

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2008

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

Implementation start date: 01/07/2008

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

Implementation start date: 01/07/2008

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

Implementation start date: 01/07/2008

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

Implementation start date: 01/07/2008

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

Implementation start date: 01/07/2008

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

Implementation start date: 01/07/2008

Aspirin therapy status

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

Value	Meaning
90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 21 - 29 Not given
If recording `Not given', record the principal reason if more than one code applies.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

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

Relational attributes

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

07/12/2005

Information specific to this data set:

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

Assistance with activities

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Source and reference attributes

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

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

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

Reference documents:

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

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

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

Australian State/Territory identifier (establishment)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Health Data Committee
National Community Services Data Committee

Relational attributes

Related metadata references:

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

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

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

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

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

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

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

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

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

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Information specific to this data set:
This data element applies to the location of the establishment and not to the patient's area of usual residence.

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Australian State/Territory identifier (jurisdiction)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

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

Source and reference attributes

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

Data element attributes

Source and reference attributes

Submitting organisation: Health expenditure advisory committee

Relational attributes

Implementation in Data Set Specifications:	Government health expenditure NMDS 2008-2009 Health, Standard 05/12/2007 *Implementation start date:* 01/07/2008

Australian state/territory identifier

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

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

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

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

Relational attributes

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

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

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

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

Australian state/territory identifier (service provider organisation)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Health Data Standard Committee

National Community Services Data Committee

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

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

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

Relational attributes

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

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

Information specific to this data set:
When used specifically in the collection of address information for a client, the following local implementation rules may be applied:

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

Behaviour-related risk factor intervention - purpose

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Smoking
2	Nutrition
3	Alcohol misuse
4	Physical inactivity
8	Other

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

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

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

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

Information specific to this data set:

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

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

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

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

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

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

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

evidence-based interventions and to ensure adoption of best practice initiatives widely through general practice.

Behaviour-related risk factor intervention

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

99	Not stated/inadequately defined

Collection and usage attributes

Guide for use:

CODE 01 No intervention

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

CODE 02 Information and education (not including written regimen)

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

CODE 03 Counselling

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

CODE 04 Pharmacotherapy

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

CODE 05 Referral provided to a health professional

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

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

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

CODE 07 Written regimen provided

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

CODE 08 Surgery

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

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

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

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

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

Beta-blocker therapy status

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

Value	Meaning
90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 15 - 29 Not given

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

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

Relational attributes

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

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

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

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

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:

Value	Meaning
9	Not stated

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee Standards Australia

Relational attributes

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

Specifications:

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

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Birth plurality

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

9	Not stated

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Birth plurality, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.59 KB)
Implementation in Data Set Specifications:	Health care client identification Health, Superseded 04/05/2005 Health care client identification DSS Health, Standard 04/05/2005 Perinatal NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Perinatal NMDS Health, Superseded 06/09/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Perinatal NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Bleeding episode using TIMI criteria (status)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

Value	Meaning
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.

CODE 4 None

No bleeding event

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

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

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

Relational attributes

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

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

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

Information specific to this data set:

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

Blindness (diabetes complication)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Blindness - (
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 (19.69 KB)
Implementation in Data Set	Diabetes (clinical) DSS Health, Superseded 21/09/2005

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

Information specific to this data set:

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

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

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

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

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

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

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

References:

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

The Diabetic Retinopathy Study Research Group. Photocoagulation treatment of proliferative diabetic retinopathy.

Clinical application of Diabetic Retinopathy Study (DRS) finding, DRS Report Number8. Ophthalmology. 1981; 88:583/600).

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

Blood pressure—diastolic (measured)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure: Millimetre of mercury (mmHg)

Data element attributes

Collection and usage attributes

Guide for use:

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

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

Collection methods:

Measurement protocol for resting blood pressure:

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

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

too small.

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

Comments:

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

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

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

National Diabetes Data Working Group

Origin:

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

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

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

Reference documents:

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

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

UKPDS 38 Tight blood pressure control and risk of

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

Relational attributes

Related metadata references:

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

Implementation in Data Set Specifications:

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

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

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

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

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

Information specific to this data set:

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

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

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

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

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

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

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

Wentworth 1992).

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

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

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

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

Information specific to this data set:
The United Kingdom Prospective Diabetes Study (1987 to 1998) showed major benefit from lowering blood pressure in preventing diabetes complications.

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

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

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

Blood pressure—systolic (measured)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure: Millimetre of mercury (mmHg)

Data element attributes

Collection and usage attributes

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

Collection methods: Measurement protocol for resting blood pressure:

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

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

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

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

Comments:

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

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

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

National Diabetes Data Working Group

Origin:

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

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

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

Reference documents:

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

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

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

Relational attributes

Related metadata references:

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

Implementation in Data Set Specifications:

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

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

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

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

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

Information specific to this data set:

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

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

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

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

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

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

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

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

The risk of disease increases as the level of blood pressure increases. When blood pressure is lowered by 4-6 mm Hg over two to three years, it is estimated that the risk reduces by14 per cent in patients with coronary heart disease and

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

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

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

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

Information specific to this data set:

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

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

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

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

Bodily location of main injury

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

Comments:

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

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

Source and reference attributes

Submitting organisation:

National Injury Surveillance Unit, Flinders University, Adelaide

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references:

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

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

Implementation in Data Set Specifications:

Injury surveillance DSS Health, Superseded 05/02/2008

Injury surveillance DSS Health, Standard 05/02/2008

Injury surveillance NMDS Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS Health, Superseded 07/12/2005

Body function

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Collection and usage attributes

Guide for use:

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

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

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

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

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

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

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

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

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

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

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

Source and reference attributes

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

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

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

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

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

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

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

Body mass index—adult (measured)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Guide for use:

Formula:BMI = weight (kg) divided by height (m) squared.

Body mass index is a continuous variable.

Code body mass index to one or two decimal places (i.e. 99.99 or 99.9). If any component necessary for its calculation (i.e. weight or height for adults) is unknown or has not been collected, code to 888.8, 999.9.

Collection methods:

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

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

Comments:

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

BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as Magnetic

Resonance Imaging and Dual X-ray Absorptiometry.

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

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

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

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

Presentation of data:

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

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

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

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

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

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

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

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

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

Source and reference attributes

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

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

Relational attributes

Related metadata references:

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

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

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

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

Body mass index—adult (self-reported)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Collection methods:

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

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

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

Comments:

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

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

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

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

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

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

Presentation of data:

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

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

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

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

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

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

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

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

Source and reference attributes

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

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

Relational attributes

Related metadata references:

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

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

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

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

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

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

Body mass index—child (measured)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Collection methods:

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

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

Comments:

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

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

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

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

are exceedingly common in Australia and their prevalence is increasing.

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

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

Presentation of data:

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

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

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

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

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

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

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

societies.

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

Source and reference attributes

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

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

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

Relational attributes

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

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

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

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

Body mass index—child (self-reported)

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Collection methods:

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

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

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

Comments:

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

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

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

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

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

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

Presentation of data:

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

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

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

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

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

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

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

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

Source and reference attributes

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

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

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

Relational attributes

Related metadata references:

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

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

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

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

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

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

Body mass index—classification

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Adults:

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

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

Children/adolescents:

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

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

To determine overweight and obesity in children and

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

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

Collection methods:

Use N for BMI category determined (1,2,3 or 9) for persons (children and adolescents) aged 2 to 17 years.

Use N.N for BMI category determined (1.1,1.2,2.1,2.2,3.1,3.2,3.3 or 9.9) for persons aged 18 years or older.

Standard definitions of overweight and obesity in terms of BMI are used to derive age-specific and age-adjusted indicators of overweight and obesity for reporting progress towards National public health policy .

Data element attributes

Collection and usage attributes

Guide for use:

Table 1: Classification of overweight and obesity for children and adolescents

Age(years)	BMI equivalent to 25 kg/m2		BMI equivalent to 30 kg/m2	
	Males	Females	Males	Females
2	18.41	18.02	20.09	19.81
2.5	18.13	17.76	19.80	19.55
3	17.89	17.56	19.57	19.36
3.5	17.69	17.40	19.39	19.23
4	17.55	17.28	19.29	19.15
4.5	17.47	17.19	19.26	19.12
5	17.42	17.15	19.30	19.17
5.5	17.45	17.20	19.47	19.34
6	17.55	17.34	19.78	19.65
6.5	17.71	17.53	20.23	20.08
7	17.92	17.75	20.63	20.51
7.5	18.16	18.03	21.09	21.01
8	18.44	18.35	21.60	21.57
8.5	18.76	18.69	22.17	22.18
9	19.10	19.07	22.77	22.81
9.5	19.46	19.45	23.39	23.46
10	19.84	19.86	24.00	24.11
10.5	20.20	20.29	24.57	24.77

11	20.55	20.74	25.10	25.42
11.5	20.89	21.20	25.58	26.05
12	21.22	21.68	26.02	26.67
12.5	21.56	22.14	26.43	27.24
13	21.91	22.58	26.84	27.76
13.5	22.27	22.98	27.25	28.20
14	22.62	23.34	27.63	28.57
14.5	22.96	23.66	27.98	28.87
15	23.29	23.94	28.30	29.11
15.5	23.60	24.17	28.60	29.29
16	23.90	24.37	28.88	29.43
16.5	24.19	24.54	29.14	29.56
17	24.46	24.70	29.41	26.69
17.5	24.73	24.85	29.70	29.84
18	25.00	25.00	30.00	30.00

Comments:

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

BMI can be considered to provide the most useful, albeit crude, population-level measure of obesity. The robust nature of the measurements and the widespread routine inclusion of weights and heights in clinical and population health surveys mean that a more selective measure of adiposity, such as skinfold thickness measurements, provides additional rather than primary information. BMI can be used to estimate the prevalence of obesity within a population and the risks associated with it, but does not, however, account for the wide variation in the nature of obesity between different individuals and populations (WHO 2000).

BMI values for adults are age-independent and the same for both sexes.

However, BMI values for children and adolescents aged 2 to 17 years are age and sex specific and are classified by comparing against the above table, Table 1: Classification of BMI for children and adolescents.

For adults and children and adolescents BMI may not correspond to the same degree of fatness in different populations due, in part, to differences in body proportions. The classification table shows a simplistic relationship between BMI and the risk of comorbidity, which can be affected by a range of factors, including the nature of the diet, ethnic group and activity level. The risks associated with increasing BMI are

continuous and graded and begin at a BMI of 25 (or equivalent to 25 for children and adolescents). The interpretation of BMI grades in relation to risk may differ for different populations. Both BMI and a measure of fat distribution (waist circumference or waist: hip ratio in adults) are important in calculating the risk of obesity comorbidities.

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

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

Presentation of data:

Methods used to establish cut-off points for overweight have been arbitrary and, as a result, cut-off points vary between countries. The data are derived mainly from studies of mortality and morbidity risk performed in people living in western Europe or the United States of America, and cut-off points for BMI as an indicator of adiposity and risk in populations who differ in body build and genetic disposition are likely to vary.

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

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

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

Source and reference attributes

Submitting organisation: World Health Organization (see also Comments) and the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; at the Children's Hospital at Westmead on behalf of the Commonwealth Department of Health & Ageing

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

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

Relational attributes

Related metadata references: Supersedes Body mass index - classification, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (79.47 KB)

Body structure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—body structure, code (ICF 2001) AN[NNNN]
Synonymous names:	Body structure code
METeOR identifier:	320147
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	An anatomical part of a person's body such as organs, limbs or their components, as represented by a code.
Data Element Concept:	Person—body structure

Value domain attributes

Representational attributes

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

Collection and usage attributes

Guide for use:

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

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

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

CODE s1 Structures of the nervous system
CODE s2 The eye, ear and related structures
CODE s3 Structures involved in voice and speech
CODE s4 Structures of the cardiovascular, immunological and respiratory systems
CODE s5 Structures related to the digestive, metabolic and endocrine systems
CODE s6 Structures related to the genitourinary and reproductive systems
CODE s7 Structures related to movement
CODE s8 Skin and related structures

Data collected at this level will provide a general description of

the structures and can only be compared with data collected at the same level.

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

An example of a value domain at the 3 digit level from the Structures of the nervous system chapter may include:

CODE s110 Structure of the brain
CODE s120 Spinal cord and related structures
CODE s130 Structure of the meninges
CODE s140 Structure of sympathetic nervous system
CODE s150 Structure of parasympathetic nervous system
CODE s198 Structure of the nervous system, other specified
CODE s199 Structure of the nervous system, unspecified

An example of a value domain at the 4 digit level from the Structures related to movement chapter may include:

CODE s7300 Structure of upper arm
CODE s7301 Structure of forearm
CODE s7302 Structure of hand
CODE s7500 Structure of thigh
CODE s7501 Structure of lower leg
CODE s7502 Structure of ankle and foot
CODE s7600 Structure of vertebral column

The prefix ***s*** denotes the domains within the component of *Body Structures*.

