National Health Data Dictionary Version 13.3 Volume 6 Data elements Sp - Y

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List of metadata items

Data Element Technical Names

Data Elements

Specialised mental health service program type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—admitted patient care program type, code N
METeOR identifier:	288889
Registration status:	Health, Standard 08/12/2004
Definition:	Type of admitted patient care program provided by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service—admitted patient care program type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Acute care
2	Other

Collection and usage attributes

Guide for use:

The categorisation of the admitted patient program is based on the principal purpose(s) of the program rather than the classification of the individual patients.

CODE 1 Acute care

Programs primarily providing specialist psychiatric care for people with acute episodes of mental disorder. These episodes are characterised by recent onset of severe clinical symptoms of mental disorder, that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that this treatment effort is focused on short-term treatment. Acute services may be focused on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing mental disorder for whom there has been an acute exacerbation of symptoms. This category applies only to services with a mental health service setting of overnight admitted patient care or residential care.

CODE 2 Other

Refers to all other programs primarily providing admitted patient care.

Includes programs providing rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery.

They are characterised by an expectation of substantial improvement over the short to mid-term. Patients treated by

rehabilitation services usually have a relatively stable pattern of clinical symptoms.

Also includes programs providing extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental disorder. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used to disaggregate data on beds, activity, expenditure and staffing for admitted patient settings in mental health service units (see Specialised mental health service—service setting, code N data element).

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Specialised mental health service setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—service setting, code N
METeOR identifier:	288899
Registration status:	Health, Standard 08/12/2004
Definition:	The setting for care provided by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service—service setting

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Admitted patient care setting
2	Residential care setting
3	Ambulatory care setting

Supplementary values:

9	Unknown/not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Admitted patient care setting

The component of specialised mental health services that provides admitted patient care. These are specialised psychiatric hospitals and specialist psychiatric units located within hospitals that are not specialised psychiatric hospitals. Excludes hospital outpatient clinics.

CODE 2 Residential care setting

The component of specialised mental health services that provides residential care within **residential mental health services**. Excludes components that provide ambulatory care to patients or clients who are not residents.

CODE 3 Ambulatory care setting

The component of specialised mental health services that provides ambulatory care (service contacts). They include hospital outpatient clinics and non-hospital community mental health services, such as crisis or mobile assessment and treatment services, day programs, outreach services and consultation/liaison services.

Data element attributes

Collection and usage attributes

Guide for use: A single mental health service unit may provide care in more than one setting. This data element is intended to allow staffing,

resource and expenditure data related to these settings to be identified and reported separately.

Relational attributes

Related metadata references:

Supersedes Specialised mental health service—service delivery setting, code N Health, Superseded 08/12/2004

Implementation in Data Set Specifications:

Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Specialised mental health service target population

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—target population group, code N
METeOR identifier:	288957
Registration status:	Health, Standard 08/12/2004
Definition:	The population group primarily targeted by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service—specialised mental health service target population group

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Child and adolescent
2	Older person
3	Forensic
4	General

Collection and usage attributes

Guide for use:

CODE 1 Child and adolescent

These services principally target children and young people under the age of 18 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

CODE 2 Older person

These services principally target people in the age group of 65 years and over. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

CODE 3 Forensic

Health services that provide services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment. This includes prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.

CODE 4 General

These services principally target the general adult population (aged 18–64 years) but may also provide services to children,

adolescents or older people. These services are those services that cannot be described as specialist child and adolescent services or services for older people. It excludes forensic services.

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used to disaggregate data on beds, activity, expenditure and staffing for admitted patient settings in mental health service units (see service setting data element).

The order of priority for coding is:

- where the forensic services are for children/adolescents or older persons these services should be coded to the category for that age group; and
- where the forensic services are for adults these services should be coded to forensic.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Specialised mental health service—hours staffed

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—number of hours staffed, average hours NN
METeOR identifier:	288877
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of hours per day during which a residential mental health service has appropriately trained staff employed on-site. Training may include formal qualifications and/or on the job training.
Data Element Concept:	Specialised mental health service—number of hours staffed

Value domain attributes

Representational attributes

Representation class:	Average	
Data type:	Number	
Format:	NN	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Unknown/not stated/inadequately described
Unit of measure:	Hour (h)	

Data element attributes

Collection and usage attributes

Guide for use:

Whole numbers of hours staffed (no decimals or fractions).

Valid numbers are 1 to 24.

The hours staffed provides a measure of service intensity for the reporting and analysis of staff, financial and activity data.

For residential mental health services, this refers to the number of hours per day during which appropriately trained staff (either with formal qualifications and/or on the job training) are employed on site, as their normal place of employment, within the service unit. It excludes periods where the service unit is only staffed by a resident sleepover staff member or any period where staff are present but not employed on site at the service unit.

Excludes ambulatory and admitted patient services.

Round to nearest whole hour.

Where the number of hours staffed varies by day, average the number of hours staffed over a week, including the weekend.

Relational attributes

Implementation in Data Set Specifications:

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

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Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Specialised mental health service—supported public housing places

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—number of supported public housing places, total N[N(5)]
METeOR identifier:	288945
Registration status:	Health, Standard 08/12/2004
Definition:	The total number of public housing places supported by specialised mental health services available at 30 June, targeted to people affected by mental illness or psychiatric disability. These are places provided by the public housing authority under a formal partnership agreement with the relevant State or Territory health authority. Such agreements commit the State or Territory health authority to assist people within their homes by providing ongoing clinical and disability support, including outreach services.
Data Element Concept:	Specialised mental health service—number of supported public housing places

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N(5)]
Maximum character length:	6

Source and reference attributes

Steward:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health,

Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (transplantation unit), yes/no code N
METeOR identifier:	270443
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to organ retrieval, transplantation and ongoing care of the transplant recipient, is provided within an establishment. • bone marrow • renal • heart, including heart-lung • liver • pancreas.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Specialised service indicators—acquired immune deficiency syndrome unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (acquired immune deficiency syndrome unit), yes/no code N
METeOR identifier:	270448
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the treatment of Acquired Immune Deficiency Syndrome (AIDS) patients is provided within an establishment as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

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Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—acute renal dialysis unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (acute renal dialysis unit), yes/no code N
METeOR identifier:	270435
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to dialysis of renal failure patients requiring acute care is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—acute spinal cord injury unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (acute spinal cord injury unit), yes/no code N
METeOR identifier:	270432
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the initial treatment and subsequent ongoing management and rehabilitation of patients with acute spinal cord injury, largely conforming to Australian Health Minister's Advisory Council guidelines for service provision, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2008

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—alcohol and drug unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (alcohol and drug unit), yes/no code N
METeOR identifier:	270431
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility/service dedicated to the treatment of alcohol and drug dependence is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—bone marrow transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (bone marrow transplantation unit), yes/no code N
METeOR identifier:	308862
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for bone marrow transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

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Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—burns unit (level III)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (burns unit (level III)), yes/no code N
METeOR identifier:	270438
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the initial treatment and subsequent rehabilitation of the severely injured burns patient (usually >10 per cent of patients body surface affected) is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—cardiac surgery unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (cardiac surgery unit), yes/no code N
METeOR identifier:	270434
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to operative and peri-operative care of patients with cardiac disease is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—clinical genetics unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (clinical genetics unit), yes/no code N
METeOR identifier:	270444
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to diagnostic and counselling services for clients who are affected by, at risk of, or anxious about genetic disorders, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

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Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—comprehensive epilepsy centre

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (comprehensive epilepsy centre), yes/no code N
METeOR identifier:	270442
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to seizure characterisation, evaluation of therapeutic regimes, pre-surgical evaluation and epilepsy surgery for patients with refractory epilepsy, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

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Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—coronary care unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (coronary care unit), yes/no code N
METeOR identifier:	270433
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to acute care services for patients with cardiac diseases is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
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Specialised service indicators—diabetes unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (diabetes unit), yes/no code N
METeOR identifier:	270449
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the treatment of diabetics is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—domiciliary care service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (domiciliary care service), yes/no code N
METeOR identifier:	270430
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility/service dedicated to the provision of nursing or other professional paramedical care or treatment and non-qualified domestic assistance to patients in their own homes or in residential institutions not part of the establishment is provided by the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—geriatric assessment unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (geriatric assessment unit), yes/no code N
METeOR identifier:	270429
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not facilities dedicated to the Commonwealth-approved assessment of the level of dependency of (usually) aged individuals either for purposes of initial **admission** to a long-stay institution or for purposes of reassessment of dependency levels of existing long-stay institution residents, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—heart, lung transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (heart, lung transplantation unit), yes/no code N
METeOR identifier:	308866
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for heart including heart lung transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—hospice care unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (hospice care unit), yes/no code N
METeOR identifier:	270427
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility dedicated to the provision of palliative care to terminally ill patients is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—in-vitro fertilisation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (in-vitro fertilisation unit), yes/no code N
METeOR identifier:	270441
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the investigation of infertility provision of in-vitro fertilisation services is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—infectious diseases unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (infectious diseases unit), yes/no code N
METeOR identifier:	270447
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the treatment of infectious diseases is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—intensive care unit (level III)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (intensive care unit (level III)), yes/no code N
METeOR identifier:	270426
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of paediatric and adult patients requiring intensive care and sophisticated technological support services is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—liver transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (liver transplantation unit), yes/no code N
METeOR identifier:	308868
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for liver transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—maintenance renal dialysis centre

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (maintenance renal dialysis centre), yes/no code N
METeOR identifier:	270437
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a specialised facility dedicated to maintenance dialysis of renal failure patients, as represented by a code. It may be a separate facility (possibly located on hospital grounds) or known as a satellite centre or a hospital-based facility but is not a facility solely providing training services.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—major plastic/reconstructive surgery unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (major plastic/reconstructive surgery unit), yes/no code N
METeOR identifier:	270439
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to general purpose plastic and specialised reconstructive surgery, including maxillofacial, microsurgery and hand surgery, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—neonatal intensive care unit (level III)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (neonatal intensive care unit (level III)), yes/no code N
METeOR identifier:	270436
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of neonates requiring care and sophisticated technological support, is provided within an establishment, as represented by a code. Patients usually require intensive cardiorespiratory monitoring, sustained assistance ventilation, long-term oxygen administration and parenteral nutrition.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—neuro surgical unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (neuro surgical unit), yes/no code N
METeOR identifier:	270446
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the surgical treatment of neurological conditions is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—nursing home care unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (nursing home care unit), yes/no code N
METeOR identifier:	270428
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility dedicated to the provision of nursing home care is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—obstetric/maternity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (obstetric/maternity), yes/no code N
METeOR identifier:	270150
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of obstetric/maternity patients is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—oncology unit, cancer treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (oncology unit) (cancer treatment), yes/no code N
METeOR identifier:	270440
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to multidisciplinary investigation, management, rehabilitation and support services for cancer patients, is provided within an establishment, as represented by a code. Treatment services include surgery, chemotherapy and radiation.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—pancreas transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (pancreas transplantation unit), yes/no code N
METeOR identifier:	308870
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for pancreas transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—psychiatric unit/ward

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (psychiatric unit/ward), yes/no code N
METeOR identifier:	270425
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised unit/ward dedicated to the treatment and care of admitted patients with psychiatric, mental, or behavioural disorders, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—rehabilitation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (rehabilitation unit), yes/no code N
METeOR identifier:	270450
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not dedicated units within recognised hospitals which provide post-acute rehabilitation and are designed as such by the State health authorities (see metadata item Type of episode of care) are provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health,

Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—renal transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (renal transplantation unit), yes/no code N
METeOR identifier:	308864
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for renal transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialised service indicators—sleep centre

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (sleep centre), yes/no code N
METeOR identifier:	270445
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility linked to a sleep laboratory dedicated to the investigation and management of sleep disorders is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Specialised service indicators—specialist paediatric

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (specialist paediatric), yes/no code N
METeOR identifier:	270424
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of children aged 14 or less is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.98 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Specialist private sector rehabilitation care indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—specialist private sector rehabilitation care indicator, code N
METeOR identifier:	270397
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the rehabilitation care that a patient receives from a private hospital meets the criteria for 'Specialist private sector rehabilitation care', as represented by a code.
Data Element Concept:	Episode of care—specialist private sector rehabilitation care indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item is a qualifier of the three 'Rehabilitation' care types for admitted patients in private hospitals. When an admitted patient in a private hospital is receiving rehabilitation care (as defined in Hospital service—care type, code N[N].N), this metadata item should be recorded to denote whether or not that care meets the criteria for 'specialist rehabilitation'.

These are the criteria determined by The Commonwealth Department of Health and Ageing in respect of patients treated in the private sector, specialist rehabilitation is:

- Provided by a specialist rehabilitation unit (a separate physical space and a specialist rehabilitation team providing admitted patient and/or ambulatory care) meeting guidelines issued by the Commonwealth Department of Health and Ageing, and
- provided by a multi-disciplinary team which is under the clinical management of a consultant in rehabilitation medicine or equivalent, and
- provided for a person with limited functioning (impairments, activity limitations and participation restrictions) and for whom there is a reasonable expectation of functional gain, and
- for whom the primary treatment goal is improvement in functioning status which is evidenced in the medical record by:

  an individualised and documented initial and periodic

assessment of functional ability, or

an individualised multi-disciplinary rehabilitation plan which includes agreed rehabilitation goals and indicative timeframes.

Comments: This metadata item has been developed by the Private Rehabilitation Working Group, and agreed by the private rehabilitation hospital sector, the private health insurance sector and the Commonwealth Department of Health and Ageing. Whilst most patients will be treated by a consultant in rehabilitation medicine (a Fellow of the Australasian Faculty of Rehabilitation Medicine) there are circumstances in which the treating doctor will not be a Fellow of the Faculty. These include, but are not limited to, care provided in geographic areas where there is a shortage of Fellows of the Australasian Faculty of Rehabilitation Medicine.

Source and reference attributes

Submitting organisation: Private Rehabilitation Working Group
Commonwealth Department of Health and Ageing

Staging basis of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer staging—staging basis of cancer, code A
METeOR identifier:	296981
Registration status:	Health, Standard 04/06/2004
Definition:	The timing and evidence for T, N and M cancer stage values, as represented by a code.
Data Element Concept:	Cancer staging—staging basis of cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
P	Pathological
C	Clinical

Collection and usage attributes

Guide for use:

CODE P Pathological

Pathological stage is based on histological evidence acquired before treatment, supplemented or modified by additional evidence acquired from surgery and from pathological examination.

CODE C Clinical

Clinical stage is based on evidence obtained prior to treatment from physical examination, imaging, endoscopy, biopsy, surgical exploration or other relevant examinations.

Refer to the latest edtion of the UICC reference manual TNM Classification of Malignant Tumours for coding rules.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Collection methods:	From information provided by the treating doctor and recorded on the patient's medical record.

Relational attributes

Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Staging scheme source

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer staging—cancer staging scheme source, code N
METeOR identifier:	296988
Registration status:	Health, Standard 04/06/2004
Definition:	The reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer at the time of diagnosis, as represented by a code.
Data Element Concept:	Cancer staging—cancer staging scheme source

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	TNM Classification of Malignant Tumours (UICC)
2	Durie & Salmon for multiple myeloma staging
3	FAB for leukaemia classification
4	Australian Clinico-Pathological Staging (ACPS) System
8	Other
9	Unknown

Supplementary values:

Source and reference attributes

Reference documents:

Durie BGM, Salmon SE. *A clinical staging system for multiple myeloma correlation of measured myeloma cell mass with presenting clinical features, response to treatment and survival.* Cancer 36:842-54 (1975).

Bennett JM, Catovsky D, Daniel MT, Flandrin G, Galton DA, Gralnick HR, Sultan C. *Proposed revised criteria for the classification of acute myeloid leukemia: a report of the French-American-British Cooperative Group.* Ann Intern Med 103(4): 620-625 (1985).

Cheson BD, Cassileth PA, Head DR, Schiffer CA, Bennett JM, Bloomfield CD, Brunning R, gale RP, Grever MR, Keating MJ, et al. *Report of the National Cancer Institute-sponsored workshop on definitions of diagnosis and response in acute myeloid leukemia.* J Clin Oncol 8(5): 813-819 (1990).

Davis NC, Newland RC. *The reporting of colorectal cancer: the Australian Clinicopathological Staging system.* Aust NZ J Surg 52:395-397 (1982).

Public Health Division *NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1* Sydney NSW

Health Dept (2001).

NHMRC *Guidelines for the prevention, early detection and management of colorectal cancer (CRC)* (1999)).

Data element attributes

Collection and usage attributes

Guide for use:

It is recommended that the TNM Manual of the UICC be used whenever it is applicable. The classifications published in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual are identical to the TNM classifications of the UICC.

TNM is not applicable to all tumour sites. Staging is of limited use in acute leukaemias, although a staging system is used for chronic lymphocytic leukaemia. Separate staging systems exist for lymphomas and myeloma. The *NHMRC Guidelines for the prevention, early detection and management of colorectal cancer (CRC)* support the use of the Australian Clinico-Pathological Staging (ACPS) System. A table of correspondences between ACPS and TNM classifications is available.

The current edition of each staging scheme should be used.

Source and reference attributes

Origin:

International Union Against Cancer (UICC).

FAB (French-American-British) Group.

NSW Health Department.

National Health & Medical Research Council.

Clinical Oncological Society of Australia.

Australian Cancer Network.

Relational attributes

Related metadata references:

Supersedes Staging scheme source, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.82 KB)

See also Cancer staging—cancer staging scheme source edition number, code N[N] Health, Standard 04/06/2004

Implementation in Data Set Specifications:

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

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

Conditional obligation:
Recorded if the recommended data standard is not used, e.g. the recommended standard specifies the 6th edition, but the 5th edition is used; or if another classification (not the TNM) is used to stage the cancer, e.g. FAB for leukaemia classification is used.

Staging scheme source edition number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer staging—cancer staging scheme source edition number, code N[N]
METeOR identifier:	297011
Registration status:	Health, Standard 04/06/2004
Definition:	The edition of the reference used for the purposes of staging the cancer, as represented by a code.
Data Element Concept:	Cancer staging—cancer staging scheme source edition number

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
88	Not applicable (Cases that do not have a recommended staging scheme)
99	Unknown edition

Collection and usage attributes

Guide for use: Record the edition number (i.e. 1 - 87).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Origin: Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references: Supersedes Staging scheme source edition number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.74 KB)

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

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

Conditional obligation:
Recorded if the recommended data standard is not used, e.g. the recommended standard specifies the 6th edition, but the 5th edition is used; or if another classification (not the TNM) is used to stage the cancer, e.g. FAB for leukaemia classification is used.

Standards assessment indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—standards assessment indicator, yes/no code N
METeOR identifier:	356457
Registration status:	Health, Standard 05/12/2007
Definition:	Whether a service provider organisation routinely undertakes or undergoes formal assessment against defined industry standards, as represented by a code.
Data Element Concept:	Service provider organisation—standards assessment indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Formal assessment against the relevant standards may occur via self-assessment or external assessment methods. A 'formal' self-assessment should involve a number of aspects, including the planning and development of a clear structure for the assessment process; the use of an accepted evaluation method such as a peer review; and the use of validated tools where these are available. A 'formal' assessment also includes a formal in-depth review against the relevant standards by an independent external reviewer. This may take place in the context of an accreditation process for the service provider organisation or the organisation of which the service provider organisation is a sub-unit.

CODE 1 Yes
The service provider organisation routinely undertakes or undergoes formal assessment against the specified healthcare standards.

CODE 2 No
The service provider organisation does not routinely undertake or undergo formal assessment against the specified healthcare standards.

Collection methods: Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

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

Information specific to this data set:
This information is required for the calculation of the national palliative care performance indicator number 2: 'The proportion of palliative care agencies, within their setting of care, that routinely undertake or undergo formal assessment against the Palliative Care Australia standards'.

Standards assessment level

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—standards assessment level, code N
METeOR identifier:	359019
Registration status:	Health, Standard 05/12/2007
Definition:	The level of assessment undertaken or undergone by a service provider organisation against relevant industry standards as represented by a code.
Data Element Concept:	Service provider organisation—standards assessment level

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Formally assessed
2	Accredited

Collection and usage attributes

Guide for use:

CODE 1 Formally assessed

Formal assessment may entail self-assessment and/or assessment by an independent external reviewer. This assessment may take place in the context of an accreditation process for the organisation.

A formal assessment, whether self-assessed or externally reviewed, should involve a number of aspects, including the planning and development of a clear structure for the assessment process, the use of an accepted evaluation method such as a peer review, and the use of validated tools where these are available.

CODE 2 Accredited

This code should only be recorded where accreditation has been granted to the organisation and is current.

Data element attributes

Source and reference attributes

Submitting organisation:	Palliative Care Intergovernmental Forum

Relational attributes

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

Recorded when the data element Service provider organisation—standards assessment indicator, yes/no code N value is 'yes' (code 1).

Standards assessment method

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—standards assessment method, code N
METeOR identifier:	287762
Registration status:	Health, Standard 05/12/2007
Definition:	The method used by a service provider organisation to undertake or undergo formal assessment against defined industry standards, as represented by a code.
Data Element Concept:	Service provider organisation—standards assessment method

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Formal self-assessment
2	In-depth external review

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Formal self-assessment

The service provider organisation undertakes formal self-assessment, on a routine basis, against the agreed criteria outlined in the defined industry standards.

A formal self-assessment should involve a number of aspects, including the planning and development of a clear structure for the assessment process; the use of an accepted evaluation method such as a peer review; and the use of validated tools where these are available.

CODE 2 In-depth external review

The service provider organisation routinely undergoes an in-depth review against the defined industry standards by an independent external reviewer. This may take place in the context of an accreditation process for the service provider organisation.

Collection methods: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Palliative care performance indicators DSS Health, Standard

Specifications: 05/12/2007

Conditional obligation:
Recorded when the data element *Service provider organisation – standards assessment indicator, yes/no code N* value is 'yes' (code 1).

Information specific to this data set:

The acceptable industry-agreed standards for the purposes of this data element are the most recent standards developed and published by Palliative Care Australia.

State/Territory of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—state/territory of birth, code N
METeOR identifier:	270151
Registration status:	Health, Standard 01/03/2005
Definition:	The state/territory in which the baby was delivered, as represented by a code.
Data Element Concept:	Birth event—state/territory of birth

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

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

Source and reference attributes

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

Data element attributes

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references:

Supersedes State/Territory of birth, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.18 KB)

Implementation in Data Set Specifications:

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

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

Perinatal NMDS Health, Superseded 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

Status of the baby

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth—birth status, code N
METeOR identifier:	269949
Registration status:	Health, Standard 01/03/2005
Definition:	The status of the baby at birth as represented by a code.
Data Element Concept:	Birth—birth status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Live birth
	2	Stillbirth (fetal death)
Supplementary values:	9	Not stated

Collection and usage attributes

Guide for use:

Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered liveborn (WHO, 1992 definition).

Stillbirth is a fetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more **birthweight**; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. (This is the same as the WHO definition of fetal death, except that there are no limits of gestational age or birthweight for the WHO definition.)

Source and reference attributes

Reference documents: International Classification of Diseases and Related Health Problems, 10th Revision, Vol 1, WHO 1992.

Data element attributes

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Status of the baby, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.95 KB)

Implementation in Data Set Specifications:

Perinatal NMDS Health, Superseded 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:

Essential to analyse outcome of pregnancy.

Street name (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—street name, text [A(30)]
METeOR identifier:	270019
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The concatenation of a person's street type and street suffix resulting in a name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality, as represented by text.
Data Element Concept:	Person (address)—street name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(30)]
Maximum character length:	30

Data element attributes

Collection and usage attributes

Guide for use:	To be used in conjunction with street type. To be used in conjunction with street suffix.
Comments:	Where suburb/town/locality, state/territory and Postcode - Australian are insufficient to assign a Statistical Local Area (SLA) code from the Australian Standard Geographical Classification (Australian Bureau of Statistics, Cat. No. 1216.0) , the Street name metadata item in conjunction with street type, house/property identifier and street suffix should also be used.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Supersedes Street name, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.12 KB) Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005 Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Street name (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—street name, text [A(30)]
METeOR identifier:	290218
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The concatenation of an organisation's street type and street suffix resulting in a name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality, as represented by text.
Data Element Concept:	Service provider organisation (address)—street name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(30)]
Maximum character length:	30

Data element attributes

Collection and usage attributes

Guide for use:	To be used in conjunction with street type. To be used in conjunction with street suffix.
Comments:	Where suburb/town/locality, state/territory and Postcode - Australian are insufficient to assign a Statistical Local Area (SLA) code from the Australian Standard Geographical Classification (Australian Bureau of Statistics, Cat. No. 1216.0) , the Street name metadata item in conjunction with street type, house/property identifier and street suffix should also be used.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Street suffix code (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—street suffix, code A[A]
METeOR identifier:	270022
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The abbreviated suffix that identifies the type of street where a person resides, as represented by a code.
Data Element Concept:	Person (address)—street suffix

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
CN	Central
E	East
EX	Extension
LR	Lower
N	North
NE	North East
NW	North West
S	South
SE	South East
SW	South West
UP	Upper
W	West

Data element attributes

Collection and usage attributes

Collection methods:	To be used in conjunction with street name. To be used in conjunction with street type. For example: Browns Rd W

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Supersedes Street suffix code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.91 KB) Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005 Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Street suffix code (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—street suffix, code A[A]
METeOR identifier:	290170
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The abbreviated suffix that identifies the type of street where an organisation is located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—street suffix

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
CN	Central
E	East
EX	Extension
LR	Lower
N	North
NE	North East
NW	North West
S	South
SE	South East
SW	South West
UP	Upper
W	West

Data element attributes

Collection and usage attributes

Collection methods:	To be used in conjunction with street name. To be used in conjunction with street type. For example: Browns Rd W

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address) – address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Street type code (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—street type, code A[AAA]
METeOR identifier:	270020
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The type of public thoroughfare where a person resides, as represented by a code.
Data Element Concept:	Person (address)—street type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[AAA]
Maximum character length:	4

Collection and usage attributes

Guide for use: The following is a list of commonly used abbreviations from AS 4590:

Street type	Abbreviation
Alley	Ally
Arcade	Arc
Avenue	Ave
Boulevard	Bvd
Bypass	Bypa
Circuit	Cct
Close	Cl
Corner	Crn
Court	Ct
Crescent	Cres
Cul-de-sac	Cds
Drive	Dr
Esplanade	Esp
Green	Grn
Grove	Gr
Highway	Hwy
Junction	Jnc
Lane	Lane
Link	Link
Mews	Mews
Parade	Pde
Place	Pl
Ridge	Rdge
Road	Rd

Square	Sq
Street	St
Terrace	Tce

Data element attributes

Source and reference attributes

Submitting organisation: Standards Australia

Origin: Health Data Standards Committee

AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references: Supersedes Street type code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.75 KB)

Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

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

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

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

Street type code (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—street type, code A[AAA]
METeOR identifier:	290193
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The type of public thoroughfare where an organisation is located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—street type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[AAA]
Maximum character length:	4

Collection and usage attributes

Guide for use: The following is a list of commonly used abbreviations from AS 4590:

Street type	Abbreviation
Alley	Ally
Arcade	Arc
Avenue	Ave
Boulevard	Bvd
Bypass	Bypa
Circuit	Cct
Close	Cl
Corner	Crn
Court	Ct
Crescent	Cres
Cul-de-sac	Cds
Drive	Dr
Esplanade	Esp
Green	Grn
Grove	Gr
Highway	Hwy
Junction	Jnc
Lane	Lane
Link	Link
Mews	Mews
Parade	Pde
Place	Pl
Ridge	Rdge

Road	Rd
Square	Sq
Street	St
Terrace	Tce

Data element attributes

Collection and usage attributes

Collection methods: To be collected in conjunction with street name. To be collected in conjunction with street suffix.

Source and reference attributes

Origin: AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references: Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

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

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

Suburb/town/locality name (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—suburb/town/locality name, text [A(50)]
METeOR identifier:	287326
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	The full name of the locality contained within the specific address of a person, as represented by text.
Data Element Concept:	Person (address)—suburb/town/locality name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(50)]
Maximum character length:	50

Data element attributes

Collection and usage attributes

Guide for use:	The suburb/town/locality name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community. This metadata item may be used to describe the location of person. It can be a component of a street or postal address. The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names.
Collection methods:	Enter 'Unknown' when the locality name or geographic area for a person or event is not known. Enter 'No fixed address' when a person has no fixed address or is **homeless**.

Source and reference attributes

Origin:	National Health Data Committee National Community Services Data Committee
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia Australia Post 2005. Australia Postcode File. Viewed 12 April, www.auspost.com.au/postcodes

Relational attributes

Related metadata references:	Supersedes Person (address)—suburb/town/locality name, text [A(50)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Is used in the formation of Person (address) — postal delivery point identifier, {N(8)} Health, Standard 04/05/2005, Community services, Standard 25/08/2005

Is used in the formation of Dwelling — geographic location, remoteness structure code (ASGC 2004) N[N] Housing assistance, Retired 10/02/2006

Implementation in Data Set Specifications:

Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Information specific to this data set:

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

What is your suburb, town or community?

(Single response)

Enter town/suburb/community.

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

Information specific to this data set:

This data should be verified against the Australia Post Postcode File (see www.auspost.com.au/postcodes). Alternatively, contact State or Territory Health Authorities for Postcode files.

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

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

Information specific to this data set:

This data should be verified against the Australia Post Postcode File (see www.auspost.com.au/postcodes). Alternatively, contact State or Territory Health Authorities for Postcode files.

Suburb/town/locality name (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—suburb/town/locality name, text [A(50)]
METeOR identifier:	290059
Registration status:	Health, Standard 04/05/2005 Community services, Standard 31/08/2005
Definition:	The full name of the general locality containing the specific address of an organisation, as represented by text.
Data Element Concept:	Service provider organisation (address)—suburb/town/locality name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(50)]
Maximum character length:	50

Data element attributes

Collection and usage attributes

Guide for use:	The suburb/town/locality name, may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community. The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names. This metadata item may be used to describe the location of an organisation. It can be a component of a street or postal address.
Collection methods:	Enter 'Unknown' when the locality name or geographic area for an organisation is not known.

Source and reference attributes

Origin:	National Health Data Committee National Community Services Data Committee Australia Post 2005. Australia Postcode File. Viewed 12 April www.auspost.com.au/postcodes
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Is used in the formation of Service provider organisation (address)—postal delivery point identifier, {N(8)} Health, Standard 04/05/2005, Community services, Standard 31/08/2005

Implementation in Data Set Specifications:

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

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

Information specific to this data set:
This data should be verified against the Australia Post Postcode File (see www.auspost.com.au/postcodes). Alternatively, contact State or Territory Health Authorities for Postcode files.

Surgical specialty

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—surgical specialty (of scheduled doctor), code NN
METeOR identifier:	270146
Registration status:	Health, Standard 01/03/2005
Definition:	The area of clinical expertise held by the doctor who will perform the elective surgery, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—surgical specialty (of scheduled doctor)

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Cardio-thoracic surgery
02	Ear, nose and throat surgery
03	General surgery
04	Gynaecology
05	Neurosurgery
06	Ophthalmology
07	Orthopaedic surgery
08	Plastic surgery
09	Urology
10	Vascular surgery
11	Other

Collection and usage attributes

Comments: The above classifications are consistent with the Recommended Medical Specialties and Qualifications agreed by the National Specialist Qualification Advisory Committee of Australia, September 1993. Vascular surgery is a subspecialty of general surgery. The Royal Australian College of Surgeons has a training program for vascular surgeons. The specialties listed above refer to the surgical component of these specialties - ear, nose and throat surgery refers to the surgical component of the specialty otolaryngology; gynaecology refers to the gynaecological surgical component of obstetrics and gynaecology; ophthalmology refers to the surgical component of the specialty (patients awaiting argon laser phototherapy are not included).

Data element attributes

Source and reference attributes

Submitting organisation: Hospital Access Program Waiting Lists Working Group
Waiting Times Working Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Surgical specialty, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (15.68 KB)

Implementation in Data Set Specifications: Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005

Implementation start date: 30/09/2006

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS Health, Standard 07/12/2005

Implementation start date: 01/07/2006

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Surgical treatment procedure for cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—surgical procedure for cancer, procedure code (ACHI 6th edn) NNNNN-NN
METeOR identifier:	364304
Registration status:	Health, Standard 05/02/2008
Definition:	The surgical procedure used in the primary treatment of the cancer, as represented by a code.
Data Element Concept:	Cancer treatment—surgical procedure for cancer

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 6th edition
Representation class:	Code
Data type:	Number
Format:	NNNNN-NN
Maximum character length:	7

Data element attributes

Collection and usage attributes

Guide for use:	Each surgical treatment procedure used in the initial treatment of the cancer should be recorded. Surgical procedures performed for palliative purposes only should not be included. For surgical procedures involved in the administration of another modality (eg., implantation of infusion pump, isolated limb perfusion/infusion, intra-operative radiotherapy) record both the surgery and the other modality. Any systemic treatment which can be coded as a procedure through ACHI should be so coded (eg., stem cell or bone marrow infusion).

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	National Centre for Classification in Health New South Wales Department of Health, Public Health Division
Reference documents:	NSW Department of Health NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 (2001).