Source and reference attributes

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

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

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

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

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

Data element attributes

Collection and usage attributes

Guide for use: This data element consists of a single, neutral list of body structures that can be used to record positive or neutral body function. In conjunction with *Impairment extent code N*, it enables the provision of information about the presence and extent of impairment for any given body structures; with

Impairment nature code N, the provision of information about the nature of the impairment for given body functions; and *Impairment location code N*, the location of the impairment for given body functions.

Where multiple body structures or **impairments of body structures** are recorded, the following prioritising system should be useful:

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

Source and reference attributes

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

Relational attributes

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

Building/complex sub-unit number (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—building/complex sub-unit identifier, [X(7)]
METeOR identifier:	270018
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The unique number or identifier for a building/complex, marina, etc. where a person resides.
Data Element Concept:	Person (address)—building/complex sub-unit identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[X(7)]
Maximum character length:	7

Data element attributes

Collection and usage attributes

Guide for use:	The building/complex sub-unit number must be recorded with its corresponding building/complex unit type - abbreviation. Where applicable, the number may be followed by an alphanumeric suffix.
Collection methods:	To be collected in conjunction with building/complex sub-unit type - abbreviation.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Supersedes Building/complex sub-unit number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.38 KB) Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005 Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Building/complex sub-unit number (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—building/complex sub-unit identifier, [X(7)]
METeOR identifier:	290291
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The unique number or identifier of a building/complex, marina, etc. where an organisation is located.
Data Element Concept:	Service provider organisation (address)—building/complex sub-unit identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[X(7)]
Maximum character length:	7

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Building/complex sub-unit type—abbreviation (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—building/complex sub-unit type, code A[AAA]
METeOR identifier:	270023
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The type of building/complex where a person can be located, as represented by a code.
Data Element Concept:	Person (address)—building/complex sub-unit type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[AAA]
Maximum character length:	4

Permissible values:

Value	Meaning
APT	Apartment
CTGE	Cottage
DUP	Duplex
FY	Factory
F	Flat
HSE	House
KSK	Kiosk
MSNT	Maisonette
MB	Marine Berth
OFF	Office
PTHS	Penthouse
RM	Room
SHED	Shed
SHOP	Shop
SITE	Site
SL	Stall
STU	Studio
SE	Suite
TNHS	Townhouse
U	Unit
VLLA	Villa
WARD	Ward
WE	Warehouse

Collection and usage attributes

Guide for use:

Addresses may contain multiple instances of building/complex type. Record each instance of building/complex type with its corresponding building/complex number when appropriate.

Examples:

APT 6

SHOP 3A

U 6

PTHS

Data element attributes

Collection and usage attributes

Collection methods:

To be collected in conjunction with building/complex sub unit number.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Origin:

Health Data Standards Committee

Relational attributes

Related metadata references:

Supersedes Building/complex sub-unit type - abbreviation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.76 KB)

Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

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

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

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

Building/complex sub-unit type—abbreviation (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—building/complex sub-unit type, code A[AAA]
METeOR identifier:	290278
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The type of building/complex where an organisation can be located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—building/complex sub-unit type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[AAA]
Maximum character length:	4

Permissible values:

Value	Meaning
APT	Apartment
CTGE	Cottage
DUP	Duplex
FY	Factory
F	Flat
HSE	House
KSK	Kiosk
MSNT	Maisonette
MB	Marine Berth
OFF	Office
PTHS	Penthouse
RM	Room
SHED	Shed
SHOP	Shop
SITE	Site
SL	Stall
STU	Studio
SE	Suite
TNHS	Townhouse
U	Unit
VLLA	Villa
WARD	Ward

WE Warehouse

Collection and usage attributes

Guide for use: Addresses may contain multiple instances of building/complex type. Record each instance of building/complex type with its corresponding building/complex number when appropriate.

Examples:

APT 6

SHOP 3A

U 6

PTHS

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Health Data Standards Committee

Relational attributes

Related metadata references: Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

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

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

Building/property name (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—building/property name, text [X(30)]
METeOR identifier:	270028
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The name of a building or property where a person resides, as represented by text.
Data Element Concept:	Person (address)—building/property name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(30)]
Maximum character length:	30

Data element attributes

Collection and usage attributes

Guide for use:

Usually this information is not abbreviated.

Should include any reference to a wing or other components of a building complex, if applicable.

A comma is to be used to separate the wing reference from the rest of the building name.

Record each Building/property name relevant to the address:

- Building/property name 1 (30 alphanumeric characters)
- Building/property name 2 (30 alphanumeric characters)

For example:

Building - TREASURY BUILDING

Property - BRINDABELLA STATION

Source and reference attributes

Origin:

Health Data Standards Committee

Australia Post Address Presentation Standard

Relational attributes

Related metadata references:

Supersedes Building/property name, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.77 KB)

Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

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

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

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

Building/property name (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—building/property name, text [X(30)]
METeOR identifier:	290295
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The name of a building or property where an organisation is located, as represented by text.
Data Element Concept:	Service provider organisation (address)—building/property name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(30)]
Maximum character length:	30

Data element attributes

Collection and usage attributes

Guide for use:

Usually this information is not abbreviated.

Should include any reference to a wing or other components of a building complex, if applicable.

A comma is to be used to separate the wing reference from the rest of the building name.

Record each Building/property name relevant to the address:

- Building/property name 1 (30 alphanumeric characters)
- Building/property name 2 (30 alphanumeric characters)

For example:

Building - TREASURY BUILDING

Property - BRINDABELLA STATION

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

CVD drug therapy—condition

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cardiovascular disease condition targeted by drug therapy, code NN
METeOR identifier:	270193
Registration status:	Health, Standard 01/03/2005
Definition:	The condition(s) for which drug therapy is being used for the prevention or long-term treatment of cardiovascular disease, as represented by a code.
Data Element Concept:	Person—cardiovascular disease condition targeted by drug therapy

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Heart failure
02	Ischaemic heart disease
03	Hypertension
04	Atrial fibrillation (AF)
05	Other dysrhythmia or conductive disorder
06	Dyslipidaemia
07	Peripheral vascular disease (PVD)
08	Renal vascular disease
09	Stroke
10	Transient ischaemic attack (TIA)
97	Other
98	No CVD drugs prescribed

Supplementary values:

Value	Meaning
99	Not recorded

Collection and usage attributes

Guide for use:	The categorisations may be made using the most recent version of the Australian Modification of the appropriate International Classification of Diseases codes.

Data element attributes

Collection and usage attributes

Guide for use:	More than one code can be recorded.
Comments:	References such as the Australian Medicines Handbook can be used to identify specific drugs that are appropriate for use in

the management of the conditions identified in the value domain.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references: Supersedes CVD drug therapy - condition, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.03 KB)

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

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

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

Caesarean section indicator, last previous birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—caesarean section indicator (last previous birth) code N
METeOR identifier:	301993
Registration status:	Health, Standard 29/11/2006
Definition:	Whether a caesarean section was performed for the woman's last previous birth, as represented by a code.
Data Element Concept:	Female—caesarean section indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:	This item should be completed if there has been a previous birth. In the case of no previous births, the item should be left blank.
Comments:	Previous caesarean sections are associated with a higher risk of obstetric complications, and when used with other indicators provides important information on the quality of obstetric care. This item can be used to determine vaginal births occurring after a caesarean section delivery (VBAC).

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Cancer initial treatment completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—non-surgical cancer treatment completion date, DDMMYYYY
METeOR identifier:	288136
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which the initial non-surgical treatment for cancer was completed.
Data Element Concept:	Cancer treatment—non-surgical cancer treatment completion date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Collected for radiation therapy and systemic therapy.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Cancer initial treatment - completion date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.65 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This field must:

- be greater than or equal to the date of initial cancer diagnosis, and
- be greater than or equal to the date of the initial course of treatment for cancer.

This item is collected for the analysis of outcome by treatment type.

Collecting dates for radiotherapy treatment and systemic therapy agent treatment will allow evaluation of treatments delivered and of time intervals from diagnosis

to treatment, from treatment to recurrence and from treatment to death.

Cancer initial treatment starting date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—non-surgical cancer treatment start date, DDMMYYYY
METeOR identifier:	288103
Registration status:	Health, Standard 04/06/2004
Definition:	The start date of the initial course of non-surgical treatment for cancer.
Data Element Concept:	Cancer treatment—non-surgical cancer treatment start date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

The start date of the treatment is recorded regardless of whether treatment is completed as intended or not. Treatment subsequent to a recurrence will not be recorded.

Collected for radiation therapy and systemic therapy.

Date of surgical treatment is collected as a separate item.

Source and reference attributes

Submitting organisation:	National Cancer Control Institute
Origin:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references:

Supersedes Cancer initial treatment - starting date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.08 KB)

Implementation in Data Set Specifications:

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

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

Information specific to this data set:

This field must:

- be greater than or equal to the date of initial cancer diagnosis, and
- be less than or equal to the date on which initial treatment for cancer was completed.

This metadata item is collected for the analysis of outcome by treatment type.

Collecting dates for radiotherapy treatment and systemic

therapy agent treatment will allow evaluation of treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death.

Cancer staging—M stage code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX
METeOR identifier:	293231
Registration status:	Health, Standard 13/06/2004
Definition:	Absence or presence of distant metastasis at the time of diagnosis of the primary cancer, as represented by a code.
Data Element Concept:	Person with cancer—distant metastasis status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer TNM Classification of Malignant Tumours 5th edition
Representation class:	Code
Data type:	String
Format:	XX
Maximum character length:	2

Supplementary values:

Value	Meaning
88	Not applicable

Collection and usage attributes

Guide for use: Valid M codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Refer to the UICC reference manual, TNM Classification of Malignant Tumours for coding rules.

Data element attributes

Collection and usage attributes

Guide for use: Choose the lower (less advanced) M category when there is any uncertainty.

Collection methods: From information provided by the treating doctor and recorded on the patient's medical record.

Comments: Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site.

Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence

or absence of tumour at sites distant from the primary site.

TNM staging applies to solid tumours excluding brain tumours.

Source and reference attributes

Origin:

International Union Against Cancer (UICC)

Commission on Cancer, American College of Surgeons

Reference documents:

UICC TNM Classification of Malignant Tumours (5th Edition) (1997)

Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references:

Supersedes Cancer staging - M stage code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.45 KB)

Is used in the formation of Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours 5th ed) code XXXX{[X]XX} Health, Standard 04/06/2004

Implementation in Data Set Specifications:

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

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

Conditional obligation:

Collection of this data element is conditional on the disease site being listed in the UICC TNM classification.

Information specific to this data set:

For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Cancer staging—N stage code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX
METeOR identifier:	293254
Registration status:	Health, Standard 13/06/2004
Definition:	Extent of regional lymph node metastasis at the time of diagnosis of the primary cancer, as represented by a code.
Data Element Concept:	Person with cancer—regional lymph node metastasis status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer TNM Classification of Malignant Tumours 5th edition
Representation class:	Code
Data type:	String
Format:	XX
Maximum character length:	2

Supplementary values:

Value	Meaning
88	Not applicable

Collection and usage attributes

Guide for use: Valid N codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Refer to the UICC reference manual, TNM Classification of Malignant Tumours for coding rules.

Data element attributes

Collection and usage attributes

Guide for use: Choose the lower (less advanced) N category when there is any uncertainty.

Collection methods: From information provided by the treating doctor and recorded on the patient's medical record.

Comments: Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site.

Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence

or absence of tumour at sites distant from the primary site.

TNM staging applies to solid tumours excluding brain tumours.

Source and reference attributes

Reference documents: Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references: Supersedes Cancer staging - N stage code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.54 KB)

Is used in the formation of Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours 5th ed) code XXXX{[X]XX} Health, Standard 04/06/2004

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Superseded 07/12/2005

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

Conditional obligation:

Collection of this data element is conditional on the disease site being listed in the UICC TNM classification.