Relational attributes

Related metadata references:	Supersedes Cancer treatment—surgical procedure for cancer, procedure code (ACHI 5th edn) NNNNN-NN Health,

Systemic therapy agent name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—systemic therapy agent name (primary cancer), antineoplastic drug code (Self-Instructional Manual for Tumour Registrars Book 8 3rd edn) X[X(39)]
METeOR identifier:	288446
Registration status:	Health, Standard 04/06/2004
Definition:	The chemotherapeutic agent or anti-cancer drug used for treatment of the primary cancer, as represented by a code.
Data Element Concept:	Cancer treatment—systemic therapy agent name (primary cancer)

Value domain attributes

Representational attributes

Classification scheme:	Self-Instructional Manual for Tumour Registrars Book 8 Antineoplastic Drugs, 3rd edition
Representation class:	Code
Data type:	String
Format:	X[X(39)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The purpose of collecting specific treatment information is to account for all treatment types, which may assist in evaluation of effectiveness of different treatment patterns. The actual agents used will sometimes be of interest. Systemic therapy often involves treatment with a combination of agents. These may be known by acronyms but since details of drugs and acronyms may vary it is recommended that each agent be recorded separately. Oral chemotherapy normally given on an outpatient basis should also be included. New codes and names will need to be added as new agents become available for clinical use. Hormone therapy agents and immunotherapy agents should be recorded under this data element.
Collection methods:	The full name of the agent(s) should be recorded if the coding manual is not available.
Comments:	Collecting dates for systemic therapy will allow evaluation of treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death.

Source and reference attributes

Origin: National Cancer Institute Surveillance, Epidemiology and End Results (SEER) Program

Reference documents: Surveillance, Epidemiology and End Results (SEER) Program Self-instructional manual for tumour registrars: Book 8 - Antineoplastic drugs 3rd Edition National Cancer Institute.

Relational attributes

Related metadata references: Supersedes Systemic therapy agent name, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.5 KB)

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

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

Information specific to this data set:

This item is collected for the analysis of outcome by treatment type.

Teaching status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—teaching status (university affiliation), code N
METeOR identifier:	270148
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator to identify the non-direct patient care activity of teaching for a particular establishment, as represented by a code.
Data Element Concept:	Establishment—teaching status (university affiliation)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Unknown

Data element attributes

Collection and usage attributes

Guide for use:

In this context, teaching relates to teaching hospitals affiliated with universities providing undergraduate medical education as advised by the relevant state health authority.

Comments:

The initial intention based on the Taskforce on National Hospital Statistics approach had been to have non-direct care activity indicators for all of the following non-direct patient care activities:

- teaching
- research
- group or community contacts
- public health activities
- mobile centre and/or part-time service.

However, the Resources Working Party decided to delete 2, 3, 4 and 5 and place the emphasis on teaching where teaching (associated with a university) was a major program activity of the hospital. The working party took the view that it was extremely difficult to identify research activities in health institutions because many staff consider that they do research as part of their usual duties. The research indicator was thus deleted and the teaching indicator was agreed to relate to teaching hospitals affiliated with universities providing undergraduate medical education, as advised by the relevant

state health authority. If a teaching hospital is identified by a Yes/no indicator then it is not necessary to worry about research (based on the assumption that if you have teaching, you have research).

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Teaching status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.1 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Telephone number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—telephone number, text [X(40)]
METeOR identifier:	270266
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	The person's contact telephone number, as represented by text.
Data Element Concept:	Person—telephone number

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	More than one phone number may be recorded as required. Each phone number should have an appropriate telephone number type code assigned. Record the full phone number (including any prefixes) with no punctuation (hyphens or brackets).
Collection methods:	Prefix plus telephone number: Record the prefix plus telephone number. The default should be the local prefix with an ability to overtype with a different prefix. For example, 08 8226 6000 or 0417 123456. Punctuation: Do not record punctuation. For example, (08) 8226 6000 or 08-8226 6000 would not be correct. Unknown: Leave the field blank.
Comments:	Concerned with the use of person identification data. For organisations that create, use or maintain records on people. Organisations should use this standard, where appropriate, for collecting data when registering people. The positive and unique identification of people is a critical event in service delivery, with direct implications for the safety and quality of care delivered by health and community services.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee

National Community Services Data Committee

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references: Supersedes Telephone number, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (15.42 KB)

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

Telephone number type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (telephone)—telephone number type, code A
METeOR identifier:	270299
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	The type of telephone number recorded for a person, as represented by a code.
Data Element Concept:	Person (telephone)—telephone number type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
B	Business or work
H	Home
M	Personal mobile
N	Contact number (not own)
O	Business or work mobile
T	Temporary

Data element attributes

Collection and usage attributes

Guide for use:	Where more than one telephone number has been recorded, then each telephone number should have the appropriate telephone number type code assigned.
Comments:	Concerned with the use of person identification data. For organisations that create, use or maintain records on people. Organisations should use this standard, where appropriate, for collecting data when registering people. The positive and unique identification of people is a critical event in service delivery, with direct implications for the safety and quality of care delivered by health and community services.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee
Reference documents:	Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Telephone number type, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (15.45 KB)
Implementation in Data Set Specifications:	Health care client identification Health, Superseded 04/05/2005

Time creatine kinase MB isoenzyme measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme measured time, hhmm
METeOR identifier:	285179
Registration status:	Health, Standard 04/06/2004
Definition:	The time at which the person's creatine kinase myocardial band (CK-MB) isoenzyme was measured.
Data Element Concept:	Person—creatine kinase myocardial band isoenzyme measured time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Record the time in 24-hour clock format.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Time creatine kinase MB isoenzyme (CK-MB) measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.23 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Time of first angioplasty balloon inflation or stenting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—first angioplasty balloon inflation or stenting time, hhmm
METeOR identifier:	285191
Registration status:	Health, Standard 04/06/2004
Definition:	The time of the first angioplasty balloon inflation or stent placement.
Data Element Concept:	Person—first angioplasty balloon inflation or stenting time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Time of first angioplasty balloon inflation or stenting, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.55 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, 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, refers to coronary arteries.

Time of intravenous fibrinolytic therapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—intravenous fibrinolytic therapy time, hhmm
METeOR identifier:	285201
Registration status:	Health, Standard 04/06/2004
Definition:	The time intravenous (IV) fibrinolytic therapy was first administered to a person.
Data Element Concept:	Person—intravenous fibrinolytic therapy time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	If initiated by a bolus dose whether in a pre-hospital setting, emergency department or inpatient unit/ward, the time the initial bolus was administered should be reported.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Time of intravenous fibrinolytic therapy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, 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, refers to coronary arteries.

Time of triage

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—triage time, hhmm
METeOR identifier:	313817
Registration status:	Health, Standard 07/12/2005
Definition:	The time at which the patient is **triaged**.
Context:	Emergency Department care.
Data Element Concept:	Non-admitted patient emergency department service episode—triage time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Collection methods:	Collected in conjunction with non-admitted patient emergency department service episode—**triage** date.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:	Supersedes Triage—triage time, hhmm Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Non-admitted patient emergency department care NMDS 2007-

2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Time patient presents

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—presentation time, hhmm
METeOR identifier:	270080
Registration status:	Health, Standard 01/03/2005
Definition:	The time at which the patient presents for the delivery of a service.
Data Element Concept:	Health service event—presentation time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

For community health care, outreach services and services provided via telephone or telehealth, this may be the time at which the service provider presents to the patient or the telephone/telehealth session commences.

The time of patient presentation at the **emergency department** is the earliest occasion of being registered clerically or triaged.

The time that the patient presents is not necessarily:

- the listing time for care (see listing date for care for an analogous concept), nor
- the time at which care is scheduled to be provided, nor
- the time at which commencement of care actually occurs (for admitted patients see admission time, for hospital non-admitted patient care and community health care see service commencement time).

Source and reference attributes

Submitting organisation:	National Institution Based Ambulatory Model Reference Group
Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Time patient presents, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.17 KB) Is used in the formation of Non-admitted patient emergency

department service episode – waiting time (to service delivery), total minutes NNNNN Health, Standard 01/03/2005

Is used in the formation of Non-admitted patient emergency department service episode – service episode length, total minutes NNNNN Health, Standard 01/03/2005

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

Implementation in Data Set Specifications:

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

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

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Time troponin measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin level measured time, hhmm
METeOR identifier:	285211
Registration status:	Health, Standard 04/06/2004
Definition:	The time at which the troponin (T or I) was measured.
Data Element Concept:	Person—troponin level measured time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item pertains to the measuring of troponin at any time point during this current event.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Time troponin measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.53 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Tobacco smoking status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking status, code N
METeOR identifier:	270311
Registration status:	Health, Standard 01/03/2005
Definition:	A person's current and past smoking behaviour, as represented by a code.
Context:	Public health and health care
Data Element Concept:	Person—tobacco smoking status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Daily smoker
2	Weekly smoker
3	Irregular smoker
4	Ex-smoker
5	Never smoked

Collection and usage attributes

Guide for use:

CODE 1 Daily smoker

A person who smokes daily

CODE 2 Weekly smoker

A person who smokes at least weekly but not daily

CODE 3 Irregular smoker

A person who smokes less than weekly

CODE 4 Ex-smoker

A person who does not smoke at all now, but has smoked at least 100 cigarettes or a similar amount of other tobacco products in his/her lifetime.

CODE 5 Never-smoker

A person who does not smoke now and has smoked fewer than 100 cigarettes or similar amount of other tobacco products in his/her lifetime.

Source and reference attributes

Reference documents:	Standard Questions on the Use of Tobacco Among Adults (1998)

Data element attributes

Collection and usage attributes

Collection methods:

The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults - interviewer administered (Questions 1 and 4) and self-administered (Questions 1 and 1a) versions. The questionnaires are designed to cover persons aged 18 years and over.

Comments:

There are two other ways of categorising this information:

- Regular and irregular smokers where a regular smoker includes someone who is a daily smoker or a weekly smoker. 'Regular' smokers is the preferred category to be reported in prevalence estimates.
- Daily and occasional smokers where an occasional smoker includes someone who is a weekly or irregular smoker. The category of 'occasional' smoker can be used when the aim of the study is to draw contrast between daily smokers and other smokers.
  Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

Smoker type is used to define subpopulations of adults (age 18+ years) based on their smoking behaviour.

Smoking has long been known as a health risk factor. Population studies indicate a relationship between smoking and increased mortality/morbidity.

This data element can be used to estimate smoking prevalence. Other uses are:

- To evaluate health promotion and disease prevention programs (assessment of interventions)
- To monitor health risk factors and progress towards National Health Goals and Targets

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.55 KB)

Implementation in Data Set Specifications:

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

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

Information specific to this data set:
Smoker type is used to define sub-populations of adults (age 18+ years) based on their smoking behaviour. Smoking has long been known as a health risk factor. Population studies indicate a relationship between smoking and increased mortality/morbidity. This metadata item can be used to estimate smoking prevalence.

Other uses are:

- To evaluate health promotion and disease prevention programs (assessment of interventions)
- To monitor health risk factors and progress towards National Health Goals and Targets

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

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

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

Tobacco smoking status (diabetes mellitus)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—regular tobacco smoking indicator (last 3 months), code N
METeOR identifier:	302467
Registration status:	Health, Standard 21/09/2005
Definition:	Whether an individual has been a regular smoker (daily or weekly) of any tobacco material over the previous 3 months, as represented by a code.
Data Element Concept:	Person—regular tobacco smoking indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if the person has smoked daily or weekly over the previous 3 months. CODE 2 No: Record if the person has not smoked daily or weekly over the previous 3 months or has been an irregular smoker.
Collection methods:	Ask the individual if he/she has regularly smoked (daily or weekly) any tobacco material over the past 3 months.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Person—tobacco smoking status (previous three months), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

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

Information specific to this data set:
For people with diabetes smoking is one of the most powerful treatable risk factors. Associated with hypertension, diabetes and hypercholesterolemia, smoking is a definite health hazard for coronary heart disease.

Tobacco smoking—consumption/quantity (cigarettes)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—number of cigarettes smoked (per day), total N[N]
METeOR identifier:	270332
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of cigarettes (manufactured or roll-your-own) smoked per day by a person.
Context:	Public health and health care
Data Element Concept:	Person—number of cigarettes smoked

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item is relevant only for persons who currently smoke cigarettes daily or at least weekly. Daily consumption should be reported, rather than weekly consumption. Weekly consumption is converted to daily consumption by dividing by 7 and rounding to the nearest whole number.

Quantities greater than 98 (extremely rare) should be recorded as 98.

Collection methods:

The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Questions 3a and 3b) and self-administered (Questions 2a and 2b) versions.

The questions cover persons aged 18 and over.

Comments:

The number of cigarettes smoked is an important measure of the magnitude of the tobacco problem for an individual.

Research shows that of Australians who smoke, the overwhelming majority smoke cigarettes (manufactured or roll-your-own) rather than other tobacco products.

From a public health point of view, consumption level is relevant only for regular smokers (those who smoke daily or at least weekly).

Data on quantity smoked can be used to:

- evaluate health promotion and disease prevention programs
  (assessment of interventions)

- monitor health risk factors and progress towards National Health
  Goals and Targets
- ascertain determinants and consequences of smoking
- assess a person's exposure to tobacco smoke.

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

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - consumption/quantity (cigarettes), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)

Implementation in Data Set Specifications:

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

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

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

Information specific to this data set:

The number of cigarettes smoked is an important measure of the magnitude of the tobacco problem for an individual. Research shows that of Australians who smoke, the overwhelming majority smoke cigarettes (manufactured or roll-your-own) rather than other tobacco products. From a public health point of view, consumption level is relevant only for regular smokers (those who smoke daily or at least weekly).

Data on quantity smoked can be used to:

- evaluate health promotion and disease prevention programs (assessment of interventions)
- monitor health risk factors and progress towards National Health Goals and Targets
- ascertain determinants and consequences of smoking
- assess a person's exposure to tobacco smoke.

Tobacco smoking—duration (daily smoking)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking duration (daily smoking), total years N[N]
METeOR identifier:	270330
Registration status:	Health, Standard 01/03/2005
Definition:	The total duration in years, of daily smoking for a person who is now a daily smoker or has been a daily smoker in the past.
Context:	Public health and health care
Data Element Concept:	Person—tobacco smoking duration

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	In order to estimate duration of smoking the person's date of birth or current age should also be collected. If a person reports that they smoke daily now then duration is the difference between the start-age and the person's current age. If a person reports that they smoked daily in the past but do not smoke daily now then duration is the difference between the quit age and the start age. Record duration of less than one year as 0.
Collection methods:	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 1, 5, 6, 7) and self-administered (Question 1, 3, 3a, 4) versions. The questions cover persons aged 18 years and over.
Comments:	Duration of daily smoking is an indicator of exposure to increased risk to health. In this data element, duration is measured as the years elapsed from the time the person first started smoking daily and when they most recently quit smoking daily (or the present for those persons who still smoke daily). There may have been intervening periods when the person did not smoke daily. However, as the negative health effects of smoking accumulate over time, the information on duration of daily smoking, as measured in this data element, remains useful, despite any intervening periods of non-daily smoking.

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

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - duration (daily smoking), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.68 KB)

Is formed using Person—tobacco smoking start age (daily smoking), total years NN Health, Standard 01/03/2005

Is formed using Person—tobacco smoking quit age (daily smoking), total years NN Health, Standard 01/03/2005

Tobacco smoking—ever daily use

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking daily use status, code N
METeOR identifier:	270329
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of whether a person has ever smoked tobacco in any form on a daily basis in their lifetime, as represented by a code.
Data Element Concept:	Person—tobacco smoking daily use status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Ever-daily
2	Never-daily

Collection and usage attributes

Guide for use:

CODE 1 Ever-daily

If a person reports that they now smoke cigarettes, cigars, pipes or any other tobacco products daily OR if they report that in the past they have been a daily smoker, they are coded to 1 (ever-daily).

CODE 2 Never-daily

If a person reports that they have never smoked cigarettes, cigars, pipes or any other tobacco products daily AND they have never in the past been a daily smoker then they are coded to 2 (never-daily).

Data element attributes

Collection and usage attributes

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 1 and 5) and self-administered (Question 1 and 3) versions. The questions cover persons aged 18 years and over.

Comments: Whether a person has ever smoked on a daily basis can be used to assess an individual's health risk from smoking and to monitor population trends in smoking behaviour.

It can also be used to:

- evaluate health promotion and disease prevention programs (assessment of interventions);

- monitor health risk factors;
- ascertain determinants and consequences of smoking.