Information specific to this data set:

For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Cancer staging—T stage code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX[X]
METeOR identifier:	293270
Registration status:	Health, Standard 13/06/2004
Definition:	Extent of primary cancer including tumour size, at the time of diagnosis, as represented by a code.
Data Element Concept:	Person with cancer—primary tumour status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer TNM Classification of Malignant Tumours 5th edition
Representation class:	Code
Data type:	String
Format:	XX[X]
Maximum character length:	3

Supplementary values:

Value	Meaning
88	Not applicable

Collection and usage attributes

Guide for use: Valid T codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Refer to the UICC reference manual, TNM Classification of Malignant Tumours for coding rules.

Data element attributes

Collection and usage attributes

Guide for use: Choose the lower (less advanced) T category when there is any uncertainty.

Collection methods: From information provided by the treating doctor and recorded on the patient's medical record.

Comments: Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site.

Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence

or absence of tumour at sites distant from the primary site.
TNM staging applies to solid tumours excluding brain tumours.

Source and reference attributes

Reference documents: Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references: Supersedes Cancer staging - T stage code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.48 KB)
Is used in the formation of Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours 5th ed) code XXXX{[X]XX} Health, Standard 04/06/2004

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Superseded 07/12/2005
Cancer (clinical) DSS Health, Standard 07/12/2005

Conditional obligation:
Collection of this data element is conditional on the disease site being listed in the UICC TNM classification.

Information specific to this data set:
For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Cancer staging—TNM stage grouping code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours 5th ed) code XXXX{[X]XX}
METeOR identifier:	296925
Registration status:	Health, Standard 04/06/2004
Definition:	The anatomical extent of disease at diagnosis based on the previously coded T,N and M stage categories, as represented by a code.
Data Element Concept:	Person with cancer—extent of primary cancer

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer TNM Classification of Malignant Tumours 5th edition
Representation class:	Code
Data type:	String
Format:	XXXX{[X]XX}
Maximum character length:	6

Supplementary values:

Value	Meaning
8888	Not applicable
9999	Unknown, Stage X

Collection and usage attributes

Guide for use:	Valid stage grouping codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Data element attributes

Collection and usage attributes

Guide for use:	Refer to the UICC reference manual, TNM Classification of Malignant Tumours for coding rules. Choose the lower (less advanced) T category when there is any uncertainty.
Collection methods:	From information provided by the treating doctor and recorded on the patient's medical record.

Relational attributes

Related metadata references:	Supersedes Cancer staging - TNM stage grouping code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.35 KB) Is formed using Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX Health, Standard 13/06/2004 Is formed using Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of

Malignant Tumours 5th ed) code XX Health, Standard 13/06/2004

Is formed using Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX[X] Health, Standard 13/06/2004

Implementation in Data Set Specifications:

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

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

Conditional obligation:
Collection of this data element is conditional on the disease site being listed in the UICC TNM classification.

Information specific to this data set:
For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Cancer treatment type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—cancer treatment type, code N
METeOR identifier:	288185
Registration status:	Health, Standard 04/06/2004
Definition:	The type of treatment for cancer given as initial treatment for the particular patient, as represented by a code.
Data Element Concept:	Cancer treatment—cancer treatment type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
0	No treatment
1	Surgical treatment
2	Radiation therapy
3	Systemic agent therapy
4	Surgical and radiation treatment
5	Surgical treatment and systemic agent treatment
6	Radiation and systemic agent treatment
7	All three treatment types

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Origin:	Commission on Cancer, American College of Surgeons. New South Wales Health Department.
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998) Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references:	Supersedes Cancer treatment type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.38 KB)

Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Cancer treatment—target site (ICD-10-AM)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—target site for cancer treatment, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361029
Registration status:	Health, Standard 05/02/2008
Definition:	The site or region which is the target of particular surgical or radiotherapy treatment, as represented by an ICD-10-AM code.
Data Element Concept:	Cancer treatment—target site for cancer treatment

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	This information is collected for surgical and radiotherapy treatments. Current edition of International Classification of Diseases (ICD-10-AM), Australian Modification, National Centre for Classification in Health, Sydney is used.

Relational attributes

Related metadata references:	Supersedes Cancer treatment—target site for cancer treatment, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Cancer treatment—target site (ICDO-3)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—target site for cancer treatment, code (ICDO-3) ANN
METeOR identifier:	293161
Registration status:	Health, Standard 13/06/2004
Definition:	The site or region of cancer which is the target of a particular surgical or radiotherapy treatment, as represented by an ICDO-3 code.
Data Element Concept:	Cancer treatment—target site for cancer treatment

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:	This information is collected for surgical and radiotherapy treatments. Current edition of International Classification of Diseases for Oncology (ICD-O), World Health Organisation is used. Major organ only - first 3 characters.

Relational attributes

Related metadata references:	Supersedes Cancer treatment - target site, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.22 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Cardiovascular medication (current)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cardiovascular medication taken (current), code N
METeOR identifier:	270237
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual is currently taking cardiovascular medication, as represented by a code.
Data Element Concept:	Person—cardiovascular medication taken

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Angiotensin converting enzyme (ACE) inhibitors
2	Angiotensin II (A2) receptor blockers
3	Beta blockers
4	Calcium antagonists
8	None of the above

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Angiotensin converting enzyme (ACE) inhibitors

Use this code for ACE inhibitors (captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril and trandolapril).

CODE 2 Angiotensin II (A2) receptor blockers

Use this code for Angiotensin II receptor blockers (candesartan, eprosartan, irbesartan and telmisartan).

CODE 3 Beta blockers

Use this code for Beta blockers (atenolol, carvedilol, labetalol, metoprolol, oxprenolol, pindolol, propranolol and sotalol).

CODE 4 Calcium antagonists

Use this code for Calcium antagonists (amlodipine, diltiazem, felodipine, lercanidipine, nifedipine and verapamil).

CODE 8 None of the above

This code is used when none of the listed medications is being taken by the person.

CODE 9 Not stated/inadequately described

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

Collection methods:

The person should be asked a series of questions about any current medication for a cardiovascular condition as follows:

Are you currently taking any medication for a cardiovascular condition?

___Yes ___No

If the person answers 'NO', then code 8 should be applied.

If the person answers 'YES', then ask which one(s) (from the list of drugs in the Guide for use).

Ace Inhibitors ___Yes ___No

Angiotensin II receptor blockers ___Yes ___No

Beta blockers ___Yes ___No

Calcium antagonists ___Yes ___No

The appropriate code should be recorded for each type of medication currently in use.

Data element attributes

Collection and usage attributes

Collection methods: A person may be taking one or more of the following medications for a cardiovascular condition. Therefore more than one code may be reported.

Source and reference attributes

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary. Australian Medicines Handbook: last modified by February 2001 Contents of Cardiovascular, Version 3, 1999 Therapeutic Guidelines Limited (05.04.2002)].

Relational attributes

Related metadata references: Supersedes Cardiovascular medication - Superseded 01/03/2005, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.07 KB)

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

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

Information specific to this data set:

A person may be taking one or more of the following medications for a cardiovascular condition. Therefore more than one code may be reported.

Example 1:

If a person takes one of the ACE inhibitors and a Beta blocker, the code recorded would be 13.

Example 2:

If a person takes one of the ACE inhibitors, an Angiotensin II receptor blocker and a Beta blocker, the code recorded would be 123.

Care type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital service—care type, code N[N].N
METeOR identifier:	270174
Registration status:	Health, Standard 01/03/2005
Definition:	The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or **posthumous organ procurement** (other care), as represented by a code.
Data Element Concept:	Hospital service—care type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1.0	Acute care (Admitted care)
2.0	Rehabilitation care (Admitted care)
2.1	Rehabilitation care delivered in a designated unit (optional)
2.2	Rehabilitation care according to a designated program (optional)
2.3	Rehabilitation care is the principal clinical intent (optional)
3.0	Palliative care
3.1	Palliative care delivered in a designated unit (optional)
3.2	Palliative care according to a designated program (optional)
3.3	Palliative care is the principal clinical intent (optional)
4.0	Geriatric evaluation and management
5.0	Psychogeriatric care
6.0	Maintenance care
7.0	Newborn care
8.0	Other admitted patient care
9.0	Organ procurement - posthumous (Other care)
10.0	Hospital boarder (Other care)

Collection and usage attributes

Guide for use:	Persons with mental illness may receive any one of the care types (except newborn and organ procurement). Classification

depends on the principal clinical intent of the care received.

Admitted care can be one of the following:

CODE 1.0 Acute care (Admitted care)

Acute care is care in which the clinical intent or treatment goal is to:

- manage labour (obstetric)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury (excluding palliative care)
- reduce severity of an illness or injury
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function
- perform diagnostic or therapeutic procedures.

CODE 2.0 Rehabilitation care (Admitted care)

Rehabilitation care is care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by a periodic assessment using a recognised functional assessment measure. It includes care provided:

- in a designated rehabilitation unit (code 2.1), or
- in a designated rehabilitation program, or in a psychiatric rehabilitation program as designated by the state health authority for public patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation (code 2.2), or
- under the principal clinical management of a rehabilitation physician or, in the opinion of the treating doctor, when the principal clinical intent of care is rehabilitation (code 2.3).

Optional:

CODE 2.1 Rehabilitation care delivered in a designated unit (optional)

A designated rehabilitation care unit is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for rehabilitation care and/or primarily delivers rehabilitation care.

CODE 2.2 Rehabilitation care according to a designated program (optional)

In a designated rehabilitation care program, care is delivered by a specialised team of staff who provide rehabilitation care to patients in beds that may or may not be dedicated to rehabilitation care. The program may, or may not be funded through identified rehabilitation care funding. Code 2.1 should be used instead of code 2.2 if care is being delivered in a designated rehabilitation care program and a designated rehabilitation care unit.

CODE 2.3 Rehabilitation care is the principal clinical intent (optional)

Rehabilitation as principal clinical intent (code 2.3) occurs when the patient is primarily managed by a medical practitioner who is a specialist in rehabilitation care or when, in the opinion of

the treating medical practitioner, the care provided is rehabilitation care even if the doctor is not a rehabilitation care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 2.1 or 2.2 should be used, respectively.

Code 3.0 Palliative care

Palliative care is care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family. It includes care provided:

- in a palliative care unit (code 3.1); or
- in a designated palliative care program (code 3.2); or
- under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, when the principal clinical intent of care is palliation (code 3.3).

Optional:

CODE 3.1 Palliative care delivered in a designated unit (optional)

A designated palliative care unit is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for palliative care and/or primarily delivers palliative care.

CODE 3.2 Palliative care according to a designated program (optional)

In a designated palliative care program, care is delivered by a specialised team of staff who provide palliative care to patients in beds that may or may not be dedicated to palliative care. The program may, or may not be funded through identified palliative care funding. Code 3.1 should be used instead of code 3.2 if care is being delivered in a designated palliative care program and a designated palliative care unit.

CODE 3.3 Palliative care is the principal clinical intent (optional)

Palliative care as principal clinical intent occurs when the patient is primarily managed by a medical practitioner who is a specialist in palliative care or when, in the opinion of the treating medical practitioner, the care provided is palliative care even if the doctor is not a palliative care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 3.1 or 3.2 should be used, respectively. For example, code 3.3 would apply to a patient dying of cancer who was being treated in a geriatric ward without specialist input by palliative care staff.

CODE 4.0 Geriatric evaluation and management

Geriatric evaluation and management is care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age. This

care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. Geriatric evaluation and management includes care provided:

- in a geriatric evaluation and management unit; or
- in a designated geriatric evaluation and management program; or
- under the principal clinical management of a geriatric evaluation and management physician or,
- in the opinion of the treating doctor, when the principal clinical intent of care is geriatric evaluation and management.

CODE 5.0 Psychogeriatric care

Psychogeriatric care is care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with an age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance. The care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. It includes care provided:

- in a psychogeriatic care unit;
- in a designated psychogeriatic care program; or
- under the principal clinical management of a psychogeriatic physician or,
- in the opinion of the treating doctor, when the principal clinical intent of care is psychogeriatic care.

CODE 6.0 Maintenance care

Maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting eg at home, or in a residential aged care service, by a relative or carer, that is unavailable in the short term.

CODE 7.0 Newborn care

Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the care type changes or the patient is separated:

- patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders
- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated
- patients aged less than 10 days and not admitted at birth (eg transferred from another hospital) are admitted with newborn care type
- patients aged greater than 9 days not previously admitted

(eg transferred from another hospital) are either boarders or admitted with an acute care type

- within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day
- a newborn is qualified when it meets at least one of the criteria detailed in **Newborn qualification status**.

Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day. Newborn qualified days are equivalent to acute days and may be denoted as such.

CODE 8.0 Other admitted patient care

Other admitted patient care is care where the principal clinical intent does meet the criteria for any of the above.