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

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - ever daily use, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.97 KB)

Tobacco smoking—frequency

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking frequency, code N
METeOR identifier:	270328
Registration status:	Health, Standard 01/03/2005
Definition:	How often a person now smokes a tobacco product, as represented by a code.
Data Element Concept:	Person—tobacco smoking frequency

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Smokes daily
2	Smokes at least weekly, but not daily
3	Smokes less often than weekly
4	Does not smoke at all

Data element attributes

Collection and usage attributes

Guide for use:	To record multiple use data, repeat the data field as many times as necessary, viz: product1, product2 etc. In most instances, data on both product and frequency are needed. In such situations, repeat both fields as many times as necessary, viz: product1, frequency1, product2, frequency2 etc.
Collection methods:	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 1) and self-administered (Question 1) versions. The questions relate to smoking of manufactured cigarettes, roll-your-own cigarettes, cigars, pipes and other tobacco products and are designed to cover persons aged 18 years and over.
Comments:	The frequency of smoking helps to assess a person's exposure to tobacco smoke which is a known risk factor for cardiovascular disease and cancer. From a public health point of view, the level of consumption of tobacco as measured by frequency of smoking tobacco products is only relevant for regular smokers (persons who smoke daily or at least weekly). Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references: Supersedes Tobacco smoking - frequency, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.71 KB)

Tobacco smoking—product

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco product smoked, code N
METeOR identifier:	270327
Registration status:	Health, Standard 01/03/2005
Definition:	The type of tobacco product smoked by a person, as represented by a code.
Data Element Concept:	Person—tobacco product smoked

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Cigarettes - manufactured
2	Cigarettes - roll-your-own
3	Cigars
4	Pipes
5	Other tobacco product
6	None

Data element attributes

Collection and usage attributes

Guide for use:	To record multiple use data, repeat the data field as many times as necessary, viz: product1, product2 etc. In most instances, data on both product and frequency are needed. In such situations, repeat both fields as many times as necessary, viz: product1, frequency1, product2, frequency2 etc.
Collection methods:	The recommended standard for collecting information about smoking the above tobacco products is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer or self-administered versions.
Comments:	Tobacco smoking is a known risk factor for cardiovascular disease and cancer. The type of tobacco product smoked by a person in conjunction with information about the frequency of smoking assists with establishing a profile of smoking behaviour at the individual or population level and with monitoring shifts from cigarette smoking to other types of tobacco products and vice versa. It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including

pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references: Supersedes Tobacco smoking - product, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.09 KB)

Tobacco smoking—quit age (daily smoking)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking quit age (daily smoking), total years NN
METeOR identifier:	270323
Registration status:	Health, Standard 01/03/2005
Definition:	The age in years at which a person who has smoked daily in the past and is no longer a daily smoker most recently stopped smoking daily.
Context:	Public health and health care
Data Element Concept:	Person—tobacco smoking quit age

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	In order to estimate quit-age, the person's date of birth or current age should also be collected. Quit-age may be directly reported, or derived from the date the person quit smoking or the length of time since quitting, once the person's date of birth (or current age) is known. Quit-age is relevant only to persons who have been daily smokers in the past and are not current daily smokers.
Collection methods:	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults - interviewer administered (Question 6) and self-administered (Question 3a) versions. The questions cover persons aged 18 years and over. The relevant question in each version of the questionnaires refers to when the person finally stopped smoking daily, whereas the definition for this metadata item refers to when the person most recently stopped smoking daily. However, in order to provide information on when the person most recently stopped smoking daily, the most appropriate question to ask at the time of collecting the information is when the person finally stopped smoking daily.
Comments:	Quit-age and start-age provide information on the duration of

daily smoking and exposure to increased risk to health.

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

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - quit age (daily smoking), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.76 KB)

Is used in the formation of Person—time since quitting tobacco smoking (daily smoking), code NN Health, Standard 01/03/2005

Is used in the formation of Person—tobacco smoking duration (daily smoking), total years N[N] Health, Standard 01/03/2005

Tobacco smoking—start age (daily smoking)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking start age (daily smoking), total years NN
METeOR identifier:	270324
Registration status:	Health, Standard 01/03/2005
Definition:	The age in years at which a person who has ever been a daily smoker, first started to smoke daily.
Context:	Public health and health care
Data Element Concept:	Person—tobacco smoking start age

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Record age in completed years. This information is relevant only if a person currently smokes daily or has smoked daily in the past.
Collection methods:	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 7) and self-administered (Question 4) versions. The questions cover persons aged 18 years and over.
Comments:	Start-age may be used to derive duration of smoking, which is a much stronger predictor of the risks associated with smoking than is the total amount of tobacco smoked over time. Where the information is collected by survey and the sample permits, population estimates should be presented by sex and age groups. The recommended age groups are: It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:	Supersedes Tobacco smoking - start age (daily smoking), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.65 KB) Is used in the formation of Person—tobacco smoking duration (daily smoking), total years N[N] Health, Standard 01/03/2005

Tobacco smoking—time since quitting (daily smoking)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—time since quitting tobacco smoking (daily smoking), code NN
METeOR identifier:	270356
Registration status:	Health, Standard 01/03/2005
Definition:	The time since a person most recently quit daily smoking, as represented by a code.
Context:	Public health and health care
Data Element Concept:	Person—time since quitting tobacco smoking

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	12 months (1 year)
02	2 years etc. to 78
79	79+ years
80	Less than 1 month
81	1 month
82	2 months
83	3 months
84	4 months
85	5 months
86	6 months
87	7 months
88	8 months
89	9 months
90	10 months
91	11 months
92	months, not specified
93	years, not specified

Supplementary values:

Value	Meaning
99	not stated

Data element attributes

Collection and usage attributes

Guide for use:	In order to estimate time since quitting for all respondents, the person's date of birth or current age should also be collected.

For optimal flexibility of use, the time since quitting is coded as months or years. However, people may report the time that they quit smoking in various ways (e.g. age, a date, or a number of days or weeks ago). When the information is reported in weeks and is less than 4, or in days and is less than 28, then code 80.

When the person reports the time since quitting as weeks ago, convert into months by dividing by 4 (rounded down to the nearest month).

If days reported are between 28 and 59, then code 81.

Where the information is about age only, time since quitting (daily use) is the difference between quit-age and age at survey.

Collection methods:

The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 6) and self-administered (Question 3) versions.

Comments:

Time since quitting daily smoking may give an indication of improvement in the health risk profile of a person. It is also useful in evaluating health promotion campaigns.

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

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - time since quitting (daily smoking), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.98 KB)

Is formed using Person—tobacco smoking quit age (daily smoking), total years NN Health, Standard 01/03/2005

Total contract patient days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Admitted patient hospital stay—number of patient days (of contracted care), total N[NN]
METeOR identifier:	270301
Registration status:	Health, Standard 01/03/2005
Definition:	Sum of the number of contract patient days for all periods within the hospital stay.
Data Element Concept:	Admitted patient hospital stay—number of patient days (of contracted care)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Count number of days.

A day is measured from midnight to 2359 hours.

Contract patient days are included in the total count of patient days. If necessary, contract patient days can be distinguished from other patient days by using the following rules:

- The day the contract commences is counted as a contract patient day.
- If the patient is on contract from midnight to 2359 count as a contract patient day.
- The day a contract is completed is not counted as a contract patient day.
- If the patient is admitted and commences a contract on the same day, this is not counted as a contract patient day.
- If a contract is completed and the patient is separated on the same day, the day should not be counted as a contract or other patient day.

Relational attributes

Related metadata references:

Supersedes Total contract patient days, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.87 KB)

Total hours worked by a medical practitioner

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical practitioner—hours worked, total NNN
METeOR identifier:	270136
Registration status:	Health, Standard 01/03/2005
Definition:	The total hours worked in a week in a job by a medical practitioner, including any on-call hours actually worked (includes patient care and administration).
Context:	Health labour force
Data Element Concept:	Medical practitioner—hours worked

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	999	Not stated/inadequately described
Unit of measure:	Hour (h)	

Collection and usage attributes

Guide for use:	Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item relates to each position (job) held by a medical practitioner, not the aggregate of hours worked in all.
Collection methods:	There are inherent problems in asking for information on number of hours usually worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.
Comments:	It is often argued that health professionals contribute a considerable amount of time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from data on paid hours worked.

Source and reference attributes

Submitting organisation:	National Health Labour Force Data Working Group

Relational attributes

Related metadata references:

Supersedes Total hours worked by a medical practitioner, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.95 KB)

Implementation in Data Set Specifications:

Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Information specific to this data set:

Value must be less than 169 (except for 999).

Used in relation to issues of economic activity, productivity, wage rates, working conditions etc. Used to develop capacity measures relating to total time available. Assists in analysis of human resource requirements and labour force modelling. Used to determine full-time and part-time work status and to compute full-time equivalents (FTE) (see entry for FTE). Often the definition for full-time or FTE differs (35, 37.5 and 40 hours) and knowing total hours and numbers of individuals allows for variances in FTE.

Total leave days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—number of leave days, total N[NN]
METeOR identifier:	270251
Registration status:	Health, Standard 01/03/2005
Definition:	Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.
Data Element Concept:	Episode of admitted patient care—number of leave days

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

A day is measured from midnight to midnight.

The following rules apply in the calculation of leave days for both overnight and **same-day patients**:

- The day the patient goes on leave is counted as a leave day.
- The day the patient is on leave is counted as a leave day.
- The day the patient returns from leave is counted as a patient day.
- If the patient is admitted and goes on leave on the same day, this is counted as a patient day, not a leave day.
- If the patient returns from leave and then goes on leave again on the same day, this is counted as a leave day.
- If the patient returns from leave and is separated on the same day, the day should not be counted as either a patient day or a leave day.

Comments:

It should be noted that for private patients in public and private hospitals, s.3 (12) of the Health Insurance Act 1973 (Cwlth) currently applies a different leave day count, Commonwealth Department of Human Services and Health HBF Circular 354 (31 March 1994). This metadata item was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Total leave days, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.62 KB)

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

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

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

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

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Information specific to this data set:

For the provision of state and territory hospital data to Commonwealth agencies:

(Episode of admitted patient care — separation date, DDMMYYYY minus Episode of admitted patient care — admission date, DDMMYYYY) minus Admitted patient hospital stay — number of leave days, total N[NN] must be ≥ 0 days.

Admitted patient mental health care NMDS Health, Superseded 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:

For the provision of state and territory hospital data to Commonwealth agencies:

(Episode of admitted patient care—separation date, DDMMYYYY minus Episode of admitted patient care—admission date, DDMMYYYY) minus Admitted patient hospital stay—number of leave days, total N[NN] must be ≥ 0 days.

Total psychiatric care days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—number of psychiatric care days, total N[NNNN]
METeOR identifier:	270300
Registration status:	Health, Standard 01/03/2005
Definition:	The sum of the number of days or part days of stay that the person received care as an admitted patient or **resident** within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit.
Data Element Concept:	Episode of care—number of psychiatric care days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN]
Maximum character length:	5
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

Designated psychiatric units are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder. The unit may or may not be recognised under relevant State and Territory legislation to treat patients on an involuntary basis. Patients are admitted patients in the acute and psychiatric hospitals and residents in community based residences.

Public acute care hospitals:

Designated psychiatric units in public acute care hospitals are normally recognised by the State/Territory health authority in the funding arrangements applying to those hospitals.

Private acute care hospitals:

Designated psychiatric units in private acute care hospitals normally require license or approval by the State/Territory health authority in order to receive benefits from health funds for the provision of psychiatric care.

Psychiatric hospitals:

Total psychiatric care days in stand-alone psychiatric hospitals are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Psychiatric hospitals are establishments devoted primarily to

the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the Health Insurance Act 1973 (Commonwealth) (now licensed/approved by each State/Territory health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Community-based residential services:

Designated psychiatric units refers to 24-hour staffed community-based residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. Special psychiatric units for the elderly are covered by this category, including psychogeriatric hostels or psychogeriatric nursing homes. Note that residences occupied by admitted patients located on hospital grounds, whether on the campus of a general or stand-alone psychiatric hospital, should be counted in the category of admitted patient services and not as community-based residential services.

Counting of patient days and leave days in designated psychiatric units should follow the standard definitions applying to these items.

For each period of care in a designated psychiatric unit, total days is calculated by subtracting the date on which care commenced within the unit from the date on which the specialist unit care was completed, less any leave days that occurred during the period.

Total psychiatric care days in 24-hour community-based residential care are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Admitted patients in acute care:

Commencement of care within a designated psychiatric unit may be the same as the date the patient was admitted to the hospital, or occur subsequently, following transfer of the patient from another hospital ward. Where commencement of psychiatric care occurs by transfer from another ward, a new episode of care may be recorded, depending on whether the care type has changed (see metadata item Care type).

Completion of care within a designated psychiatric unit may be the same as the date the patient was discharged from the hospital, or occur prior to this on transfer of the patient to another hospital ward. Where completion of psychiatric care is followed by transfer to another hospital ward, a new episode of care may be recorded, depending on whether the care type has changed (see metadata item Care type. Total psychiatric care days may cover one or more periods in a designated psychiatric unit within the overall hospital stay.

Collection methods:

Accurate counting of total days in psychiatric care requires periods in designated psychiatric units to be identified in the person-level data collected by state or territory health authorities. Several mechanisms exist for this data field to be implemented:

- Ideally, the new data field should be collected locally by

hospitals and added to the unit record data provided to the relevant state/territory health authority.

- Acute care hospitals in most states and territories include details of the wards in which the patient was accommodated in the unit record data provided to the health authority. Local knowledge should be used to identify designated psychiatric units within each hospital's ward codes, to allow total psychiatric care days to be calculated for each episode of care.
- Acute care hospitals and 24-hour staffed community-based residential services should be identified separately at the level of the establishment.

Comments: This metadata item was originally designed to monitor trends in the delivery of psychiatric admitted patient care in acute care hospitals. It has been modified to enable collection of data in the community-based residential care sector. The metadata item is intended to improve understanding in this area and contribute to the ongoing evaluation of changes occurring in mental health services.

Source and reference attributes

Submitting organisation: National Mental Health Information Strategy Committee

Reference documents: Health Insurance Act 1973 (Commonwealth)

Relational attributes

Related metadata references:

Supersedes Total psychiatric care days, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (23.85 KB)

Is formed using Establishment—establishment type, sector and services provided code AN.N{.N} Health, Standard 01/03/2005

Is formed using Hospital service—care type, code N[N].N Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Information specific to this data set:

Total days in psychiatric care must be: ≥ zero; and ≤ length of stay.

Admitted patient mental health care NMDS Health, Superseded 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:

Total days in psychiatric care must be ≥ zero;

Total days in psychiatric care must be ≤ length of stay.

Treatment delivery setting for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—service delivery setting, code N
METeOR identifier:	270068
Registration status:	Health, Standard 01/03/2005
Definition:	The main physical setting in which the type of treatment that is the principal focus of a client's alcohol and other drug treatment episode is actually delivered irrespective of whether or not this is the same as the usual location of the service provider, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—service delivery setting

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Non-residential treatment facility
2	Residential treatment facility
3	Home
4	Outreach setting
8	Other

Collection and usage attributes

Guide for use:

Only one code to be selected at the end of the alcohol and other drug treatment episode. Agencies should report the setting in which most of the main type of treatment was received by the client during the treatment episode.

CODE 1 Non-residential treatment facility

This code refers to any non-residential centre that provides alcohol and other drug treatment services, including hospital outpatient services and community health centres.

CODE 2 Residential treatment facility

This code refers to community-based settings in which clients reside either temporarily or long-term in a facility that is not their home or usual place of residence to receive alcohol and other drug treatment. This does not include ambulatory situations, but does include therapeutic community settings.

CODE 3 Home

This code refers to the client's own home or usual place of residence.

CODE 4 Outreach setting

This code refers to an outreach environment, excluding a client's home or usual place of residence, where treatment is provided. An outreach environment may be any public or private location that is not covered by Codes 1-3. Mobile/outreach alcohol and other drug treatment service providers would usually provide treatment within this setting.

Data element attributes

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Treatment delivery setting for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.79 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Triglyceride level (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—triglyceride level (measured), total millimoles per litre N[N].N
METeOR identifier:	270229
Registration status:	Health, Standard 01/03/2005
Definition:	A person's triglyceride level measured in millimoles per litre.
Data Element Concept:	Person—triglyceride level

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described.

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use: Record the absolute result of the total triglyceride measurement.

Collection methods: Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.

- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.

Note that to calculate the low-density lipoprotein - cholesterol (LDL-C) from the Friedwald Equation (Friedwald et al, 1972):

- a fasting level of plasma triglyceride and knowledge of the levels of plasma total cholesterol and high-density lipoprotein - cholesterol (HDL-C) is required,
- the Friedwald equation becomes unreliable when the plasma triglyceride exceeds 4.5 mmol/L, and
- that while levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 6 weeks after an event.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references:

Supersedes Triglycerides - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.12 KB)

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, 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:

A relationship between triglyceride and High-density Lipoprotein Cholesterol (HDL-C) and chronic heart disease (CHD) event rates has been shown. This view is supported by the observation that the remnants of triglyceride-rich lipoproteins are the particles that occur in dysbetalipoproteinaemia, a condition associated with a very high risk of premature atherosclerotic vascular disease. There have been two comprehensive reviews of the relationship between plasma triglyceride and CHD (see Criqui et al. 1993 and Austin et al. 1991). Criqui concludes that triglyceride is not an independent predictor of CHD and is probably not causally related to the disease, while Austin provides a compelling case for a causal role of (at least) some triglyceride rich lipoproteins. Conclusions drawn from population studies of the relationship between plasma triglyceride and the risk of CHD include the following:

- an elevated concentration of plasma triglyceride (> 2.0 mmol/L) is predictive of CHD when associated with either an increased concentration of LDL-C or a decreased concentration of HDL-C.
- the relationship between CHD risk and plasma triglyceride is not continuous, with evidence that the risk is greatest in people with triglyceride levels between 2 and 6 mmol/L (Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88. National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand).

It is likely that the positive relationship between plasma triglyceride and CHD, as observed in many population studies, is because an elevated level of plasma triglyceride in some people is a reflection of an accumulation of the atherogenic remnants of chylomicrons and very Low-density Lipoprotein (LDL). These particles are rich in both triglyceride and cholesterol and appear to be at least as atherogenic as LDL.

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

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

Information specific to this data set:

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

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

Alterations in fat transport, often resulting in hyper-triglyceridaemia, are well-recognised concomitants of diabetes mellitus.

Elevated plasma triglyceride levels are present in about one third of diabetic patients. It seems that triglycerides are related to the critical role of insulin in the production and removal from plasma of triglyceride-rich lipoproteins.

Lifestyle modifications, including weight loss and reduction of excess alcohol intake, are particularly effective for reducing triglyceride and increasing HDL-C.

Troponin assay type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin assay type, code N
METeOR identifier:	285225
Registration status:	Health, Standard 04/06/2004
Definition:	The type of troponin assay (I or T) used to assess the person's troponin levels, as represented by a code.
Data Element Concept:	Person—troponin assay type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Cardiac troponin T (cTnT)
2	Cardiac troponin I (cTnI)
3	Not taken

Supplementary values:

9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Troponin assay type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.06 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, 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, record the type of troponin assay (I or T) used to assess troponin levels during this presentation.

Troponin assay—upper limit of normal range (micrograms per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for troponin assay, total micrograms per litre N[NNN]
METeOR identifier:	285326
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of `troponin T' or `troponin I' measured in micrograms per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range of troponin assay

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described

Unit of measure: Microgram per litre (µg/L)

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of normal (usually the ninety-ninth percentile of a normal population) for the individual laboratory.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Troponin assay - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.88 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Troponin level (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin level (measured), total micrograms per litre NN.NN
METeOR identifier:	285253
Registration status:	Health, Standard 04/06/2004
Definition:	A person's troponin measured in micrograms per litre.
Data Element Concept:	Person—troponin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN.NN
Maximum character length:	4

Supplementary values:

Value	Meaning
88.88	Not measured
99.99	Not stated/inadequately described

Unit of measure: Microgram per litre (µg/L)

Collection and usage attributes

Guide for use: CODE 88.88 Not measured

This code is used if test for troponin (T or I) was not done.

Data element attributes

Collection and usage attributes

Guide for use: Measured in different assays dependant upon laboratory methodology.

When only one troponin level is recorded, this should be the peak level during the admission.

Source and reference attributes

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

Relational attributes

Related metadata references: Supersedes Troponin measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.14 KB)

See also Laboratory standard—upper limit of normal range for troponin assay, total micrograms per litre N[NNN] Health, Standard 04/06/2004

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 used to determine diagnostic strata.

Tumour size at diagnosis (solid tumours)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—solid tumour size (at diagnosis), total millimetres NNN
METeOR identifier:	270184
Registration status:	Health, Standard 01/03/2005
Definition:	The largest dimension of a solid tumour, measured in millimetres.
Data Element Concept:	Person with cancer—solid tumour size

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN
Maximum character length:	3
Supplementary values:	Value: 999 — Meaning: Unknown
Unit of measure:	Millimetre (mm)

Collection and usage attributes

Guide for use:	Size in millimetres with valid values 001 to 997.

Data element attributes

Collection and usage attributes

Guide for use:	The reporting standard for the size of solid tumours is: Breast cancer or other solid neoplasms - the largest tumour dimension, measured to a precision of 1mm.

Relational attributes

Related metadata references:	Supersedes Tumour size at diagnosis - solid tumours, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.37 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005 *Information specific to this data set:* This is used to measure the diameter of the largest dimension of breast cancers and other solid neoplasms for patient management, population cancer statistics and research.

Tumour thickness at diagnosis (melanoma)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—melanoma thickness (at diagnosis), total millimetres NNN.NN
METeOR identifier:	270185
Registration status:	Health, Standard 01/03/2005
Definition:	The measured thickness of a melanoma in millimetres.
Data Element Concept:	Person with cancer—melanoma thickness

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN.NN
Maximum character length:	5

Supplementary values:

Value	Meaning
999.99	Unknown

Unit of measure: Millimetre (mm)

Data element attributes

Collection and usage attributes

Guide for use:

The reporting standard for the thickness of melanoma is:

Primary cutaneous melanoma - the depth of penetration of tumour cells below the basal layer of the skin; measured to a precision of 0.01mm.

Size in millimetres - valid values are: 000.01 to 997.99

Relational attributes

Related metadata references:	Supersedes Tumour thickness at diagnosis - melanoma, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.3 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Type and sector of employment establishment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health professional—establishment type (employment), industry code NN
METeOR identifier:	269954
Registration status:	Health, Standard 01/03/2005
Definition:	The sector of employment and main type of work/speciality area of the health professional, as represented by a code.
Data Element Concept:	Health professional—establishment type (employment)

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Private medical practitioner rooms/surgery (including 24-hour medical clinics)
02	Other public non-residential health care facility (e.g. Aboriginal health service, ambulatory centre, outpatient clinic, day surgery centre, medical centre, community health centre)
03	Other private non-residential health care (e.g. Aboriginal health service, ambulatory centre, outpatient clinic, day surgery centre, medical centre, community health centre)
04	Hospital - acute care (including psychiatric or specialist hospital) hospital (public)
05	Hospital - acute care (including psychiatric or specialist hospital) hospital (private)
06	Residential health care (e.g. nursing home, hospice, physical disabilities residential centre) facility (public)
07	Residential health care (e.g. nursing home, hospice, physical disabilities residential centre) facility (private)
08	Tertiary education institution (public)
09	Tertiary education institution (private)
10	Defence forces
11	Government department or agency (e.g. laboratory, research organisation etc.)
12	Private industry/private enterprise (e.g. insurance, pathology, bank)
13	Other (specified) public

	14	Other (specified) private
Supplementary values:	99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

Establishments are coded into self reporting groupings in the public and private sectors. This can be seen in the code list for medical practitioners.

Minor variations in ordering of sequence and disaggregation of the principal categories will be profession-specific as appropriate; where a more detailed set of codes is used, the essential criterion is that there should not be an overlap of the detailed codes across the Australian and New Zealand Standard Industrial Classification category definitions.

Note:

Public psychiatric hospitals are non-acute care facilities, whereas private psychiatric hospitals are acute care facilities. To minimise the possibility of respondent confusion and mis-reporting, public psychiatric hospitals are included in the grouping for acute care public hospitals.

Source and reference attributes

Origin:

Australian Bureau of Statistics 1993. Australian and New Zealand Standard Industrial Classification (ANZSIC). Cat. No. 1292.0. Canberra: ABS

Data element attributes

Collection and usage attributes

Comments:

Day surgery centres, outpatient clinics and medical centres approved as hospitals under the Health Insurance Act 1973 (Commonwealth) have emerged as a new category for investigation. These will be included in a review of the National Health Labour Force Collection questions and coding frames.

Source and reference attributes

Submitting organisation:

National Health Labour Force Data Working Group

Reference documents:

Australian Bureau of Statistics 1993. Australian and New Zealand Standard Industrial Classification (ANZSIC). Cat. No. 1292.0. Canberra: ABS

Relational attributes

Related metadata references:

Supersedes Type and sector of employment establishment, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.83 KB)

Implementation in Data Set Specifications:

Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Information specific to this data set:

To analyse distribution of service providers by setting (defined by industry of employer and sector), cross-classified with main type of work and/or specialty area.

Type of accommodation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—accommodation type (usual), code N[N]
METeOR identifier:	270088
Registration status:	Health, Standard 01/03/2005
Definition:	The type of accommodation setting in which a person usually lives/lived, as represented by a code.
Context:	Admitted patient mental health care: Permits analysis of the usual residential accommodation type of people prior to admission to institutional health care. The setting in which the person usually lives can have a bearing on the types of treatment and support required by the person and the outcomes that result from their treatment.
Data Element Concept:	Person—accommodation type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Private residence (e.g. house, flat, bedsitter, caravan, boat, independent unit in retirement village), including privately and publicly rented homes
2	Psychiatric hospital
3	Residential aged care service
4	Specialised alcohol/other drug treatment residence
5	Specialised mental health community-based residential support service
6	Domestic-scale supported living facility (eg. group home for people with disability)
7	Boarding/rooming house/hostel or hostel type accommodation, not including aged persons' hostel
8	Homeless persons' shelter
9	Shelter/refuge (not including homeless persons' shelter)
10	Other supported accommodation
11	Prison/remand centre/youth training centre
12	Public place (homeless)
13	Other accommodation, not elsewhere classified

Supplementary values:	14	Unknown/unable to determine

Collection and usage attributes

Guide for use:

CODE 3 Residential aged care service

Includes nursing home beds in acute care hospitals.

CODE 4 Specialised alcohol/other drug treatment residence

Includes alcohol/other drug treatment units in psychiatric hospitals.

CODE 5 Specialised mental health community-based residential support service

Specialised mental health community-based residential support services are defined as community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provides 24-hour support/rehabilitation on a residential basis.

CODE 6 Domestic-scale supported living facility (eg. group home for people with disability)

Domestic-scale supported living facilities include group homes for people with disability, cluster apartments where a support worker lives on-site, community residential apartments (except mental health), congregate care arrangements. Support is provided by staff on either a live-in or rostered basis, and they may or may not have 24-hour supervision and care.

CODE 10 Other supported accommodation

Includes other supported accommodation facilities such as hostels for people with disability and Residential Services/Facilities (Victoria and South Australia only). These facilities provide board and lodging and rostered care workers provide client support services.

Data element attributes

Collection and usage attributes

Guide for use:

'Usual' is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to admission to institutional health care or first contact with a community service setting. If a person stays in a particular place of accommodation for four or more days a week over the period, that place of accommodation would be the person's type of usual accommodation. In practice, receiving an answer to questioning about a person's usual accommodation setting may be difficult to achieve. The place the person perceives as their usual accommodation will often prove to be the best approximation of their type of usual accommodation.

Comments:

The changes made to this metadata item are in accordance with the requirements of the National Mental Health Information Strategy Committee and take into consideration corresponding definitions in other data dictionaries (e.g. Home and Community Care Data Dictionary Version 1 and National Community Services Data Dictionary Version 1).

Relational attributes

Related metadata references:

Supersedes Type of accommodation, version 2, DE, NHDD,

NHIMG, Superseded 01/03/2005.pdf (19.41 KB)

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS Health, Superseded 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

Type of augmentation of labour

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—labour augmentation type, code N
METeOR identifier:	270036
Registration status:	Health, Standard 01/03/2005
Definition:	Methods used to assist progress of labour, as represented by a code.
Data Element Concept:	Birth event—labour augmentation type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	0	None
	1	Oxytocin
	2	Prostaglandins
	3	Artificial rupture of membranes (ARM)
	4	Other
Supplementary values:	5	Not stated

Collection and usage attributes

Comments:	Prostaglandin is listed as a method of augmentation in the data domain. Advice from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the manufacturer indicates that vaginal prostaglandin use is not recommended or supported as a method of augmentation of labour as it may significantly increase the risk of uterine hyperstimulation. In spite of this, the method is being used and it is considered important to monitor its use for augmentation.

Data element attributes

Collection and usage attributes

Guide for use:	More than one method of augmentation can be recorded, except where 0=none applies. Collection units need to edit carefully the use of prostaglandins as an augmentation method. Results from checking records have shown that either the onset of labour was incorrect or that the augmentation method was incorrectly selected.
Comments:	Type of augmentation determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Type of augmentation of labour, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.39 KB)

Type of health or health related function

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—type of health or health related function, code NNN
METeOR identifier:	352187
Registration status:	Health, Standard 05/12/2007
Definition:	Describes the type of activities or programs with a health or health-related function provided by an organisation, as represented by a code.
Data Element Concept:	Organisation—type of health or health related function

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NNN
Maximum character length:	3

Permissible values:

Value	Meaning
101	Admitted patient care – Mental health program
102	Admitted patient care – Non-Mental health program
199	Admitted patient care – Not further defined
201	Residential care – Mental health program
202	Residential care – Non-Mental health program
299	Residential care – Not further defined
301	Ambulatory care – Mental health program
302	Ambulatory care – Emergency department
303	Ambulatory care – General practitioner
304	Ambulatory care – Medical specialist
305	Ambulatory care – Imaging/pathology
306	Ambulatory care – Dental service
307	Ambulatory care – Optometry service
308	Ambulatory care – Allied health service
309	Ambulatory care – Community health service
388	Ambulatory care – Other
399	Ambulatory care – Not further defined
401	Public health – Communicable disease control
402	Public health – Selected health promotion
403	Public health – Organised immunisation
404	Public health – Environmental health
405	Public health – Food standards and hygiene
406	Public health – Breast cancer screening

407	Public health – Cervical screening
408	Public health – Bowel cancer screening
409	Public health – Prevention of hazardous and harmful drug use
410	Public health – Public health research
488	Public health – Other public health
499	Public health – Not further defined
501	Health related care – Patient transport
502	Health related care – Patient transport subsidies
503	Health related care – Medications
504	Health related care – Aids and appliances
505	Health related care – Health administration
506	Health related care – Health research
588	Health related care – Other
599	Health related care – Not further defined
601	Other function – Home and Community Care
602	Other function – Aged care
603	Other function – Other welfare
688	Other function – Other
699	Other function – Not further defined

Collection and usage attributes

Guide for use:

CODE 101 Admitted patient care – Mental health program

An **admission** to a mental health program includes:

The component of the mental health program that provides admitted patient care. These services are delivered through specialised psychiatric hospitals and designated psychiatric units located within hospitals that are not specialised psychiatric hospitals.

NOTE: This is the admitted patient component of the mental health care program reported to the Mental Health Establishments NMDS.

Excludes residential care mental health programs, **ambulatory care** mental health programs which are provided **outpatient** and **emergency department** care to non-admitted patients, and community-based (non-hospital) mental health programs.

CODE 102 Admitted patient care – Non-mental health program

An admitted patient non-mental health program includes:

All services, excluding mental health services, provided to admitted patients, including acute care, rehabilitative care, palliative care, geriatric evaluation and management, psychogeriatric care, maintenance care, newborn care and any other admitted patient care e.g. organ procurement – posthumous. Also includes admitted patient services where service delivery is contracted to private hospitals or treatment facilities and **hospital in the home** services.

Excludes emergency department and outpatient care provided to non-admitted patients, and community-based (non hospital) care.

CODE 199 Admitted patient care – Not further defined

Comprises admitted patient care services that could be a combination of categories 101 and 102 but which could not be further disaggregated.

State and territory health authorities are only to report admitted patient care under codes 101 or 102.

CODE 201 Residential care – Mental health program

A residential mental health care program includes:

The component of the specialised mental health program that provides residential care. A **resident** in one **residential mental health service** cannot be concurrently a resident in another residential mental health service. A resident in a residential mental health service can be concurrently a patient admitted to a hospital.

Comprises the residential component of the mental health care program reported to the Mental Health Establishments NMDS.

Excludes residential aged care services, residential disability, alcohol and other drug treatment health care services and residential type care provided to admitted patients in hospitals. Also excludes mental health programs provided to admitted patients, emergency and outpatient care patients, and community health (non-hospital) and other ambulatory care patients.

CODE 202 Residential care – Non-mental health program

A residential non-mental health care program includes alcohol and other drug treatment health care services.

Excludes residential mental health care program services, residential aged care services, residential disability services and residential type care provided to admitted patients in hospitals. Also excludes services provided to admitted patients and patients receiving ambulatory care.

CODE 299 Residential care – Not further defined

Comprises residential care services that could be a combination of categories 201 and 202 but which could not be further disaggregated.

State and territory health authorities are only to report residential care under codes 201 or 202.

CODE 301 Ambulatory care – Mental health program

The component of a specialised mental health program supplied by a specialised mental health service that provides **ambulatory health care**.

Comprises the ambulatory component of the mental health care program reported to the Mental Health Establishments NMDS, i.e. specialised mental health program services provided by emergency departments, outpatient clinics and community-based (non-hospital) services.

Excludes specialised mental health care provided to admitted and residential patients.

CODE 302 Ambulatory care – Emergency department

Comprises emergency department services provided in an **emergency department**.

Excludes specialised mental health services provided by emergency departments, outpatient clinics and community-based (non-hospital) services. Also excludes residential and admitted patient services.

CODE 303 Ambulatory care – General practitioner

This item is not currently required to be reported by state and territory health authorities.

The definition relates to the broad type of non-referred general practitioner services as specified on the Medicare Benefits Schedule website. These services comprise general practitioner attendances, including General Practitioner, Vocationally Registered General Practitioner (GP/VRGP) and other non-referred attendances, to non-admitted patients, and services provided by a practice nurse or registered Aboriginal Health Worker on behalf of a general practitioner.