Other care can be one of the following:

CODE 9.0 Organ procurement - posthumous (Other care)

Organ procurement - posthumous is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.

Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant ICD-10-AM Australian Coding Standards. These patients are not admitted to the hospital but are registered by the hospital.

CODE 10.0 Hospital boarder (Other care)

Hospital boarder is a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.
Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days of less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

Comments: Unqualified newborn days (and separations consisting entirely of unqualified newborn days are not to be counted under the Australian Health Care Agreements and they are ineligible for health insurance benefit purposes.

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Care type, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (33.13 KB)

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005

Implementation in Data Set Specifications: Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Carer participation arrangements—carer consultants employed

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N
METeOR identifier:	288833
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a specialised mental health service organisation has carer consultants employed on a paid basis to represent the interests of carers and advocate for their needs, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (carer consultants employed)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Carer participation arrangements—carer satisfaction surveys

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N
METeOR identifier:	290367
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a specialised mental health service organisation periodically conducts carer satisfaction surveys, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004
Implementation in Data Set	Mental health establishments NMDS 2005-2006 Health,

Specifications:

Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Carer participation arrangements—formal complaints mechanism

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N
METeOR identifier:	290370
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a specialised mental health service organisation has a formal internal complaints mechanism in which complaints made by carers are regularly reviewed by a committee that includes carers, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed),

code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Carer participation arrangements—formal participation policy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N
METeOR identifier:	290365
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a specialised mental health service organisation has developed a formal and documented policy on participation by carers, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (formal participation policy)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004

Implementation in Data Set Mental health establishments NMDS 2005-2006 Health,

Specifications:

Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Carer participation arrangements—regular discussion groups

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N
METeOR identifier:	290359
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service holds regular discussion groups to seek the views of carers about the service, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (regular discussion groups)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Cataract - history

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cataract status, code N
METeOR identifier:	270252
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has a cataract present in either or both eyes or has had a cataract previously removed from either or both eyes, as represented by a code.
Data Element Concept:	Person—cataract status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Cataract currently present or has been previously removed from the right eye
2	Cataract currently present or has been previously removed from the left eye
3	Cataract currently present or has been previously removed from both eyes
4	No cataract present or has not been previously removed from either eye

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:

Examination of the lens of the eye through a dilated pupil (visible through the pupil by the use of an ophthalmoscope) by an ophthalmologist or optometrist, as a part of the ophthalmological assessment.

Ask the individual if he/she has a cataract in either or both eyes or has had a cataract removed from either or both eyes previously. Alternatively obtain information from an ophthalmologist or optometrist or from appropriate documentation.

Comments:

Cataract is a clouding of the lens of the eye or its capsule sufficient to reduce vision. The formation of cataract occurs more rapidly in patients with a history of ocular trauma, uveitis, or diabetes mellitus. Cataract is an associated diabetic eye problem that could lead to blindness.

Regular eye checkups are important for patients suffering from diabetes mellitus. This helps to early detect abnormalities and

to avoid or postpone vision-threatening complications. A comprehensive ophthalmological examination includes:

- check visual acuity with Snellen chart -correct with pinhole if indicated
- examine for cataract
- examine fundi with pupils dilated.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Cataract - history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.36 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Category reassignment date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective care waiting list episode—category reassignment date, DDMMYYYY
METeOR identifier:	270010
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a patient awaiting elective hospital care is assigned to a different urgency category as a result of **clinical review** for the awaited procedure, or is assigned to a different patient listing status category.
Data Element Concept:	Elective care waiting list episode—category reassignment date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The date needs to be recorded each time a patient's urgency classification or listing status changes.
Comments:	This date is necessary for the calculation of the waiting time at admission and the waiting time at a census date.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Category reassignment date, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.16 KB) Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005 Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005

Census date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital census (of elective surgery waitlist patients)—census date, DDMMYYYY
METeOR identifier:	270153
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which the hospital takes a point in time (census) count of and characterisation of patients on the waiting list.
Data Element Concept:	Hospital census (of elective surgery waitlist patients)—census date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This date is recorded when a census is done of the patients on a waiting list.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Census date, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.42 KB) Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005 *Implementation start date:* 30/09/2006 Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005 *Implementation start date:* 30/09/2002 *Implementation end date:* 30/06/2006

Centrelink customer reference number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—government funding identifier, Centrelink customer reference number {N(9)A}
Synonymous names:	CRN; Centrelink reference number
METeOR identifier:	270098
Registration status:	Health, Standard 01/03/2005 Community services, Recorded 27/03/2007
Definition:	A personal identifier assigned by Centrelink for the purposes of identifying people (and organisations) eligible for specific services, including some public health care services, such as oral health services.
Data Element Concept:	Person—government funding identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	{N(9)A}
Maximum character length:	10

Data element attributes

Collection and usage attributes

Guide for use:	The CRN should only be collected from persons eligible to receive health services that are to be funded by Centrelink. The number may be reported to a Centrelink agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any purpose unless specifically authorised by law. For example, data linkage should not be carried out unless specifically authorised by law.
Collection methods:	The Centrelink Customer Reference Number (CRN) is provided on 'Health Care Cards' and 'Pensioner Concession Cards'.
Comments:	When a person accesses health services on the basis of being a Centrelink customer, collection of the CRN is usually necessary. This data should not be collected and recorded if it is not needed to support the provision of such health services.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS5017 Health Care Client Identification

Relational attributes

Related metadata references:	Supersedes Centrelink customer reference number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (14.52 KB)
Implementation in Data Set	Health care client identification Health, Superseded 04/05/2005

Specifications:	Health care client identification DSS Health, Standard 04/05/2005

Cerebral stroke due to vascular disease (history)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cerebral stroke due to vascular disease (history), code N
METeOR identifier:	270355
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has had a cerebral stroke due to vascular disease, as represented by a code.
Data Element Concept:	Person—cerebral stroke due to vascular disease

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Cerebral stroke - occurred in the last 12 months
2	Cerebral stroke - occurred prior to the last 12 months
3	Cerebral stroke - occurred both in and prior to the last 12 months
4	No history of cerebral stroke due to vascular disease
Supplementary values: 9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:	Obtain this information from appropriate documentation or from the patient.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Cerebral stroke due to vascular disease - history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.35 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Cerebral stroke is a medical emergency condition with a

high mortality rate, which is often recognised as a vascular complication of diabetes mellitus.

The risk of stroke in patients with diabetes is at least twice that in non-diabetic patients according to Meigs et al. (Intern Med. 1998). Diabetes may increase actual stroke risk up to fivefold by increasing atheromatous deposits. Patients with diabetes who have a first stroke have 5-year survival rate reduced to 50% in comparison to non-diabetic stroke patients. The duration of diabetes clearly influences the severity of vascular disease. Atherosclerosis is more common and more severe earlier in the course of diabetes. In large arteries, plaque occurs from direct endothelial membrane injury, adverse balance of lipoproteins, and hyperinsulinemia (JAMA 1997). Small vessels are also affected more frequently than they are in non-diabetic stroke, resulting in an increased risk of lacunar stroke.

References:

Meigs J, Nathan D, Wilson P et al. Metabolic risk factors worsen continuously across the spectrum of non-diabetic glucose tolerance. Ann Intern Med. 1998; 128:524-533

Gorelick PB, Sacco RL, Smith DB, et al. Prevention of a first stroke: a review of guidelines and a multidisciplinary consensus statement from the National Stroke Association. JAMA 1999; 281:1112-1120

Change to body structure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—nature of impairment of body structure, code (ICF 2001) N
METeOR identifier:	320171
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The qualitative or quantitative change of a person's impairment in a specified body structure, as represented by a code.
Data Element Concept:	Person—nature of impairment of body structure

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	No change in structure
1	Total absence
2	Partial absence
3	Additional part
4	Aberrant dimensions
5	Discontinuity
6	Deviating position
7	Qualitative changes in structure

Supplementary values:

8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Impairments of body structure are problems in body structure such as a loss or significant departure from population standards or averages.

CODE 0 No change in structure

Used when the structure of the body part is within the range of the population standard.

CODE 1 Total absence

Used when the body structure is not present. For example total absence of the structures of the lower leg following a thorough knee amputation.

CODE 2 Partial absence

Used when only part of a body structure is present. For example partial absence of the bones of the lower leg following below knee amputation.

CODE 3 Additional part

Used when a structure, not usually present in the population is present, for example a sixth lumbar vertebra or an sixth digit on one hand.

CODE 4 Aberrant dimensions

Used when the shape and size of a body structure is significantly different from the population standard. For example radial aplasia where the shape and size of the radial bone does not develop.

CODE 5 Discontinuity

Used when parts of a body structure are separated, for example cleft palate or fracture.

CODE 6 Deviating position

Used when the location of a structure is not according to population standard; for example, transposition of the great vessels, where the aorta arises from the right ventricle and the pulmonary vessels from the left ventricle.

CODE 7 Qualitative changes in structure

Used when the structure of a body part is altered from the population standard. This includes accumulation of fluid, changes in bone structure as a result of osteoporosis or Paget's disease.

CODE 8 Not specified

Used when there is a change to a body structure, but the nature of the change is not described.

CODE 9 Not applicable

Used when it is not appropriate to code the nature of the change to a body structure.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.html

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

Implementation in Data Set Specifications: Body structures cluster Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Chest pain pattern category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—chest pain pattern, code N
METeOR identifier:	284823
Registration status:	Health, Standard 04/06/2004
Definition:	The person's chest pain pattern, as represented by a code.
Data Element Concept:	Person—chest pain pattern

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Atypical chest pain
2	Stable chest pain pattern
3	Unstable chest pain pattern: rest &/or prolonged
4	Unstable chest pain pattern: new & severe
5	Unstable chest pain pattern: accelerated & severe
8	No chest pain/discomfort
9	Not stated/inadequately described

Supplementary values:

Collection and usage attributes

Guide for use:

Chest pain or discomfort of myocardial ischaemic origin is usually described as chest pain, discomfort or pressure, jaw pain, arm pain or other equivalent discomfort suggestive of cardiac ischaemia. Ask the person when the symptoms first occurred or obtain this information from appropriate documentation.

CODE 1 Atypical chest pain

Use this code for pain, pressure, or discomfort in the chest, neck, or arms not clearly exertional or not otherwise consistent with pain or discomfort of myocardial ischaemic origin.

CODE 2 Stable chest pain pattern

Use this code for chest pain without a change in frequency or pattern for the 6 weeks before this presentation or procedure. Chest pain is controlled by rest and/or sublingual/oral/transcutaneous medications.

CODE 3 Unstable chest pain pattern: rest and/or prolonged

Use this code for chest pain that occurred at rest and was prolonged, usually lasting more than 10 minutes

CODE 4 Unstable chest pain pattern: new and severe.

Use this code for new-onset chest pain that could be described

as at least Canadian Cardiovascular Society (CCS) classification III severity.

CODE 5 Unstable chest pain pattern: accelerated and severe

Use this code for recent acceleration of chest pain pattern that could be described by an increase in severity of at least 1 CCS class to at least CCS class III.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Chest pain pattern category, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.14 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

The Canadian Cardiovascular Society classes of angina can be used to support categorisation of chest pain patterns. Canadian Cardiovascular Society (CCS) classes of angina (Campeau L. Grading of angina pectoris. Circulation 1976; 54:522.)

1. Ordinary physical activity (for example, walking or climbing stairs) does not cause angina; angina occurs with strenuous or rapid or prolonged exertion at work or recreation.
2. Slight limitation of ordinary activity (for example, angina occurs walking or stair climbing after meals, in cold, in wind, under emotional stress, or only during the few hours after awakening; walking more than 2 blocks on the level or climbing more than 1 flight of ordinary stairs at a normal pace; and in normal conditions).
3. Marked limitation of ordinary activity (for example, angina occurs with walking 1 or 2 blocks on the level or climbing 1 flight of stairs in normal conditions and at a normal pace).
4. Inability to perform any physical activity without discomfort; angina syndrome may be present at rest.

Cholesterol—HDL (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—high-density lipoprotein cholesterol level (measured), total millimoles per litre [N].NN
METeOR identifier:	270401
Registration status:	Health, Standard 01/03/2005
Definition:	A person's high-density lipoprotein cholesterol (HDL-C), measured in mmol/L.
Data Element Concept:	Person—high-density lipoprotein cholesterol level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	[N].NN
Maximum character length:	3

Supplementary values:

Value	Meaning
9.99	Not measured/inadequately described

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use:

When reporting, record whether or not the measurement of High-density Lipoprotein Cholesterol (HDL-C) was performed in a fasting specimen.

In settings where the monitoring of a person's health is ongoing and where a measure can change over time (such as general practice), the date of assessment should be recorded.

Collection methods:

When reporting, record absolute result of the most recent HDL-Cholesterol measurement in the last 12 months to the nearest 0.01 mmol/L.

Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.

- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.
- Prolonged tourniquet use can artefactually increase levels by up to 20%.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group National Diabetes Data Working Group
Origin:	National Heart Foundation of Australia and the Cardiac Society

of Australia and New Zealand, Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88.

Relational attributes

Related metadata references:

Supersedes Cholesterol-HDL - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.97 KB)

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

High-density Lipoprotein Cholesterol (HDL-C) is easily measured and has been shown to be a negative predictor of future coronary events.

An inverse relationship between the level of HDL-C and the risk of developing premature coronary heart disease (CHD) has been a consistent finding in a large number of prospective population studies. In many of these studies, the level of HDL-C has been the single most powerful predictor of future coronary events. Key studies of the relationship between HDLs and CHD include the Framingham Heart Study (Castelli et al. 1986), the PROCAM Study (Assman et al 1998), the Helsinki Heart Study (Manninen et al. 1992) and the MRFIT study (Stamler et al. 1986; Neaton et al 1992).

There are several well-documented functions of HDLs that may explain the ability of these lipoproteins to protect against arteriosclerosis (Barter and Rye 1996). The best recognised of these is the cholesterol efflux from cells promoted by HDLs in a process that may minimise the accumulation of foam cells in the artery wall. The major proteins of HDLs and also other proteins (e.g. paraoxonase) that co-transport with HDLs in plasma have anti-oxidant properties. Thus, HDLs have the ability to inhibit the oxidative modification of LDLs and may therefore reduce the atherogenicity of these lipoproteins.

Overall, it has been concluded from the prospective population studies that for every 0.025 mmol/L increase in HDL-C, the coronary risk is reduced by 2-5%. For a review of the relationship between HDL-C and CHD, see Barter and Rye (1996). A level below 1.0 mmol/L increases risk approximately 2-fold (Gordon et al. 1989; Assmann et al. 1998). (Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88.

In settings such as general practice where the monitoring of a person's health is ongoing and where a measure can change over time, the Service contact date should be

recorded.

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Lowered HDL-Cholesterol, with increased serum triglyceride and increased low-density lipoprotein cholesterol are important risk factors for vascular disease in type 2 diabetes.

In the New South Wales Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, recommendations are that HDL, total cholesterol, triglycerides are to be measured:

- every 1-2 years (if normal)
- every 3-6 months (if abnormal or on treatment)

and the target is:

- to increase HDL Cholesterol to more than or equal to 1.0 mmol/L
- to reduce total Cholesterol to less than 5.5 mmol/L
- to reduce triglyceride levels to less than 2.0 mmol/L.

If pre-existing cardiovascular disease (bypass surgery or myocardial infarction) total cholesterol should be less than 4.5 mmol/L. A level below 1.0 mmol/L increases risk approximately 2-fold (Gordon et al. 1989; Assmann et al, 1998), (Draft NHF Lipid Guidelines Paper 2001). It has been concluded from prospective population studies that for every 0.025 mmol/L increase in HDL-C, the coronary risk is reduced by 2-5%.

In settings such as general practice where the monitoring of a person's health is ongoing and where a measure can change over time, the date of assessment should be recorded.

References:

National Heart Foundation of Australia - Lipid Management Guidelines 2001.

Cholesterol—LDL (calculated)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N
METeOR identifier:	270402
Registration status:	Health, Standard 01/03/2005
Definition:	A person's calculated low-density lipoprotein cholesterol (LDL-C).
Data Element Concept:	Person—low-density lipoprotein cholesterol level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use:

Formula:

LDL-C = (plasma total cholesterol) - (high density lipoprotein cholesterol) - (fasting plasma triglyceride divided by 2.2).

Collection methods:

The LDL-C is usually calculated from the Friedwald Equation (Friedwald et al. 1972), which depends on knowing the blood levels of the total cholesterol and HDL-C and the fasting level of the triglyceride.

Note that the Friedwald equation becomes unreliable when the plasma triglyceride exceeds 4.5 mmol/L.

Note also that while cholesterol levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 6 weeks after an event.

- Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.
- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.

Comments:

High blood cholesterol is a key factor in heart, stroke and vascular disease, especially coronary heart disease (CHD).

Poor nutrition can be a contributing factor to heart, stroke and vascular disease as a population's level of saturated fat intake is

the prime determinant of its level of blood cholesterol.

The majority of the cholesterol in plasma is transported as a component of LDL-C. Thus, the evidence linking CHD to plasma total cholesterol and LDL-C is essentially the same.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88.

Relational attributes

Related metadata references:

Is formed using Person—cholesterol level (measured), total millimoles per litre N[N].N Health, Standard 01/03/2005

Is formed using Person—high-density lipoprotein cholesterol level (measured), total millimoles per litre [N].NN Health, Standard 01/03/2005

Is formed using Person—triglyceride level (measured), total millimoles per litre N[N].N Health, Standard 01/03/2005

Supersedes Cholesterol-LDL calculated, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (19.67 KB)

Is formed using Health service event—fasting indicator, code N Health, Standard 21/09/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

Many studies have demonstrated the significance of blood cholesterol components as risk factors for heart, stroke and vascular disease.

Scientific studies have shown a continuous relationship between lipid levels and Coronary Heart Disease (CHD) and overwhelming evidence that lipid lowering interventions reduces CHD progression, morbidity and mortality.

There are many large-scale, prospective population studies defining the relationship between plasma total (and Low-density Lipoprotein (LDL)) cholesterol and the future risk of developing CHD. The results of prospective population studies are consistent and support several general conclusions:

- the majority of people with CHD do not have markedly elevated levels of plasma total cholesterol or LDL-C,
- there is a continuous positive but curvilinear relationship between the concentration of plasma total (and LDL) cholesterol and the risk of having a

coronary event and of dying from CHD,

- there is no evidence that a low level of plasma (or LDL) cholesterol predisposes to an increase in non-coronary mortality.

The excess non-coronary mortality at low cholesterol levels in the Honolulu Heart Study (Yano et al. 1983; Stemmermann et al. 1991) was apparent only in people who smoked and is consistent with a view that smokers may have occult smoking related disease that is responsible for both an increased mortality and a low plasma cholesterol.

It should be emphasised that the prospective studies demonstrate an association between plasma total cholesterol and LDL-C and the risk of developing CHD. (Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88 and Commonwealth Department of Health & Ageing and Australian Institute of Health and Welfare (1999) National Health Priority Areas Report: Cardiovascular Health 1998. AIHW Cat. No. PHE 9. HEALTH and AIHW, Canberra pgs 14-17).

In settings such as general practice where the monitoring of a person's health is ongoing and where a measure can change over time, the service contact date should be recorded.

Cholesterol—total (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cholesterol level (measured), total millimoles per litre N[N].N
METeOR identifier:	270403
Registration status:	Health, Standard 01/03/2005
Definition:	A person's total cholesterol (TC), measured in mmol/L.
Data Element Concept:	Person—cholesterol level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described.

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use:

Measurement in mmol/L to 1 decimal place.

Record the absolute result of the total cholesterol measurement. When reporting, record whether or not the measurement of Cholesterol-total - measured was performed in a fasting specimen.

Collection methods:

When reporting, record absolute result of the most recent Cholesterol-total - measured in the last 12 months to the nearest 0.1 mmol/L.

Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.

- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.
- Prolonged tourniquet use can artefactually increase levels by up to 20%.

Comments:

In settings where the monitoring of a person's health is ongoing and where a measure can change over time (such as general practice), the Service contact—service contact date, DDMMYYYY should be recorded.

High blood cholesterol is a key factor in heart, stroke and vascular disease, especially coronary heart disease.

Poor nutrition can be a contributing factor to heart, stroke and

vascular disease as a population's level of saturated fat intake is the prime determinant of its level of blood cholesterol.

Large clinical trials have shown that people at highest risk of cardiovascular events (e.g. pre-existing ischaemic heart disease) will derive the greatest benefit from lipid lowering drugs. For this group of patients, the optimum threshold plasma lipid concentration for drug treatment is still a matter of research. In May 1999 the PBS threshold total cholesterol concentration, for subsidy of drug treatment, was reduced from 5.5 to 4.0 mmol/L. (Australian Medical Handbook).

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88

National Health Priority Areas Report: Cardiovascular Health 1998. AIHW Cat. No. PHE 9. HEALTH and AIHW, Canberra.

The Royal College of Pathologists of Australasia web based Manual of Use and Interpretation of Pathology Tests

Relational attributes

Related metadata references: Supersedes Cholesterol-total - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.35 KB)

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Information specific to this data set:

Scientific studies have shown a continuous relationship between lipid levels and coronary heart disease and overwhelming evidence that lipid lowering interventions reduce coronary heart disease progression, morbidity and mortality. Studies show a positive relationship between an individual's total blood cholesterol level and risk of coronary heart disease as well as death (Kannel & Gordon 1970; Pocock et al. 1989).

Many studies have demonstrated the significance of blood cholesterol components as risk factors for heart, stroke and vascular disease.

Several generalisations can be made from these cholesterol lowering trials:

- that the results of the intervention trials are consistent with the prospective population studies in which (excluding possible regression dilution bias) a 1.0

mmol/L reduction in plasma total cholesterol translates into an approximate 20% reduction in the risk of future coronary events.

- It should be emphasised, however, that this conclusion does not necessarily apply beyond the range of cholesterol levels which have been tested in these studies.
- That the benefits of cholesterol lowering are apparent in people with and without coronary artery disease.

There is high level evidence that in patients with existing coronary heart disease, lipid intervention therapy reduces the risk of subsequent stroke

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

The risk of coronary and other macrovascular disorders is 2-5 times higher in people with diabetes than in non-diabetic subjects and increases in parallel with the degree of dyslipidaemia.

Following Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, the targets for lipids management are:

- To reduce total Cholesterols to less than 5.5 mmol/L
- To reduce triglyceride levels to less than 2.0 mmol/L
- To increase high density lipoprotein Cholesterols to more than or equal to 1.0 mmol/L.

If pre-existing cardiovascular disease (bypass surgery or myocardial infarction), total cholesterol should be less than 4.5 mmol/L

Classification of health labour force job

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health professional—occupation, code ANN
METeOR identifier:	270140
Registration status:	Health, Standard 01/03/2005
Definition:	The position or job classification of a health professional, as represented by a code.
Data Element Concept:	Health professional—occupation

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Medicine - General practitioner working mainly in general practice
A02	Medicine - General practitioner working mainly in a special interest area
A03	Medicine - Salaried non-specialist hospital practitioner: Resident medical officer or intern
A04	Medicine - Salaried non-specialist hospital practitioner: other hospital career medical officer
A05	Medicine - Specialist
A06	Medicine - Specialist in training (e.g. registrar)
B01	Dentistry (private practice only) - Solo practitioner
B02	Dentistry (private practice only) - Solo principal with assistant(s)
B03	Dentistry (private practice only) - Partnership
B04	Dentistry (private practice only) - Associateship
B05	Dentistry (private practice only) - Assistant
B06	Dentistry (private practice only) - Locum
C01	Nursing - Enrolled nurse
C02	Nursing - Registered nurse
C03	Nursing - Clinical nurse
C04	Nursing - Clinical nurse consultant/supervisor
C05	Nursing - Nurse manager
C06	Nursing - Nurse educator
C07	Nursing - Nurse researcher
C08	Nursing - Assistant director of nursing

C09	Nursing - Deputy director of nursing
C10	Nursing - Director of nursing
C11	Nursing - Tutor/lecturer/senior lecturer in nursing (tertiary institution)
C12	Nursing - Associate professor/professor in nursing (tertiary institution)
C98	Nursing - Other (specify)
D01	Pharmacy (community pharmacist) - Sole proprietor
D02	Pharmacy (community pharmacist) - Partner-proprietor
D03	Pharmacy (community pharmacist) - Pharmacist-in-charge
D04	Pharmacy (community pharmacist) - Permanent assistant
D05	Pharmacy (community pharmacist) - Reliever, regular location
D06	Pharmacy (community pharmacist) - Reliever, various locations
E01	Pharmacy (Hospital/clinic pharmacist) - Director/deputy director
E02	Pharmacy (Hospital/clinic pharmacist) - Grade III pharmacist
E03	Pharmacy (Hospital/clinic pharmacist) - Grade II pharmacist
E04	Pharmacy (Hospital/clinic pharmacist) - Grade I pharmacist
E05	Pharmacy (Hospital/clinic pharmacist) - Sole pharmacist
F01	Podiatry - Own practice (or partnership)
F02	Podiatry - Own practice and sessional appointments elsewhere
F03	Podiatry - Own practice and fee-for-service elsewhere
F04	Podiatry - Own practice, sessional and fee-for-service appointments elsewhere
F05	Podiatry - Salaried podiatrist
F06	Podiatry - Locum, regular location
F07	Podiatry - Locum, various locations
F08	Podiatry - Other (specify)
G01	Physiotherapy - Own practice (or partnership)
G02	Physiotherapy - Own practice and sessional appointments elsewhere
G03	Physiotherapy - Own practice and fee-for-service elsewhere
G04	Physiotherapy - Own practice, sessional and fee-for-service appointments elsewhere
G05	Physiotherapy - Salaried physiotherapist

	G06	Physiotherapy - Locum, regular location
	G07	Physiotherapy - Locum, various locations
Supplementary values:	C99	Nursing - Unknown/inadequately described/not stated

Data element attributes

Collection and usage attributes

Comments:

Position or job classifications are specific to each profession and may differ by state or territory. The classifications above are simplified so that comparable data presentation is possible and possible confounding effects of enterprise specific structures are avoided. For example, for medicine, the job classification collected in the national health labour force collection is very broad. State/territory health authorities have more detailed classifications for salaried medical practitioners in hospitals.