This category is not limited to services funded by Medicare Australia. It also includes services funded from other sources such as Motor Vehicle Third Party Insurance and Workers Compensation Insurance, among others. Therefore, general or nurse practitioner services such as vaccinations for overseas travel are included regardless of their funding source.These non-referred general practitioner services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Excludes mental health care services reported under code 301 and services provided to non-admitted patients in an emergency department.

CODE 304 Ambulatory care – Medical specialist

This item is not currently required to be reported by state and territory health authorities.

Specialist attendances, obstetrics, anaesthetics, radiotherapy, operations and assistance at operations care. These services are defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Includes salaried medical officers.

Excludes mental health care services reported under code 301 and services provided to non-admitted patients in an emergency department.

CODE 305 Ambulatory care – Imaging/pathology service.

This item is not currently required to be reported by state and territory health authorities.

Pathology and diagnostic imaging services as defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Excludes services provided to admitted or residential care patients and non-admitted patients in an emergency department.

CODE 306 Ambulatory care – Dental service

Includes any non-admitted patient and community dental services, including dental assessments, preventative services and treatments, regardless of funding source. Oral and maxillofacial services and cleft lip and palate services, as

defined in the current Medicare Benefits Schedule, are also included in this category.

Includes dental services funded from a range of sources such as Medicare Benefits Scheme, Motor Vehicle Third Party Insurance and dental services funded by vouchers for dental care.

These dental services are provided in private or group practices in dental clinics, community health care centres or hospital outpatient clinics.

Excludes dental care provided to admitted patients in hospitals (same day or overnight) or to non-admitted patients in an emergency department.

CODE 307 Ambulatory care – Optometry service

This item is not currently required to be reported by state and territory health authorities.

Optometry services as defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are mainly provided in private or group practices, but may be provided in hospital outpatient centres.

Excludes optometry services provided to admitted or residential care patients or to non-admitted patients in an emergency department.

CODE 308 Ambulatory care – Allied health service

Includes services provided by the following allied health items. Aboriginal health worker, diabetes educator, audiologists, exercise physiologist, dietician, mental health worker, occupational therapist, physiotherapist, podiatrist or chiropodist, chiropractor, osteopath, psychologist and speech pathologist. These services are defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments.

Excludes allied health services provided to admitted or residential care patients or to non-admitted patients in an emergency department.

CODE 309 Ambulatory care – Community health services

Includes community health services such as family, maternal, child and youth health (including well baby clinics) as well as Aboriginal and Torres Strait Islander and migrant health services. Also includes health care for people with acute, post-acute, chronic and end of life illnesses, alcohol and drug treatment services, child psychology services, community midwifery, community nursing, school and district nursing, community rehabilitation, continence services, telehealth, dietetics, family planning and correctional health services.

Excludes mental health services reported under code 301 and services provided to admitted and residential care patients and non-admitted patients in an emergency department. Also excludes services already reported under codes 303 to 308.

CODE 388 Ambulatory care – Other

Comprises ambulatory care services other than those reported under codes 301 to 309.

CODE 399 Ambulatory care – Not further defined

Comprises ambulatory care services that could be a combination of categories 301 to 309 and 388, but which could not be further disaggregated, such as public outpatient services.

CODE 401 Public health – Communicable disease control

This category includes all activities associated with the development and implementation of programs to prevent the spread of communicable diseases.

Communicable disease control is recorded using three sub-categories:

HIV/AIDS, hepatitis C and sexually transmitted infections

Needle and syringe programs

Other communicable disease control.

The **public health** component of the HIV/AIDS, hepatitis C and STI strategies includes all activities associated with the development and implementation of prevention and education programs to prevent the spread of HIV/AIDS, hepatitis C and sexually transmitted infections.

CODE 402 Public health – Selected health promotion

This category includes those activities fostering healthy lifestyle and a healthy social environment overall, and health promotion activities targeted at health risk factors which lead to injuries, skin cancer and cardiovascular disease (for example diet, inactivity) that are delivered on a population-wide basis. The underlying criterion for the inclusion of health promotion programs within this category was that they are population health programs promoting health and wellbeing.

The Selected health promotion programs are:

Healthy settings (for example municipal health planning)

Public health nutrition

Exercise and physical activity

Personal hygiene

Mental health awareness promotion

Sun exposure and protection

Injury prevention including suicide prevention and female genital mutilation.

CODE 403 Public health – Organised immunisation

This category includes immunisation clinics, school immunisation programs, immunisation education, public awareness, immunisation databases and information systems.

Organised immunisation is recorded using three sub-categories:

Organised childhood immunisation (as defined by the National Health and Medical Research Council Schedule/Australian Standard Vaccination Schedule)

Organised pneumococcal and influenza immunisation—the target groups for pneumococcal immunisation are Indigenous people over 50 years and high-risk Indigenous younger people aged 15–49 years. Influenza vaccine is available free to all Australians 65 years of age and over, Indigenous people over 50 years and high-risk Indigenous younger people aged 15–19 years.

All other organised immunisation (for example tetanus)—as opposed to ad hoc or opportunistic immunisation.

CODE 404 Public health – Environmental health

This category relates to health protection education (for example safe chemical storage, water pollutants), expert advice on specific issues, development of standards, risk management and public health aspects of environmental health protection. The costs of monitoring and regulating are to be included where costs are borne by a regulatory agency and principally have a public health focus (for example radiation safety, and pharmaceutical regulation and safety).

CODE 405 Public health – Food standards and hygiene

This category includes the development, review and implementation of food standards, regulations and legislation as well as the testing of food by the regulatory agency.

CODE 406 Public health – Breast cancer screening

This category relates to Breast cancer screening and includes the complete breast cancer screening pathway through organised programs.

The breast cancer screening pathway includes such activities as recruitment, screen taking, screen reading, assessment (this includes fine needle biopsy), core biopsy, open biopsy, service management and program management.

CODE 407 Public health – Cervical screening

This category relates to organised cervical screening programs such as the state cervical screening programs and rural access programs, including coordination, provision of screens and assessment services.

Cervical screening, funded through Medicare, for both screening and diagnostic services is also included. The methodology used in deriving the estimates is set out in the Jurisdictions' technical notes (section 11.2 of NPHER 2004-05).

CODE 408 Public health – Bowel screening

This category relates to organised bowel screening programs, such as the National Bowel Cancer Screening Program (NBCSP) and the Bowel Cancer Screening Pilot program. The screening pathway includes self administered home based tests by persons turning 55 years or 65 years of age across Australia who mail results in for analysis, the assessment/diagnostic service and program management.

CODE 409 Public health – Prevention of hazardous and harmful drug use

This category includes activities targeted at the general population with the aim of reducing the overuse or abuse of alcohol, tobacco, illicit and other drugs of dependence, and mixed drugs. The Australian Standard Classification of Drugs of Concern includes analgesics, sedatives and hypnotics, stimulants and hallucinogens, anabolic agents and selected hormones, antidepressants and anti-psychotics, and also miscellaneous drugs of concern.

Report for each sub-category as below, the aggregate of which will be total expenditure on Prevention of hazardous and harmful drug use:

Alcohol

Tobacco

Illicit and other drugs of dependence

Mixed.

CODE 410 Public health – Public health research

The basic criterion for distinguishing public health research and development from other public health activities is the presence in research and development of an appreciable element of novelty and resolution of scientific and/or technical uncertainty.

Includes mainly new or one-off research in the 8 core public health functions listed under codes 401 to 409.

General research and development work relating to the running of ongoing public health programs is included under the other relevant public health activities in codes 401 to 409.

CODE 488 Public health – Other public health

Comprises public health functions not reported to the National Public Health Expenditure Project.

CODE 499 Public health – Not further defined

Comprises public health services that could be a combination of categories 401 to 410 but which could not be further disaggregated.

State and territory health authorities are only to report public health services under codes 401 to 409.

CODE 501 Health related care – Patient transport

This item comprises transportation in a specially-equipped surface vehicle or in a designated air ambulance to and from facilities for the purposes of receiving medical and surgical care.

Includes all government ambulance services and transport provided by the Royal Flying Doctors Service, care flight and similar services, emergency transport services of public fire rescue departments or defence that operate on a regular basis for civilian emergency services (not only for catastrophe medicine).

Includes transport between hospitals or other medical facilities and transport to or from a hospital or other medical facility and a private residence or other non-hospital/medical services location.

The provider of this service could be a public or private hospital or an ambulance service.

CODE 502 Health related care – Patient transport subsidies

Government subsidies to private ambulance services e.g. patient transport vouchers, support programs to assist isolated patients with travel to obtain specialised health care.

It also includes transportation in conventional vehicles, such as taxi, when the latter is authorised and the costs are reimbursed to the patient (e.g. for patients undergoing renal dialysis or chemotherapy).

CODE 503 Health related care – Medications

This item is not currently required to be reported by state and territory health authorities.

Includes pharmaceuticals and other medical non-durables, prescribed medicines and over-the-counter pharmaceuticals. Included within these categories are: medicinal preparations, branded and generic medicines, drugs, patent medicines, serums and vaccines, vitamins and minerals and oral contraceptives, prescribed medicines exclusively sold to customers with a medical voucher, irrespective of whether it is covered by public or private funding. Includes branded and

generic products, private households' non-prescription medicines and a wide range of medical non-durables such as bandages, condoms and other mechanical contraceptive devices, elastic stockings, incontinence articles and toothbrushes, toothpastes and therapeutic mouth washes.

CODE 504 Health related care – Aids and appliances

This item is not currently required to be reported by state and territory health authorities.

This item comprises glasses and other vision products, orthopaedic appliances & other prosthetics, hearing aids, medico-technical devices including wheelchairs and all other miscellaneous medical durables not elsewhere classified such as blood pressure instruments.

CODE 505 Health related care – Health administration

Administrative services which cannot be allocated to a specific health good and service. Those unallocatable services might include, for example, maintaining an office of the Chief Medical Officer; a Departmental liaison officer in the office of the Minister; or a number of other agency-wide items for which it is not possible to derive appropriate or meaningful allocations to particular health programs.

CODE 506 Health related care – Health research

Includes all research on health topics that is not included in public health research (code 409). That is, it includes all research classified under ABS Australian Standard Research Classification code 320000, excluding code 321200.

Excludes public health research and non-health related research.

CODE 588 Health related care – Other

Includes for example, services provided by health and health-related call centres and e-health information services.

Excludes health related care reported under codes 501 to 506 and health assessments provided under the Aged Care Assessment Program which are reported under code 602.

CODE 599 Health related care – Not further defined

Comprises health related care that could be a combination of categories 501 to 506 but which could not be further disaggregated.

State and territory health authorities are only to report health related care under codes 501 to 506.

CODE 601 Other function – Home and community care

This item is not currently required to be reported by state and territory health authorities.

Comprises Home and Community Care services reported under the HACC NMDS.

Information on these service categories is available in the following report:

National classifications of community services. Version 2.0. AIHW Cat. No. HWI 40. Canberra: Australian Institute of Health and Welfare, 2003.

Excludes services reported under codes 602 to 604.

CODE 602 Other function – Aged care

This item is not currently required to be reported by state and territory health authorities.

Includes residential care aged care programs, aged care

assessment programs and other non-health aged care programs, such as respite care and day care activities.

Excludes services provided under the HACC program.

CODE 603 Other function – Other welfare

This item is not currently required to be reported by state and territory health authorities.

Includes services delivered to clients, or groups of clients with special needs such as the young or the disabled. Excludes aged care services reported under code 602.

CODE 688 Other function – Other

This item is not currently required to be reported by state and territory health authorities. Includes for example, car parking, accommodation for staff or for patients' relatives, or non-health related research.

CODE 699 Other function – Not further defined

This item is not currently required to be reported by state and territory health authorities.

Comprises other functions that could be a combination of categories 601 to 603 but which could not be further disaggregated.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents: Australian Bureau of Statistics 1998. Australian Standard Research Classification. Cat. no. 1297.0. Canberra: ABS.

Australian Government Department of Health and Ageing Medicare Benefits Schedule Book, 1 November 2006 available from http://www.health.gov.au/mbsonline

Australian Institute of Health and Welfare 2003. National classifications of community services. Version 2.0. AIHW cat. no. HWI 40. Canberra: AIHW.

Australian Institute of Health and Welfare 2007. National public health expenditure report 2004–05. Health and welfare series expenditure series no. 29. cat. no. HWE 36. Canberra: AIHW.

Data element attributes

Relational attributes

Implementation in Data Set Specifications: Government health expenditure function revenue data cluster Health, Standard 05/12/2007

Government health expenditure organisation expenditure data cluster Health, Standard 05/11/2007

Type of labour induction

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—labour induction type, code N
METeOR identifier:	270037
Registration status:	Health, Standard 01/03/2005
Definition:	Method used to induce labour, as represented by a code.
Data Element Concept:	Birth event—labour induction type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
0	None
1	Oxytocin
2	Prostaglandins
3	Artificial rupture of membranes (ARM)
4	Other

Data element attributes

Collection and usage attributes

Guide for use:	More than one method of induction can be recorded, except where 0=none applies.
Comments:	Type of induction determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Type of labour induction, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.89 KB)

Type of usual accommodation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—accommodation type (prior to admission), code N
METeOR identifier:	270079
Registration status:	Health, Standard 01/03/2005
Definition:	The type of physical accommodation the person lived in prior to **admission**.
Context:	Admitted patient mental health care: Permits analysis of the prior residential accommodation type of people admitted to residential aged care services or other institutional care.
Data Element Concept:	Person—accommodation type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	House or flat
2	Independent unit as part of retirement village or similar
3	Hostel or hostel type accommodation
4	Psychiatric hospital
5	Acute hospital
6	Other accommodation
7	No usual residence

Collection and usage attributes

Collection methods: The above classifications have been based on Question 16 of Form NH5.
The Australian Government Department of Health and Aged Care has introduced a new Aged Care Application and Approval form which replaces the NH5.

Data element attributes

Collection and usage attributes

Collection methods: This metadata item is not available for New South Wales State nursing homes. As this item includes only details of physical accommodation before admission it was decided to have details of the relational basis of accommodation before admission collected as a separate metadata item (see metadata item Admission mode).

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of usual accommodation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS Health, Superseded 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

Type of visit to emergency department

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—type of visit to emergency department, code N
METeOR identifier:	270362
Registration status:	Health, Standard 01/03/2005
Definition:	The reason the patient presents to an emergency department, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode—type of visit to emergency department

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Emergency presentation: attendance for an actual or suspected condition which is sufficiently serious to require acute unscheduled care.
2	Return visit, planned: presentation is planned and is a result of a previous emergency department presentation or return visit.
3	Pre-arranged admission: a patient who presents at the emergency department for either clerical, nursing or medical processes to be undertaken, and admission has been pre-arranged by the referring medical officer and a bed allocated.
4	Patient in transit: the emergency department is responsible for care and treatment of a patient awaiting transport to another facility.
5	Dead on arrival: a patient who is dead on arrival at the emergency department.

Data element attributes

Collection and usage attributes

Comments:	Required for analysis of emergency department services.

Source and reference attributes

Submitting organisation:	National Institution Based Ambulatory Model Reference Group
Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Type of visit to emergency department, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.64 KB)

Implementation in Data Set Specifications:

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

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

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Urgency of admission

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission urgency status, code N
METeOR identifier:	269986
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the **admission** has an urgency status assigned and, if so, whether **admission** occurred on an emergency basis, as represented by a code.
Data Element Concept:	Episode of admitted patient care—admission urgency status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Urgency status assigned - emergency
	2	Urgency status assigned - elective
	3	Urgency status not assigned
Supplementary values:	9	Not known/not reported

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Urgency status assigned - emergency

Emergency admission:

The following guidelines may be used by health professionals, hospitals and health insurers in determining whether an emergency admission has occurred. These guidelines should not be considered definitive.

An emergency admission occurs if one or more of the following clinical conditions are applicable such that the patient required admission within 24 hours.

Such a patient would be:

- at risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation; or
- suffering from suspected acute organ or system failure; or
- suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
- suffering from a drug overdoes, toxic substance or toxin effect; or
- experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or

- suffering severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- suffering acute significant haemorrhage and requiring urgent assessment and treatment; or
- suffering gynaecological or obstetric complications; or
- suffering an acute condition which represents a significant threat to the patient's physical or psychological wellbeing; or
- suffering a condition which represents a significant threat to public health.

If an admission meets the definition of emergency above, it is categorised as emergency, regardless of whether the admission occurred within 24 hours of such a categorisation being made, or after 24 hours or more.

CODE 2 Urgency status assigned - Elective

Elective admissions:

If an admission meets the definition of elective above, it is categorised as elective, regardless of whether the admission actually occurred after 24 hours or more, or it occurred within 24 hours. The distinguishing characteristic is that the admission could be delayed by at least 24 hours.

Scheduled admissions:

A patient who expects to have an elective admission will often have that admission scheduled in advance. Whether or not the admission has been scheduled does not affect the categorisation of the admission as emergency or elective, which depends only on whether it meets the definitions above. That is, patients both with and without a scheduled admission can be admitted on either an emergency or elective basis.

Admissions from elective surgery waiting lists:

Patients on waiting lists for elective surgery are assigned a Clinical urgency status which indicates the clinical assessment of the urgency with which a patient requires elective hospital care. On admission, they will also be assigned an urgency of admission category, which may or may not be elective:

- Patients who are removed from elective surgery waiting lists on admission as an elective patient for the procedure for which they were waiting (see code 1 in metadata item Reason for removal from an elective surgery waiting list code N) will be assigned an Admission urgency status code N code of 2. In that case, their clinical urgency category could be regarded as further detail on how urgent their admission was.
- Patients who are removed from elective surgery waiting lists on admission as an emergency patient for the procedure for which they were waiting (see code 2 in metadata item Reason for removal from an elective surgery waiting list code N), will be assigned an Admission urgency status code N code of 1.

CODE 3 Urgency status not assigned

Admissions for which an urgency status is usually not assigned:

An urgency status can be assigned for admissions of the types listed above for which an urgency status is not usually assigned. For example, a patient who is to have an obstetric admission may have one or more of the clinical conditions

listed above and be admitted on an emergency basis.

CODE 9 Not known/not reported

This code is used when it is not known whether or not an urgency status has been assigned, or when an urgency status has been assigned but is not known.

Source and reference attributes

Submitting organisation: Emergency definition working party

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Urgency of admission, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.39 KB)

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

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

Implementation start date: 01/07/2008

Vascular history

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—vascular condition status (history), code NN
METeOR identifier:	269958
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the person has had a history of vascular conditions, as represented by a code.
Context:	The vascular history of the patient is important as an element in defining future risk for a cardiovascular event and as a factor in determining best practice management for various cardiovascular risk factor(s). It may be used to map vascular conditions, assist in risk stratification and link to best practice management.
Data Element Concept:	Person—vascular condition status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Myocardial infarction
02	Unstable angina pectoris
03	Angina
04	Heart failure
05	Atrial fibrillation
06	Other dysrhythmia or conductive disorder
07	Rheumatic heart disease
08	Non-rheumatic valvular heart disease
09	Left ventricular hypertrophy
10	Stroke
11	Transient ischaemic attack
12	Hypertension
13	Peripheral vascular disease (includes abdominal aortic aneurism)
14	Deep vein thrombosis
15	Other atherosclerotic disease
16	Carotid stenosis
17	Vascular renal disease
18	Vascular retinopathy (hypertensive)
19	Vascular retinopathy (diabetic)
97	Other vascular

	98	No vascular history
Supplementary values:	99	Unknown/not stated /not specified

Collection and usage attributes

Comments: Can be mapped to the current version of ICD-10-AM.

Source and reference attributes

Origin: International Classification of Diseases - Tenth Revision - Australian Modification (3rd Edition 2000), National Centre for Classification in Health, Sydney

Data element attributes

Collection and usage attributes

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

Collection methods: Ideally, vascular history information is derived from and substantiated by clinical documentation.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: National Centre for Classification in Health

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: Supersedes Vascular history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.83 KB)

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

Vascular procedures

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—vascular procedures (history), code NN
METeOR identifier:	269962
Registration status:	Health, Standard 01/03/2005
Definition:	The vascular procedures the person has undergone, as represented by a code.
Data Element Concept:	Person—vascular procedure

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Amputation for arterial vascular insufficiency
02	Carotid endarterectomy
03	Carotid angioplasty/stenting
04	Coronary angioplasty/stenting
05	Coronary artery bypass grafting
06	Renal artery angioplasty/stenting
07	Heart transplant
08	Heart valve surgery
09	Abdominal aortic aneurism repair/bypass graft/stenting
10	Cerebral circulation angioplasty/stenting
11	Femoral/popliteal bypass/graft/stenting
12	Congenital heart and blood vessel defect surgery
13	Permanent pacemaker implantation
14	Implantable cardiac defibrillator
98	Other

Supplementary values:

99	Unknown/not recorded

Data element attributes

Collection and usage attributes

Collection methods:	Ideally, Vascular procedure information is derived from and substantiated by clinical documentation.
Comments:	In settings where the monitoring of a person's health is ongoing and where a history can change over time (such as general practice), the Service contact—service contact date,

DDMMYYYY should be recorded.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: Australian Institute of Health and Welfare (AIHW) 2001. Heart, stroke and vascular diseases - Australian facts 2001. AIHW Cat. No. CVD 13. Canberra: AIHW, National Heart foundation of Australia, National Stroke Foundation of Australia (CVD Series No. 14)

Relational attributes

Related metadata references: Supersedes Vascular procedures, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.54 KB)

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

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

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

Visual acuity (left eye)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—visual acuity (left eye), code NN
METeOR identifier:	269963
Registration status:	Health, Standard 01/03/2005
Definition:	A person's left eye visual acuity, as represented by a code.
Data Element Concept:	Person—visual acuity

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	6/5
02	6/6
03	6/9
04	6/12
05	6/18
06	6/24
07	6/36
08	6/60
09	CF (count fingers)
10	HM (hand movement)
11	PL (perceive light)
12	BL (blind)
13	6/7.5

Supplementary values:

99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Record actual result for both right and left eyes:

- 1st field: Right eye
- 2nd field: Left eye.

Test wearing distance glasses if prescribed.

Use pinhole if vision less than 6/6.

Collection methods:

One of the most often utilised tests for visual acuity uses the Snellen chart.

- At a distance of 6 metres all subjects should be able to read the 6/6 line with each eye using the proper refractive correction.

- Both eyes are to be opened and then cover one eye with the ocular occluder.
- The observer has to read out the smallest line of letters that he/she can see from the chart.
- This is to be repeated with the other eye.

Eye examination should be performed by an ophthalmologist or a suitably trained clinician:

- within five years of **diagnosis** and then every 1-2 years for patients whose diabetes onset was at age under 30 years
- at diagnosis and then every 1-2 years for patients whose diabetes onset was at age 30 years or more.

Source and reference attributes

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents: Vision Australia, No 2, 1997/8; University of Melbourne

World Health Organization

US National Library of Medicine

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

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus

Relational attributes

Related metadata references: Supersedes Visual acuity, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.3 KB)

See also Person—visual acuity (right eye), code NN Health, Standard 01/03/2005

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

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

Information specific to this data set:

Patients with diabetes have an increased risk of developing several eye complications including retinopathy, cataract and glaucoma that can lead to loss of vision. Regular eye checkups are important for patients suffering from diabetes mellitus. This helps to detect and treat abnormalities early and to avoid or postpone vision-threatening complications. Assessment by an ophthalmologist is essential:

- at initial examination if the corrected visual acuity is less than 6/6 in either eye
- if at subsequent examinations declining visual acuity is detected
- if any retinal abnormality is detected
- if clear view of retina is not obtained.

Visual acuity (right eye)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—visual acuity (right eye), code NN
METeOR identifier:	270381
Registration status:	Health, Standard 01/03/2005
Definition:	A person's right eye visual acuity, as represented by a code.
Data Element Concept:	Person—visual acuity

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	6/5
02	6/6
03	6/9
04	6/12
05	6/18
06	6/24
07	6/36
08	6/60
09	CF (count fingers)
10	HM (hand movement)
11	PL (perceive light)
12	BL (blind)
13	6/7.5

Supplementary values:

99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Record actual result for both right and left eyes:

- 1st field: Right eye
- 2nd field: Left eye.

Test wearing distance glasses if prescribed.

Use pinhole if vision less than 6/6.

Collection methods:

One of the most often utilised tests for visual acuity uses the Snellen chart.

- At a distance of 6 metres all subjects should be able to read the 6/6 line with each eye using the proper refractive correction.

- Both eyes are to be opened and then cover one eye with the ocular occluder.
- The observer has to read out the smallest line of letters that he/she can see from the chart.
- This is to be repeated with the other eye.

Eye examination should be performed by an ophthalmologist or a suitably trained clinician:

- within five years of **diagnosis** and then every 1-2 years for patients whose diabetes onset was at age under 30 years
- at diagnosis and then every 1-2 years for patients whose diabetes onset was at age 30 years or more.

Source and reference attributes

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World Health Organization

US National Library of Medicine

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

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus

Relational attributes

Related metadata references: See also Person—visual acuity (left eye), code NN Health, Standard 01/03/2005

Supersedes Visual acuity, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.3 KB)

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

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

Information specific to this data set:

Patients with diabetes have an increased risk of developing several eye complications including retinopathy, cataract and glaucoma that can lead to loss of vision. Regular eye checkups are important for patients suffering from diabetes mellitus. This helps to detect and treat abnormalities early and to avoid or postpone vision-threatening complications. Assessment by an ophthalmologist is essential:

- at initial examination if the corrected visual acuity is less than 6/6 in either eye
- if at subsequent examinations declining visual acuity is detected
- if any retinal abnormality is detected
- if clear view of retina is not obtained.

Waist circumference (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—waist circumference (measured), total centimetres NN[N].N
METeOR identifier:	270129
Registration status:	Health, Standard 01/03/2005
Definition:	A person's waist circumference measured in centimetres.
Data Element Concept:	Person—waist circumference

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N].N
Maximum character length:	4
Supplementary values:	Value: 999.9 — Meaning: Not measured
Unit of measure:	Centimetre (cm)

Data element attributes

Collection and usage attributes

Collection methods:

The collection of anthropometric measurements, particularly in those who are overweight or obese or who are concerned about their weight, should be performed with great sensitivity, and without drawing attention to an individual's weight.

The measurement protocol described below is that recommended by the World Health Organization (WHO Expert Committee 1995) which was adapted from Lohman et al. (1988) and the International Society for the Advancement of Kinanthropometry as described by Norton et al. (1996).

In order to ensure consistency in measurement, the following measurement protocol should be used.

Measurement protocol:

The measurement of waist circumference requires a narrow (

The subject should remove any belts and heavy outer clothing. Measurement of waist circumference should be taken over at most one layer of light clothing. Ideally the measure is made directly over the skin.

The subject stands comfortably with weight evenly distributed on both feet, and the feet separated about 25-30 cm. The arms should hang loosely at the sides. Posture can affect waist circumference. The measurement is taken midway between the inferior margin of the last rib and the crest of the ilium, in the mid-axillary plane. Each landmark should be palpated and marked, and the midpoint determined with a tape measure and marked.

The circumference is measured with an inelastic tape maintained in a horizontal plane, at the end of normal expiration. The tape is snug, but does not compress underlying soft tissues. The measurer is positioned by the side of the subject to read the tape. To ensure contiguity of the two parts of the tape from which the circumference is to be determined, the cross-handed technique of measurement, as described by Norton et al. (1996), should be used. Ideally an assistant will check the position of the tape on the opposite side of the subject's body.

The measurement is recorded at the end of a normal expiration to the nearest 0.1 cm. Take a repeat measurement and record it to the nearest 0.1 cm. If the two measurements disagree by more than 1 cm, take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured waist circumference is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over-reporting (Armitage & Berry 1994). For example, a mean value of 72.25 cm would be rounded to 72.2 cm, while a mean value of 72.35 cm would be rounded to 72.4 cm.

Validation and quality control measures:

Steel tapes should be checked against a 1 metre engineer's rule every 12 months. If tapes other than steel are used they should be checked daily against a steel rule.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within -) or different (between-) observers repeating the measurement, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996) between observers should not exceed 2% and be less than 1.5% within observers.

Extreme values at the lower and upper end of the distribution of measured waist circumference should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last-digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Comments:

This metadata item is recommended for use in population surveys and health care settings.

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

these variables.

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

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

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

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

Waist

35 cm = Waist

40 cm = Waist

... in 5 cm categories

105 cm = Waist

Waist => 110 cm

Source and reference attributes

Submitting organisation: World Health Organization International Society for the Advancement of Kinanthropometry

Relational attributes

Related metadata references: Supersedes Waist circumference - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.95 KB)

Is used in the formation of Adult—waist-to-hip ratio, N.NN Health, Standard 01/03/2005

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

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

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

Waist circumference risk indicator - adults

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Adult—waist circumference risk indicator, Caucasian adult code N
METeOR identifier:	270205
Registration status:	Health, Standard 01/03/2005
Definition:	The sex specific category of risk of metabolic complications associated with excess abdominal adiposity in adult Caucasians, as represented by a code.
Data Element Concept:	Adult—waist circumference risk indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Not at risk (male waist circumference
	2	Increased (male waist circumference >= 94 cm, female waist circumference >= 80 cm)
	3	Substantially increased (male waist circumference >= 102 cm, female waist circumference >= 88 cm)
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item cannot be determined if waist circumference measured has not been collected (i.e. is coded to 999.9) and/or sex is not stated (i.e. coded to 9). This metadata item applies to persons aged 18 years or older.
Collection methods:	This metadata item should be derived after the data entry of waist circumference measured. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.
Comments:	This metadata item is recommended for use in population surveys and health care settings. Recent evidence suggests that waist circumference may provide a more practical correlate of abdominal fat distribution and associated ill health. The identification of risk using waist circumference is population-specific and will depend on levels of obesity and other risk factors for cardiovascular disease and non-insulin dependant diabetes mellitus.

Populations differ in the level of risk associated with a particular waist circumference, so that globally applicable cut-off points cannot be developed. For example, complications associated with abdominal fat in black women and those of South Asian descent are markedly higher for a given level of BMI than in Europeans. Also, although women have almost the same absolute risk of coronary heart disease as men at the same WHR, they show increases in relative risk of coronary heart disease at lower waist circumferences than men. Thus, there is a need to develop sex-specific waist circumference cut-off points appropriate for different populations. Hence, the cut-off points used for this metadata item are associated with obesity in Caucasians. This issue is being investigated further.

Cut-off points for children and adolescents are also being developed. Research shows that a high childhood BMI and high trunk skin fold values are predictive of abdominal obesity as an adult and waist circumference measures in childhood track well into adulthood.

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

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

Source and reference attributes

Origin: World Health Organization

Reference documents: Obesity: Preventing and Managing the Global Epidemic: Report of a World Health Organization (WHO) Expert Committee. Geneva: WHO, 2000 as described by Han TS et al (1995)

Relational attributes

Related metadata references: Supersedes Waist circumference risk indicator - adults, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (20.53 KB)

Waist-to-hip ratio

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Adult—waist-to-hip ratio, N.NN
METeOR identifier:	270207
Registration status:	Health, Standard 01/03/2005
Definition:	A ratio calculated by dividing the waist circumference of an adult person by the hip circumference of that same person.
Data Element Concept:	Adult—waist-to-hip ratio

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	N.NN
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:	Formula: WHR = waist circumference (cm) divided by hip circumference (cm). Adult WHR is a continuous variable. Adult WHR cannot be calculated if either component necessary for its calculation (i.e. abdominal circumference or hip circumference) has not been collected (i.e. is coded to 999.9).
Collection methods:	As there are no cut-off points for waist to hip ratio for children and adolescents, it is not necessary to calculate this item for those aged under 18 years. Waist-to-hip ratio (WHR) should be derived after the data entry of waist circumference and hip circumference. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.
Comments:	Adult cut-off points for WHR, that may define increased risk of cardiovascular disease and all cause mortality, range from 0.9 to 1.0 for men and 0.8 to 0.9 for women (Croft et al. 1995, Bray 1987, Bjorntorp 1985). These values are based primarily on evidence of increased risk of death in European populations, and may not be appropriate for all age and ethnic groups. In Australia and New Zealand, the cutoffs of >0.9 for males and >0.8 for females were used in the Australian Bureau of Statistics' 1995 National Nutrition Survey. This metadata item applies to persons aged 18 years or older as no cut off points have been developed for children and adolescents. It is recommended for use in population surveys and health care settings. More recently it has emerged that waist circumference alone, or

in combination with other metabolic measures, is a better indicator of risk and reduces the errors in WHR measurements. WHR is therefore no longer a commonly used measure.

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

Body fat distribution has emerged as an important predictor of obesity-related morbidity and mortality. Abdominal obesity, which is more common in men than women, has, in epidemiological studies, been closely associated with conditions such as coronary heart disease, stroke, non-insulin dependent diabetes mellitus and high blood pressure.

Waist- to-hip ratio (WHR) can be used:

- to indicate the prevalence of abdominal obesity and its sociodemographic distribution (problem identification)
- to evaluate health promotion and disease prevention programs (assessment of interventions)
- to monitor progress towards national public health policy
- to ascertain determinants and consequences of abdominal obesity - in nutrition and physical activity surveillance and long-term planning.

Presentation of data:

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

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

Source and reference attributes

Origin:

National Health Data Committee

National Centre for Monitoring Cardiovascular Disease

Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Waist-to-hip ratio, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.96 KB)

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

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

Waiting list category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective care waiting list episode—elective care type, code N
METeOR identifier:	335048
Registration status:	Health, Standard 07/12/2005
Definition:	The type of elective hospital care that a patient requires, as represented by a code.
Data Element Concept:	Elective care waiting list episode—elective care type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Elective surgery
2	Other

Collection and usage attributes

Guide for use:

Elective surgery comprises elective care where the procedures required by patients are listed in the surgical operations section of the Medicare benefits schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians.