These classifications separate interns, the resident medical officer levels, registrar levels, career medical officer positions, and supervisory positions including clinical and medical superintendents. Space restrictions do not at present permit these classes to be included in the National Health Labour Force Collection questionnaire.

Source and reference attributes

Submitting organisation: National Health Labour Force Data Working Group

Relational attributes

Related metadata references: Supersedes Classification of health labour force job, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (24.72 KB)

Implementation in Data Set Specifications: Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Information specific to this data set:

Distribution of a professional labour force across job classification categories cross-classified with other variables allows analysis of:

- career progression
- age and gender distribution
- imputed salary/wage distribution

Client type (alcohol and other drug treatment services)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—client type, code N
METeOR identifier:	270083
Registration status:	Health, Standard 01/03/2005
Definition:	The status of a person in terms of whether the treatment episode concerns their own alcohol and/or other drug use or that of another person, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—client type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Own alcohol or other drug use
2	Other's alcohol or other drug use

Collection and usage attributes

Guide for use:

CODE 1 Own alcohol or other drug use

Use this code for a client who receives treatment or assistance concerning their own alcohol and/or other drug use.

Use this code where a client is receiving treatment or assistance for both their own alcohol and/or other drug use and the alcohol and/or other drug use of another person.

CODE 2 Other's alcohol or other drug use

Use this code for a client who receives support and/or assistance in relation to the alcohol and/or other drug use of another person.

Collection methods: To be collected on commencement of a treatment episode with a service.

Data element attributes

Collection and usage attributes

Guide for use:

Where Code 2 Other's alcohol or other drug use is reported, do not collect the following data elements:

Episode of treatment for alcohol and other drugs—drug of concern (principal), code (ASCDC 2000 extended) NNNN;

Episode of treatment for alcohol and other drugs—drug of concern (other), code (ASCDC 2000 extended) NNNN;

Client—injecting drug use status, code N; and

Client—method of drug use (principal drug of concern), code

N.

Comments: Required to differentiate between clients according to whether the treatment episode concerns their own alcohol and/or other drug use or that of another person to provide a basis for description of the people accessing alcohol and other drug treatment services.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Client type - alcohol and other drug treatment services, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.5 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Clinical evidence of chronic lung disease (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical evidence status (chronic lung disease), code N
METeOR identifier:	285285
Registration status:	Health, Standard 04/06/2004
Definition:	The status of evidence for a pre-existing clinical condition of chronic lung disease, as represented by a code.
Data Element Concept:	Person—clinical evidence status (chronic lung disease)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Objective evidence
2	No objective evidence

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Objective evidence is coded where the diagnosis is supported by current use of chronic lung disease pharmacological therapy (e.g. inhalers, theophylline, aminophylline, or steroids), or a forced expiratory volume in 1 second (FEV1) less than 80% predicted FEV1/forced vital capacity (FVC) less than 0.7 (post bronchodilator). Respiratory failure partial pressure of oxygen (PaO2) less than 60 mmHg (8kPa), or partial pressure of carbon dioxide (PaCO2) greater than 50 mmHg (6.7 kPa).
Collection methods:	For each Person—concurrent clinical condition (acute coronary syndrome), code NN, the data elements Person—clinical evidence status(chronic lung disease), code N; Person—clinical evidence status(heart failure), code N; Person—clinical evidence status(stroke), code N; Person—clinical evidence status(peripheral arterial disease), code N; Person—clinical evidence status(sleep apnoea syndrome), code N must also be recorded.
Comments:	The diagnosis rests on the airflow limitation, which is not fully reversible. Consider treating as asthma if airflow limitation is substantially reversible. (The Thoracic Society of Australia & New Zealand and the Australian Lung Foundation, Chronic Obstructive Pulmonary Disease (COPD) Australian & New Zealand Management Guidelines and the COPD Handbook.

Version 1, November 2002.)

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Clinical evidence status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.18 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This data element seeks to ensure that patients with self-reported past symptoms pertinent to acute coronary syndrome, have objective evidence supporting reported diagnoses, using current medical practice.

Clinical evidence of heart failure (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical evidence status (heart failure), code N
METeOR identifier:	285287
Registration status:	Health, Standard 04/06/2004
Definition:	The status of evidence for a pre-existing clinical condition of heart failure, as represented by a code.
Data Element Concept:	Person—clinical evidence status (heart failure)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Objective evidence
2	No objective evidence

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Objective evidence is coded where a patient has current symptoms of heart failure (typically breathlessness or fatigue), either at rest or during exercise and/or signs of pulmonary or peripheral congestion and objective evidence of cardiac dysfunction at rest. The diagnosis is derived from and substantiated by clinical documentation from testing according to current practices.
Collection methods:	For each Person—concurrent clinical condition (acute coronary syndrome), code NN, the data elements Person—clinical evidence status(chronic lung disease), code N; Person—clinical evidence status(heart failure), code N; Person—clinical evidence status(stroke), code N; Person—clinical evidence status(peripheral arterial disease), code N; Person—clinical evidence status(sleep apnoea syndrome), code N must also be recorded.
Comments:	The most widely available investigation for documenting left ventricular dysfunction is the transthoracic echocardiogram (TTE). Other modalities include: • transoesophageal echocardiography (TOE), • radionuclide ventriculography (RVG),

- left ventriculogram (LVgram),
- magnetic resonance imaging (MRI).

In the absence of any adjunctive laboratory tests, evidence of supportive clinical signs of ventricular dysfunction. These include:

- third heart sound (S3),
- cardiomegaly,
- elevated jugular venous pressure (JVP),
- chest X-ray evidence of pulmonary congestion.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Clinical evidence status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.18 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This data element seeks to ensure that patients with self-reported past symptoms pertinent to acute coronary syndrome, have objective evidence supporting reported diagnoses, using current medical practice.

Clinical evidence of peripheral arterial disease (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical evidence status (peripheral arterial disease), code N
METeOR identifier:	285289
Registration status:	Health, Standard 04/06/2004
Definition:	The status of evidence for a pre-existing clinical condition of peripheral arterial disease, as represented by a code.
Data Element Concept:	Person—clinical evidence status (peripheral arterial disease)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Objective evidence
2	No objective evidence

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

For peripheral artery disease, objective evidence is coded where the diagnosis is derived from and substantiated by clinical documentation for a patient with a history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.

For aortic aneurysm, objective evidence is coded when the diagnosis of aneurysmal dilatation of the aorta (thoracic and or abdominal) is supported and substantiated by appropriate documentation of objective testing.

For renal artery stenosis, objective evidence is coded when the diagnosis of functional stenosis of one or both renal arteries is present and is supported and substantiated by appropriate documentation of objective testing.

Collection methods:

For each Person—concurrent clinical condition (acute coronary syndrome), code NN, the data elements Person—clinical evidence status (chronic lung disease), code N; Person—clinical evidence status (heart failure), code N; Person—clinical evidence status(stroke), code N; Person—clinical evidence status (peripheral arterial disease), code N; Person—clinical evidence status (sleep apnoea syndrome), code N must also be recorded.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Clinical evidence status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.18 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This data element seeks to ensure that patients with self-reported past symptoms pertinent to acute coronary syndrome, have objective evidence supporting reported diagnoses, using current medical practice.

Clinical evidence of sleep apnoea syndrome (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical evidence status (sleep apnoea syndrome), code N
METeOR identifier:	285291
Registration status:	Health, Standard 04/06/2004
Definition:	The status of evidence for a pre-existing clinical condition of sleep apnoea syndrome, as represented by a code.
Data Element Concept:	Person—clinical evidence status (sleep apnoea syndrome)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Objective evidence
2	No objective evidence

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Objective evidence is coded where the diagnosis is derived from and substantiated by clinical documentation of sleep apnoea syndrome (SAS). SAS has been diagnosed from the results of a sleep study.
Collection methods:	For each Person—concurrent clinical condition (acute coronary syndrome), code NN, the data elements Person—clinical evidence status(chronic lung disease), code N; Person—clinical evidence status(heart failure), code N; Person—clinical evidence status(stroke), code N; Person—clinical evidence status(peripheral arterial disease), code N; Person—clinical evidence status(sleep apnoea syndrome), code N must also be recorded.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Clinical evidence status, version 1, DE, NHDD,

NHIMG, Superseded 01/03/2005.pdf (19.18 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This data element seeks to ensure that patients with self-reported past symptoms pertinent to acute coronary syndrome, have objective evidence supporting reported diagnoses, using current medical practice.

Clinical evidence of stroke (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical evidence status (stroke), code N
METeOR identifier:	285293
Registration status:	Health, Standard 04/06/2004
Definition:	The status of evidence for a pre-existing clinical condition of stroke, as represented by a code.
Data Element Concept:	Person—clinical evidence status (stroke)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Objective evidence
2	No objective evidence

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	For ischaemic: non-haemorrhagic cerebral infarction, objective evidence is coded where the diagnosis is supported by cerebral imaging (CT or MRI), or For haemorrhagic: intracerebral haemorrhage, objective evidence is coded where the diagnosis is supported by cerebral imaging (CT or MRI).
Collection methods:	For each Person—concurrent clinical condition (acute coronary syndrome), code NN, the data elements Person—clinical evidence status (chronic lung disease), code N; Person—clinical evidence status (heart failure), code N; Person—clinical evidence status (stroke), code N; Person—clinical evidence status(peripheral arterial disease), code N; Person—clinical evidence status (sleep apnoea syndrome), code N must also be recorded.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes Clinical evidence status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.18 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

This data element seeks to ensure that patients with self-reported past symptoms pertinent to acute coronary syndrome, have objective evidence supporting reported diagnoses, using current medical practice.

Clinical procedure timing (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical procedure timing, code N
METeOR identifier:	284863
Registration status:	Health, Standard 04/06/2004
Definition:	The timing of the provision of a clinical procedure, as represented by a code.
Data Element Concept:	Person—clinical procedure timing

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Procedure performed prior to an episode of admitted patient care
2	Procedure performed during an episode of admitted patient care

Data element attributes

Collection and usage attributes

Guide for use:	Record only for those procedure codes that apply.
Collection methods:	This data element should be recorded for each type of procedure performed that is pertinent to the treatment of acute coronary syndrome.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Clinical procedure timing status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.93 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Clinical urgency

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—clinical urgency, code N
METeOR identifier:	270008
Registration status:	Health, Standard 01/03/2005
Definition:	A clinical assessment of the urgency with which a patient requires elective hospital care, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—clinical urgency

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency
2	Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency
3	Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency

Data element attributes

Collection and usage attributes

Guide for use:	The classification employs a system of urgency categorisation based on factors such as the degree of pain, dysfunction and disability caused by the condition and its potential to deteriorate quickly into an emergency. All patients ready for care must be assigned to one of the urgency categories, regardless of how long it is estimated they will need to wait for surgery.
Comments:	A patient's classification may change if he or she undergoes **clinical review** during the waiting period. The need for clinical review varies with the patient's condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (metadata item Elective care waiting list episode—category reassignment date, DDMMYYYY).

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Clinical urgency, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.39 KB)

See also Elective surgery waiting list episode—overdue patient status, code N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005

Implementation start date: 30/09/2006

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS Health, Standard 07/12/2005

Implementation start date: 01/07/2006

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Clopidogrel therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clopidogrel therapy status, code NN
METeOR identifier:	284873
Registration status:	Health, Standard 04/06/2004
Definition:	The person's clopidogrel therapy status, as represented by a code.
Data Element Concept:	Person—clopidogrel therapy status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - therapy not indicated
22	Not given - patient refusal
23	Not given - true allergy to clopidogrel
24	Not given - active bleeding
25	Not given - bleeding risk
26	Not given - thrombocytopenia
27	Not given - severe hepatic dysfunction
29	Not given - other

Supplementary values:

90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 21 - 29 Not given

If recording `Not given', record the principal reason if more than one code applies.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Clopidogrel therapy status, version 1, DE, NHDD,

NHIMG, Superseded 01/03/2005.pdf (14.69 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
For Acute coronary syndrome (ACS) reporting, can be collected at any tiime point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).

Co-location status of mental health service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—co-location with acute care hospital, code N
METeOR identifier:	286995
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a mental health service is co-located with an acute care hospital, as represented by a code.
Data Element Concept:	Specialised mental health service—co-location with acute care hospital

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Co-located
2	Not co-located

Collection and usage attributes

Guide for use:

CODE 1 Co-located

Co-located health services are those that are established physically and organisationally as part of an acute care hospital service. There are two forms of co-location:

- a health service that is built and managed as a ward or unit within an acute care hospital; or
- the health service operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus.

In the second option, units and wards within a psychiatric hospital may be classified as co-located when all the following criteria apply:

- a single organisational or management structure covers the acute care hospital and the psychiatric hospital;
- a single employer covers the staff of the acute care hospital and the psychiatric hospital;
- the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus; and
- the patients of the psychiatric hospital are regarded as patients of the single integrated health service.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Collection methods:

To be reported for mental health services that primarily provide overnight admitted patient care. Excludes residential mental health services and ambulatory mental health services.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Compensable status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—compensable status, code N
METeOR identifier:	270100
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a patient is a **compensable patient**, as represented by a code.
Data Element Concept:	Patient—compensable status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Compensable
	2	Non-compensable
Supplementary values:	9	Not stated/not known

Data element attributes

Collection and usage attributes

Guide for use:	This definition of **compensable patient** excludes eligible beneficiaries (Department of Veterans' Affairs), Defence Force personnel and persons covered by the Motor Accident Compensation Scheme, Northern Territory.
Comments:	To assist in the analyses of utilisation and health care funding.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Compensable status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.25 KB)
Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005 Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Complication of labour and delivery

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—complication, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361071
Registration status:	Health, Standard 05/02/2008
Definition:	Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed delivery of the baby and placenta, as represented by a code.
Data Element Concept:	Birth event—complication

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

Guide for use:	There is no arbitrary limit on the number of conditions specified.
Comments:	Complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Birth event—complication, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Complications of pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy (current)—complication, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333938
Registration status:	Health, Standard 07/12/2005
Definition:	Complications arising up to the period immediately preceding delivery that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome, as represented by a code
Data Element Concept:	Pregnancy (current)—complication

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

Guide for use:	Examples of these conditions include threatened abortion, antepartum haemorrhage, pregnancy-induced hypertension and gestational diabetes. There is no arbitrary limit on the number of complications specified.
Comments:	Complications often influence the course and outcome of pregnancy, possibly resulting in hospital admissions and/or adverse effects on the fetus and perinatal morbidity.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Pregnancy (current)—complication, code (ICD-10-AM 4th edn) ANN{.N[N]} Health, Superseded 07/12/2005

Concurrent clinical condition (on presentation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—acute coronary syndrome concurrent clinical condition, code NN
METeOR identifier:	284891
Registration status:	Health, Standard 04/06/2004
Definition:	The concurrent medical conditions, which are pertinent to the risk stratification and treatment of acute coronary syndrome that a person has or has undergone prior to presentation, as represented by a code.
Data Element Concept:	Person—acute coronary syndrome concurrent clinical condition

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
11	Angina for more than last two weeks
12	Angina only in the last two weeks
21	Chronic lung disease
31	Heart failure
41	Hypertension
51	Ischaemic: non-haemorrhagic cerebral infarction
52	Haemorrhagic: intracerebral haemorrhage
61	Peripheral artery disease
62	Aortic aneurysm
63	Renal artery stenosis
71	Sleep apnoea

Supplementary values:

99	not stated/inadequately described

Collection and usage attributes

Guide for use:

Angina:

CODE 11 Angina for more than last two weeks

This code is used where there are symptoms, which can be described as chest pain or pressure, jaw pain, arm pain, or other equivalent discomfort suggestive of cardiac ischaemia, for more than the last two weeks.

CODE 12 Angina only in the last two weeks

This code is used where there are symptoms, which can be described as chest pain or pressure, jaw pain, arm pain, or other equivalent discomfort suggestive of cardiac ischaemia, only in the last two weeks.

Chronic lung disease:

CODE 21 Chronic lung disease

This code is used where there is a history or symptoms suggestive of chronic lung disease.

Heart failure:

CODE 31 Heart failure

This code is used where a patient has past or current symptoms of heart failure (typically breathlessness or fatigue), either at rest or during exercise and/or signs of pulmonary or peripheral congestion suggestive of cardiac dysfunction.

Hypertension:

CODE 41 Hypertension

This code is used where there is current use of pharmacotherapy for hypertension and/or clinical evidence of high blood pressure.

Stroke:

CODE 51 Ischaemic: non-haemorrhagic cerebral infarction

This code is used if there is history of stroke or cerebrovascular accident (CVA) resulting from an ischaemic event where the patient suffered a loss of neurological function with residual symptoms remaining for at least 24 hours.

CODE 52 Haemorrhagic: intracerebral haemorrhage

This code is used if there is history of stroke or cerebrovascular accident (CVA) resulting from a haemorrhagic event where the patient suffered a loss of neurological function with residual symptoms remaining for at least 24 hours.

Peripheral arterial disease:

CODE 61 Peripheral artery disease

This code is used where there is history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.

CODE 62 Aortic aneurysm

This code is used where there is a history of aneurysmal dilatation of the aorta (thoracic and or abdominal).

CODE 63 Renal artery stenosis

This code is used where there is history of functional stenosis of one or both renal arteries.

Sleep Apnoea syndrome:

CODE 71 Sleep apnoea

This code is used where there is evidence of sleep apnoea syndrome (SAS) on history.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: More than one medical condition may be recorded.

Record only those codes that apply.

Record all codes that apply.

Codes 21, 31, 51, 52, 61, 62, 63 and 71 must be accompanied by a

Clinical evidence status code.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Concurrent clinical condition - on presentation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.84 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Condition onset flag

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—condition onset flag, code N
METeOR identifier:	354816
Registration status:	Health, Standard 05/02/2008
Definition:	A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care, as represented by a code.
Data Element Concept:	Episode of admitted patient care—condition onset flag

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Condition with onset during the episode of admitted patient care
2	Condition not noted as arising during the episode of admitted patient care

Supplementary values:

9	Not reported

Collection and usage attributes

Guide for use:

1 Condition with onset during the episode of admitted patient care

- a condition which arises during the episode of admitted patient care and would not have been present on admission

Includes:

Conditions resulting from misadventure during medical or surgical care during the episode of admitted patient care.

Abnormal reactions to, or later complication of, surgical or medical care arising during the episode of admitted patient care.

Conditions arising during the episode of admitted patient care not related to surgical or medical care (for example, pneumonia).

2 Condition not noted as arising during the episode of admitted patient care

- a condition present on admission such as the presenting problem, a comorbidity, chronic disease or disease status.
- a previously existing condition not diagnosed until the episode of admitted patient care.

Includes:

In the case of neonates, the conditions present at birth.

A previously existing condition that is exacerbated during the

episode of admitted patient care.

Conditions that are suspected at the time of admission and subsequently confirmed during the episode of admitted patient care.

Conditions that were not diagnosed at the time of admission but clearly did not develop after admission (for example malignant neoplasm).

Conditions where the onset relative to the beginning of the episode of admitted patient care is unclear or unknown.

9 Not reported

The condition onset flag could not be reported due to limitations of the data management system.

Data element attributes

Collection and usage attributes

Guide for use:

Assign the relevant condition onset flag to ICD-10-AM diagnosis codes assigned in the principal diagnosis and additional diagnosis fields for the National Hospital Morbidity Database collection.

The sequencing of diagnosis codes must comply with the Australian Coding Standards and therefore diagnosis codes should not be re-sequenced in an attempt to list diagnosis codes with the same condition onset flag together.

When it is difficult to decide if a condition was present at the beginning of the episode of care or if it arose during the episode, assign a value of 1 - Condition not noted as arising during this episode of care.

The principal diagnosis should always have a condition onset flag value of 1.

Explanatory notes:

The flag on external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code.

The flag on morphology codes should match that on the corresponding neoplasm code

When a single diagnosis code describes a condition and that code contains more than one concept (e.g. diabetes with renal complications) and each concept within that code has a different condition onset flag, then assign a value of 1.

When a condition requires more than one diagnosis code to describe it, it is possible for each diagnosis code to have a different condition onset flag.

The flag on Z codes related to the outcome of delivery on the mother's record (Z37), should always be assigned a value of 1

The flag on Z codes related to the outcome of delivery on the baby's record (Z38), should always be assigned a value of 1

Collection methods:

A condition onset flag should be recorded and coded upon completion of an episode of admitted patient care.

Comments:

The condition onset flag is a means of differentiating those conditions which arise during, or arose before, an admitted patient episode of care. Having this information will provide an insight into the kinds of conditions patients already have when entering hospital and what arises during the episode of

care. A better understanding of those conditions arising during the episode of care may inform prevention strategies particularly in relation to complications of medical care.

The flag only indicates when the condition had onset, and cannot be used to indicate whether a condition was considered to be preventable.

Source and reference attributes

Origin: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Episode of admitted patient care—diagnosis onset type, code N Health, Superseded 05/02/2008

Implementation in Data Set Specifications: Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Congenital malformations

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—congenital malformation, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333934
Registration status:	Health, Standard 07/12/2005
Definition:	Structural abnormalities (including deformations) that are present at birth and diagnosed prior to **separation** from care, as represented by an ICD-10-AM code.
Context:	Admitted patient care
Data Element Concept:	Person—congenital malformation

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Source and reference attributes

Origin:	International Classification of Diseases - 10th Revision, Australian Modification (5th Edition 2004) National Centre for Classification in Health, Sydney.

Data element attributes

Collection and usage attributes

Guide for use:	Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients. However, for the perinatal data collection, the use of BPA is preferred as this is more detailed (see the metadata item Person—congenital malformations, code (BPA 1979) ANN.N[N]).
Comments:	Required to monitor trends in the reported incidence of congenital malformations, to detect new drug and environmental teratogens, to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Person—congenital malformation, code (ICD-10-AM 4th edn) ANN{.N[N]} Health, Superseded 07/12/2005

Congenital malformations—BPA code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—congenital malformation, code (BPA 1979) ANN.N[N]
METeOR identifier:	270408
Registration status:	Health, Standard 01/03/2005
Definition:	Structural abnormalities (including deformations) that are present at birth and diagnosed prior to **separation** from care, as represented by a BPA code.
Context:	Perinatal statistics
Data Element Concept:	Person—congenital malformation

Value domain attributes

Representational attributes

Classification scheme:	British Paediatric Association Classification of Diseases 1979
Representation class:	Code
Data type:	String
Format:	ANN.N[N]
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:	Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients. For perinatal data collections, the use of British Paediatric Association (BPA) Classification of Diseases is preferred as this is more detailed.
Comments:	There is no arbitrary limit on the number of conditions specified. Most perinatal data groups and birth defects registers in the states and territories have used the 5-digit BPA Classification of Diseases to code congenital malformations since the early 1980s.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee
Origin:	British Paediatric Association Classification of Diseases (1979)

Relational attributes

Related metadata references:	Supersedes Congenital malformations - BPA code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.15 KB)

Consumer committee representation arrangements

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer committee representation arrangements, code N
METeOR identifier:	288855
Registration status:	Health, Standard 08/12/2004
Definition:	Extent to which a specialised mental health service organisation has formal committee mechanisms in place to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer committee representation arrangements

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Formal position(s) for consumers exist on the organisation's management committee for the appointment of person(s) to represent the interests of consumers
2	Specific consumer advisory committee(s) exists to advise on all relevant mental health services managed by the organisation
3	Specific consumer advisory committee(s) exists to advise on some but not all relevant mental health services managed by the organisation
4	Consumers participate on a broadly based advisory committee which include a mixture of organisations and groups representing a wide range of interests
5	Consumers are not represented on any advisory committee but are encouraged to meet with senior representatives of the organisation as required
6	No specific arrangements exist for consumer participation in planning and evaluation of services

Collection and usage attributes

Guide for use:	Select the option above that best describes the type of formal committee mechanisms within your organisation for ensuring participation by mental health consumers in the planning and evaluation of services.

Data element attributes

Collection and usage attributes

Guide for use:

Select the option above that best describes the type of formal committee mechanisms with in your organisation for ensuring participation by mental health consumers in the planning and evaluation of services.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Consumer participation arrangements—consumer consultants employed

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N
METeOR identifier:	288866
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service employs consumer consultants on a paid basis to represent the interests of consumers and advocate for their needs, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Boolean	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Don't know

Data element attributes

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Consumer participation arrangements—consumer satisfaction surveys

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N
METeOR identifier:	290418
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service conducts consumer satisfaction surveys, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Don't know

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Consumer participation arrangements—formal complaints mechanism

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N
METeOR identifier:	290415
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service has developed a formal internal complaints mechanism in which complaints can be made by consumers and are regularly reviewed by a committee that includes consumers, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (formal internal complaints mechanism)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Boolean	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Don't know

Data element attributes

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Consumer participation arrangements—formal participation policy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N
METeOR identifier:	290410
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service has developed a formal and documented policy on participation by consumers, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (formal participation policy)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Boolean	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Don't know

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Consumer participation arrangements—regular discussion groups

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N
METeOR identifier:	290408
Registration status:	Health, Standard 08/12/2004
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (regular discussion groups)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Don't know

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Contract establishment identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Contracted hospital care—organisation identifier, NNX[X]NNNNN
METeOR identifier:	270013
Registration status:	Health, Standard 01/03/2005
Definition:	The unique establishment identifier of the other hospital involved in the contracted care.
Data Element Concept:	Contracted hospital care—organisation identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	NNX[X]NNNNN
Maximum character length:	9

Data element attributes

Collection and usage attributes

Guide for use:	The contracted hospital will record the establishment identifier of the contracting hospital. The contracting hospital will record the establishment identifier of the contracted hospital.

Relational attributes

Related metadata references:	Supersedes Contract establishment identifier, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.93 KB)

Contract procedure flag

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care (procedure)—contracted procedure flag, code N
METeOR identifier:	270473
Registration status:	Health, Standard 01/03/2005
Definition:	Designation that a procedure was not performed in this hospital but was performed by another hospital as a contracted service, as represented by a code.
Data Element Concept:	Episode of care (procedure)—contracted procedure flag

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	[N]
Maximum character length:	1

Permissible values:

Value	Meaning
1	Contracted admitted procedure
2	Contracted non-admitted procedure

Data element attributes

Collection and usage attributes

Guide for use:

Procedures performed at another hospital under contract (Hospital B) are recorded by both hospitals, but flagged by the contracting hospital only (Hospital A). This flag is to be used by the contracting hospital to indicate a procedure performed by a contracted hospital. It also indicates whether the procedure was performed as an admitted or non-admitted service.

Allocation of procedure codes should not be affected by the contract status of an episode: the Australian Coding Standards should be applied when coding all episodes. In particular, procedures which would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.

Procedures performed by a health care service (i.e. not a recognised hospital) should be coded if appropriate. Some jurisdictions may require these to be separately identified and they could be distinguished from contracted hospital procedures through the use of an additional code in the contract procedure flag data item.

Relational attributes

Related metadata references:

Supersedes Contract procedure flag, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.29 KB)

Contract role

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital—contract role, code A
METeOR identifier:	270114
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the hospital is the purchaser of hospital care or the provider of an admitted or non-admitted service, as represented by a code.
Data Element Concept:	Hospital—contract role

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
A	Hospital A
B	Hospital B

Collection and usage attributes

Guide for use:

CODE A Hospital A

Hospital A is the contracting hospital (purchaser).

CODE B Hospital B

Hospital B is the contracted hospital (provider).

Data element attributes

Relational attributes

Related metadata references:

Supersedes Contract role, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Is used in the formation of Episode of admitted patient care—inter-hospital contracted patient status, code N Health, Standard 01/03/2005

Contract type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital—contract type, code N
METeOR identifier:	270475
Registration status:	Health, Standard 01/03/2005
Definition:	The type of contract arrangement between contractor and the contracted hospital, as represented by a code.
Data Element Concept:	Hospital—contract type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Contract type B
2	Contract type ABA
3	Contract type AB
4	Contract type (A)B
5	Contract type BA

Collection and usage attributes

Guide for use:

The contracting hospital (purchaser) is termed Hospital A. The contracted hospital (provider) is termed Hospital B.

CODE 1 Contract Type B

A health authority / other external purchaser contracts hospital B for admitted service which is funded outside the standard funding arrangements.

CODE 2 Contract Type ABA

Patient admitted by Hospital A. Hospital A contracts Hospital B for admitted or non-admitted patient service. Patient returns to Hospital A on completion of service by Hospital B.

For example, a patient has a hip replacement at Hospital A, then receives aftercare at Hospital B, under contract to Hospital A. Complications arise and the patient returns to Hospital A for the remainder of care.

CODE 3 Contract Type AB

Patient admitted by Hospital A. Hospital A contracts Hospital B for admitted or non-admitted patient service. Patient does not return to Hospital A on completion of service by Hospital B.
For example, a patient has a hip replacement at Hospital A and then receives aftercare at Hospital B, under contract to Hospital A. Patient is separated from Hospital B.

CODE 4 Contract Type (A)B

This contract type occurs where a Hospital A contracts Hospital

B for the whole episode of care. The patient does not attend Hospital A. For example, a patient is admitted for endoscopy at Hospital B under contract to Hospital A.

CODE 5 Contract Type BA

Hospital A contracts Hospital B for an admitted patient service following which the patient moves to Hospital A for remainder of care. For example, a patient is admitted to Hospital B for a gastric resection procedure under contract to Hospital A and Hospital A provides after care.

Data element attributes

Relational attributes

Related metadata references:

Supersedes Contract type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.37 KB)

Is used in the formation of Episode of admitted patient care — inter-hospital contracted patient status, code N Health, Standard 01/03/2005

Contracted care commencement date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Contracted hospital care—contracted care commencement date, DDMMYYYY
METeOR identifier:	270105
Registration status:	Health, Standard 01/03/2005
Definition:	The date the period of contracted care commenced.
Data Element Concept:	Contracted hospital care—contracted care commencement date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item is to be used by the contracting hospital to record the commencement date of the contracted hospital care and will be the admission date for the contracted hospital.

Relational attributes

Related metadata references:	Supersedes Contracted care commencement date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.67 KB)

Contracted care completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Contracted hospital care—contracted care completed date, DDMMYYYY
METeOR identifier:	270106
Registration status:	Health, Standard 01/03/2005
Definition:	The date the period of contracted care is completed.
Data Element Concept:	Contracted hospital care—contracted care completed date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item is to be used by the contracting hospital to record the date of completion of the contracted hospital care and will be the separation date for the contracted hospital.

Relational attributes

Related metadata references:	Supersedes Contracted care completion date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.67 KB)

Coordinator of volunteers indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—coordinator of volunteers indicator, yes/no code N
METeOR identifier:	352862
Registration status:	Health, Standard 05/12/2007
Definition:	An indicator of whether a service provider organisation has at least one designated person to coordinate their volunteer labour force, as represented by a code.
Data Element Concept:	Service provider organisation—coordinator of volunteers indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

A coordinator of volunteers may be employed part-time or full-time and may be engaged on a paid or unpaid basis.
The duties of a volunteer coordinator may include:

- managing the workloads of volunteer staff;
- liaising with clinical staff regarding clients' needs;
- assessing human resource needs of the organisation;
- recruiting volunteers;
- developing orientation kits and programs;
- developing volunteer policies;
- arranging training and development opportunities; and
- maintaining volunteer records.

CODE 1 Yes
The organisation has a designated coordinator of volunteers.
CODE 2 No
The organisation does not have a designated coordinator of volunteers.

Source and reference attributes

Submitting organisation:	Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:	Palliative care performance indicators DSS Health, Standard 05/12/2007

Coronary artery disease—history of intervention or procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—coronary artery disease intervention (history), code N
METeOR identifier:	270227
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has undergone a coronary artery by-pass grafting (CABG), angioplasty or stent, as represented by a code.
Data Element Concept:	Person—coronary artery disease intervention

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	CABG, angioplasty or stent - undertaken in last 12 months
2	CABG, angioplasty or stent - undertaken prior to the last 12 months
3	CABG, angioplasty or stent - both within and prior to the last 12 months
4	No CABG, angioplasty or stent undertaken

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Comments:

CABG is known as 'bypass surgery' when a piece of vein (taken from the leg) or of an artery (taken from the chest or wrist) is used to form a connection between the aorta and the coronary artery distal to the obstructive lesion, making a bypass around the blockage. Angioplasty is an **elective surgery** technique of blood vessels reconstruction.

Stenting is a non-surgical treatment used with balloon angioplasty or after, to treat coronary artery disease to widen a coronary artery. A stent is a small, expandable wire mesh tube that is inserted. The purpose of the stent is to help hold the newly treated artery open, reducing the risk of the artery re-closing (re-stenosis) over time.

Angioplasty with stenting typically leaves less than 10% of the original blockage in the artery (Heart Center Online).

These three procedures are commonly used to improve blood flow to the heart muscle when the heart's arteries are narrowed or blocked.

The sooner procedures are done, the greater the chances of

saving heart muscle.

Data element attributes

Collection and usage attributes

Collection methods: Ask the individual if he/she has had a CABG, angioplasty or coronary stent. If so determine when it was undertaken within or prior to the last 12 months (or both).

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Coronary artery disease - history of intervention or procedure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.32 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Country of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—country of birth, code (SACC 1998) NNNN
METeOR identifier:	270277
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 20/06/2005
Definition:	The country in which the person was born, as represented by a code.
Data Element Concept:	Person—country of birth

Value domain attributes

Representational attributes

Classification scheme:	Standard Australian Classification of Countries 1998
Representation class:	Code
Data type:	Number
Format:	NNNN
Maximum character length:	4

Collection and usage attributes

Guide for use:	The Standard Australian Classification of Countries 1998 (SACC) is a four-digit, three-level hierarchical structure specifying major group, minor group and country. A country, even if it comprises other discrete political entities such as states, is treated as a single unit for all data domain purposes. Parts of a political entity are not included in different groups. Thus, Hawaii is included in Northern America (as part of the identified country United States of America), despite being geographically close to and having similar social and cultural characteristics as the units classified to Polynesia.

Data element attributes

Collection and usage attributes

Collection methods:	Some data collections ask respondents to specify their country of birth. In others, a pre-determined set of countries is specified as part of the question, usually accompanied by an 'other (please specify)' category. Recommended questions are: In which country were you/was the person/was (name) born? Australia Other (please specify) Alternatively, a list of countries may be used based on, for example common Census responses. In which country were you/was the person/was (name) born? Australia England

New Zealand
Italy
Viet Nam
Scotland
Greece
Germany
Philippines
India
Netherlands
Other (please specify)
In either case coding of data should conform to the SACC.
Sometimes respondents are simply asked to specify whether they were born in either 'English speaking' or 'non-English speaking' countries but this question is of limited use and this method of collection is not recommended.

Comments: This metadata item is consistent with that used in ABS collections and is recommended for use whenever there is a requirement for comparison with ABS data.

Source and reference attributes

Origin: National Health Data Committee
National Community Services Data Committee

Relational attributes

Related metadata references: Supersedes Country of birth, version 4, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (19.86 KB)

Implementation in Data Set Specifications:
Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005
Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005
Admitted patient care NMDS Health, Superseded 07/12/2005
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008
Implementation start date: 01/07/2008
Admitted patient mental health care NMDS Health, Superseded 07/12/2005
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
Admitted patient mental health care NMDS Health, Superseded

23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Health care client identification Health, Superseded 04/05/2005

Information specific to this data set:
County of birth for newborn babies should be 'Australia'.

Health care client identification DSS Health, Standard 04/05/2005

Information specific to this data set:
Country of birth for newborn babies should be 'Australia'.

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008