Elective care is care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least twenty-four hours.

CODE 2 Other

Patients awaiting the following procedures should be classified as Code 2 - other:

- organ or tissue transplant procedures
- procedures associated with obstetrics (e.g. elective caesarean section, cervical suture)
- cosmetic surgery, i.e. when the procedure will not attract a Medicare rebate
- biopsy of:
  - kidney (needle only)
  - lung (needle only)
  - liver and gall bladder (needle only)
- bronchoscopy (including fibre-optic bronchoscopy)
- peritoneal renal dialysis;
- haemodialysis
- colonoscopy
- endoscopic retrograde cholangio-pancreatography (ERCP)
- endoscopy of:

biliary tract
oesophagus
small intestine
stomach

- endovascular interventional procedures
- gastroscopy
- miscellaneous cardiac procedures
- oesophagoscopy
- panendoscopy (except when involving the bladder)
- proctosigmoidoscopy
- sigmoidoscopy
- anoscopy
- urethroscopy and associated procedures
- dental procedures not attracting a Medicare rebate
- other diagnostic and non-surgical procedures.

These procedure terms are also defined by the Australian Classification of Health Interventions (ACHI) codes which are listed under Comments below. This coded list is the recommended, but optional, method for determining whether a patient is classified as requiring elective surgery or other care.

CODE 1 Elective surgery

All other elective surgery should be included in this code.

Comments:

The table of Australian Classification of Health Interventions (ACHI) (5th edition) procedure codes was prepared by the National Centre for Classification in Health. Some codes were excluded from the list on the basis that they are usually performed by non-surgeon clinicians. A more extensive and detailed listing of procedure descriptors is under development. This will replace the list in the Guide for use to facilitate more readily the identification of the exclusions when the list of codes is not used.

ACHI CODES FOR THE EXCLUDED PROCEDURES:

Organ or tissue transplant:
90172-00 [555] 90172-01 [555] 90204-00 [659] 90204-01 [659] 90205-00 [660] 90205-01 [660] 13700-00 [801] 13706-08 [802] 13706-00 [802] 13706-06 [802] 13706-07 [802] 13706-09 [802] 13706-10 [802] 30375-21 [817] 90317-00 [954] 90324-00 [981] 36503-00 [1058] 36503-01 [1058] 14203-01 [1906]

Procedures associated with obstetrics: 16511-00 [1274] Obstetric Blocks [1330] to [1345] and [1347]
90463-01 [1330] 90488-00 [1330]

Biopsy (needle) of:
• kidney: 36561-00 [1047]
• lung: 38412-00 [550]
• liver and gall bladder: 30409-00 [953] 30412-00 [953] 90319-01 [951] 30094-04 [964]

Bronchoscopy:
41889-00 [543] 41892-00 [544] 41904-00 [546] 41764-02 [416] 41895-00 [544] 41764-04 [532] 41892-01 [545] 41901-00 [545] 41898-00 [543] 41898-01 [544] 41889-01 [543] 41849-00 [520] 41764-03 [520] 41855-00 [520]

Peritoneal renal dialysis:
13100-06 [1061] 13100-07 [1061] 13100-08 [1061] 13100-00 [1060]

Endoscopy of biliary tract:

30484-00 [957] 30484-01 [957] 30484-02 [974] 30494-00 [971]
30452-00 [971] 30491-00 [958] 30491-01 [958] 30485-00 [963]
30485-01 [963] 30452-01 [958] 30450-00 [959] 30452-02 [959]
90349-00 [975]

Endoscopy of oesophagus:
30473-03 [850] 30473-04 [861] 41822-00 [861] 30478-11 [856]
41819-00 [862] 30478-10 [852] 30478-13 [861] 41816-00 [850]
41822-00 [861] 41825-00 [852] 30478-12 [856] 41831-00 [862]
30478-12 [856] 30490-00 [853] 30479-00 [856]

Panendoscopy:
30476-03 [874] 32095-00 [891] 30568-00 [893] 30569-00 [894]
30473-05 [1005] 30473-00 [1005] 30473-02 [1005] 30478-00 [1006]
30478-14 [1006] 30478-01 [1007] 30478-02 [1007] 30478-03 [1007]
30478-15 [1007] 30478-16 [1007] 30478-17 [1007] 30478-20 [1007]
30478-21 [1007] 30473-01 [1008] 30478-04 [1008] 30473-06 [1008]
30478-18 [1008]

Endoscopy of large intestine, rectum and anus:
32075-00 [904] 32090-00 [905] 32084-00 [905] 30479-02 [908]
90308-00 [908] 32075-01 [910] 32078-00 [910] 32081-00 [910]
32090-01 [911] 32093-00 [911] 32084-01 [911] 32087-00 [911]
30479-01 [931] 90315-00 [933]

Miscellaneous cardiac:
38603-00 [642] 38600-00 [642] 38256-00 [647] 38256-01 [647]
38256-02 [647] 38278-00 [648] 38278-01 [648] 38284-00 [648]
90202-00 [649] 38470-00 [649] 38473-00 [649] 38281-01 [650]
38281-02 [650] 38281-03 [650] 38281-04 [650] 38281-05 [650]
38281-06 [650] 38281-07 [651] 38281-07 [651] 38281-08 [651]
38281-09 [651] 38281-10 [651] 38281-00 [652] 38278-02 [654]
38456-07 [654] 90203-00 [654] 38284-01 [654] 90219-00 [663]
38281-11 [655] 38281-12 [655] 38212-00 [665] 38209-00 [665]
38200-00 [667] 38203-00 [667] 38206-00 [667] 35324-00 [740]
35315-00 [758] 35315-01 [758] 90214-00 [648] 90202-01 [649]
38281-13 [652] 38278-03 [654] 38284-02 [654] 90214-01 [654]
90214-02 [654] 90203-01 [654] 38456-08 [654] 38281-14 [655]
38212-01 [665] 38213-00 [665]

Endovascular interventional:
35304-01 [670] 35305-00 [670] 35304-00 [670] 35305-01 [670]
35310-00 [671] 35310-01 [671] 35310-03 [671] 35310-04 [671]
35310-02 [671] 35310-05 [671] 34524-00 [694] 13303-00 [694]
34521-01 [694] 32500-01 [722] 32500-00 [722] 13300-01 [738]
13300-02 [738] 13319-00 [738] 13300-00 [738] 13815-00 [738]
13815-01 [738] 34521-02 [738] 34530-04 [738] 90220-00 [738]

Urethroscopy:
36800-00 [1090] 36800-01 [1090] 37011-00 [1093] 37008-01 [1093]
37008-00 [1093] 37315-00 [1112] 37318-01 [1116] 36815-01 [1116]
37854-00 [1116] 35527-00 [1116] 37318-04 [1117] 36800-03 [1090]
37318-02 [1116] 37318-03 [1116]

Dental:
Blocks [450] to [490]
97022-00 [451] 97025-00 [451] 97113-00 [453] 97121-01 [454]
97123-01 [454] 97165-01 [455] 97221-00 [456] 97222-00 [456]
97231-00 [456] 97232-00 [456] 97233-00 [456] 97234-00 [456]
97384-00 [461] 97386-01 [461] 97415-00 [462] 97417-00 [462]
97431-00 [463] 97433-00 [463] 97434-00 [463] 97437-00 [463]
97445-00 [464] 97455-00 [464] 97511-01 [465] 97512-01 [465]
97513-01 [465] 97514-02 [465] 97515-02 [465] 97541-01 [465]
97542-01 [465] 97543-01 [465] 97544-00 [465] 97545-00 [465]

97521-01 [466] 97522-01 [466] 97523-01 [466] 97524-00 [466] 97525-00 [466] 97531-00 [466] 97532-00 [466] 97533-00 [466] 97534-00 [466] 97535-00 [466] 97551-01 [466] 97552-01 [466] 97553-01 [466] 97554-01 [466] 97555-01 [466] 97572-01 [469] 97574-01 [469] 97575-00 [469] 97578-00 [469] 97582-01 [469] 97583-01 [469] 97631-00 [470] 97632-00 [471] 97649-00 [471] 97671-00 [473] 97672-00 [473] 97673-00 [473] 97732-00 [474] 97733-00 [474] 97739-00 [474] 97741-00 [475] 97762-00 [476] 97765-00 [476] 97768-00 [476] 97825-00 [479]

Other diagnostic and non-surgical:
90347-01 [983] 30406-00 [983] 90347-02 [983] 30408-00 [983]

Blocks [1820] to [1939], [1940] to [2016]

11003-00 [1825] 11018-00 [1826] 11018-01 [1826] 11614-00 [1851] 11602-00 [1852] 11604-00 [1852] 11605-00 [1852] 11610-00 [1852] 11611-00 [1852] 11612-00 [1852] 11709-00 [1853] 11917-00 [1860] 11919-00 [1860] 96207-00 [1921] 96207-01 [1921] 96207-02 [1921] 96207-03 [1921] 96207-04 [1921] 96207-05 [1921] 96207-06 [1921] 96207-07 [1921] 96207-08 [1921] 96207-09 [1921] 96208-00 [1921] 96208-01 [1921] 96208-02 [1921] 96208-03 [1921] 96208-04 [1921] 96208-05 [1921] 96208-06 [1921] 96208-07 [1921] 96208-08 [1921] 96208-09 [1921] 55084-00 [1943] 55600-00 [1943] 60000-01 [1992] 60048-00 [1996] 60060-00 [1997] 60060-01 [1997] 61442-00 [2012] 96196-00 [1920] 96196-01 [1920] 96196-02 [1920] 96196-03 [1920] 96196-04 [1920] 96196-05 [1920] 96196-06 [1920] 96196-07 [1920] 96196-08 [1920] 96196-09 [1920] 96197-00 [1920] 96197-01 [1920] 96197-02 [1920] 96197-03 [1920] 96197-04 [1920] 96197-05 [1920] 96197-06 [1920] 96197-07 [1920] 96197-08 [1920] 96197-09 [1920] 96198-00 [1920] 96198-01 [1920] 96198-02 [1920] 96198-03 [1920] 96198-04 [1920] 96198-05 [1920] 96198-06 [1920] 96198-07 [1920] 96198-08 [1920] 96198-09 [1920] 96199-00 [1920] 96199-01 [1920] 96199-02 [1920] 96199-03 [1920] 96199-04 [1920] 96199-05 [1920] 96199-06 [1920] 96199-07 [1920] 96199-08 [1920] 96199-09 [1920] 96200-00 [1920] 96200-01 [1920] 96200-02 [1920] 96200-03 [1920] 96200-04 [1920] 96200-05 [1920] 96200-06 [1920] 96200-07 [1920] 96200-08 [1920] 96200-09 [1920] 96201-00 [1920] 96201-01 [1920] 96201-02 [1920] 96201-03 [1920] 96201-04 [1920] 96201-05 [1920] 96201-06 [1920] 96201-07 [1920] 96201-08 [1920] 96201-09 [1920] 96202-00 [1920] 96202-01 [1920] 96202-02 [1920] 96202-03 [1920] 96202-04 [1920] 96202-05 [1920] 96202-06 [1920] 96202-07 [1920] 96202-08 [1920] 96202-09 [1920] 96203-00 [1920] 96203-01 [1920] 96203-02 [1920] 96203-03 [1920] 96203-04 [1920] 96203-05 [1920] 96203-06 [1920] 96203-07 [1920] 96203-08 [1920] 96203-09 [1920] 96204-00 [1920] 96204-01 [1920] 96204-02 [1920] 96204-03 [1920] 96204-04 [1920] 96204-05 [1920] 96204-06 [1920] 96204-07 [1920] 96204-08 [1920] 96204-09 [1920] 96205-00 [1920] 96205-01 [1920] 96205-02 [1920] 96205-03 [1920] 96205-04 [1920] 96205-05 [1920] 96205-06 [1920] 96205-07 [1920] 96205-08 [1920] 96205-09 [1920] 96206-00 [1920] 96206-01 [1920] 96206-02 [1920] 96206-03 [1920] 96206-04 [1920] 96206-05 [1920] 96206-06 [1920] 96206-07 [1920] 96206-08 [1920] 96206-09 [1920]

Source and reference attributes

Reference documents: National Centre for Classification in Health (NCCH) 2006. The Australian Classification of Health Interventions (ACHI) – Fifth Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.

Data element attributes

Source and reference attributes

Submitting organisation: Hospital Access Program Waiting Lists Working Group
Waiting Times Working Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Elective care waiting list episode—elective care type, code N Health, Superseded 07/12/2005

Waiting time at a census date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN]
METeOR identifier:	269961
Registration status:	Health, Standard 01/03/2005
Definition:	The time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list to a designated census date.
Context:	Elective surgery
Data Element Concept:	Elective surgery waiting list episode—waiting time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

The number of days is calculated by subtracting the Elective care waiting list episode—listing date for care, DDMMYYYY from the Hospital census (of elective surgery waitlist patients)—census date, DDMMYYYY, minus any days when the patient was 'not ready for care', and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at the census date.

Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as 'not ready for care' from the date(s) the person was subsequently recorded as again being 'ready for care'.

If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at the census date, then the number of days waited at the less urgent Elective surgery waiting list episode—clinical urgency, code N category should be subtracted from the total number of days waited.

In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at census date) the number of days at the less urgent clinical urgency category should be calculated by subtracting the Elective care waiting list episode—listing date for care, DDMMYYYY from the Elective care waiting list episode—category reassignment date, DDMMYYYY. If the patient's clinical urgency was reclassified more than once, days spent in

each period of less urgent clinical urgency than the one applying at the census date should be calculated by subtracting one Elective care waiting list episode—category reassignment date, DDMMYYYY from the subsequent Elective care waiting list episode—category reassignment date, DDMMYYYY, and then adding the days together.

When a patient is admitted from an elective surgery waiting list but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue. Therefore at the census date the patient's waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient.

Comments:

Elective surgery waiting times data collections include measures of waiting times at removal and at designated census dates. This metadata item is used to measure waiting times at a designated census date whereas the metadata item Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] measures waiting times at removal.

The calculation of waiting times for patients who are transferred from an elective surgery waiting list managed by one public acute hospital to another will be investigated in the future. In this case, the amount of time waited on previous lists should follow the patient to the next. Therefore at the census date, their waiting time includes the total number of days on all lists (less days not ready for care and days in lower urgency categories).

This is a critical elective surgery waiting times metadata item. It is used to determine whether patients are overdue, or had extended waits at a census date. It is used to assist doctors and patients in making decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Elective surgery waiting list episode—patient listing status, readiness for care code N Health, Standard 01/03/2005

Is formed using Hospital census (of elective surgery waitlist patients)—census date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Elective care waiting list episode—listing date for care, DDMMYYYY Health, Standard 01/03/2005

Is formed using Elective care waiting list episode—category reassignment date, DDMMYYYY Health, Standard 01/03/2005

Supersedes Waiting time at a census date, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.69 KB)

Is used in the formation of Elective surgery waiting list episode—overdue patient status, code N Health, Standard

	01/03/2005 Is used in the formation of Elective surgery waiting list episode—extended wait patient indicator, code N Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005 *Implementation start date:* 30/09/2006 Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005 *Implementation start date:* 30/09/2002 *Implementation end date:* 30/06/2006

Waiting time at removal from elective surgery waiting list

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—waiting time (at removal), total days N[NNN]
METeOR identifier:	269960
Registration status:	Health, Standard 01/03/2005
Definition:	The time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure to the date they were removed from the waiting list.
Context:	Elective surgery
Data Element Concept:	Elective surgery waiting list episode—waiting time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:	The number of days is calculated by subtracting the listing date for care from the removal date, minus any days when the patient was 'not ready for care', and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at removal. Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as 'not ready for care' from the date(s) the person was subsequently recorded as again being 'ready for care'. If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at removal, then the number of days waited at the less urgent clinical urgency category should be subtracted from the total number of days waited. In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at removal) the number of days at the less urgent clinical urgency category should be calculated by subtracting the listing date for care from the category reassignment date. If the patient's clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at removal should be calculated by subtracting one category reassignment date from the subsequent category

reassignment date, and then adding the days together.

When a patient is removed from an elective surgery waiting list, for admission on an elective basis for the procedure they were awaiting, but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue.

Therefore at the removal date, the patient's waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient.

Comments:

Elective surgery waiting times data collections include measures of waiting times at removal and at designated census dates. This metadata item is used to measure waiting times at removal whereas the metadata item waiting time at a census date measures waiting times at a designated census date.

The calculation of waiting times for patients, who are transferred from an elective surgery waiting list managed by one public acute hospital to another, will be investigated in the future. In this case, the amount of time waited on previous lists would follow the patient to the next. Therefore when the patient is removed from the waiting list (for admission or other reason), their waiting time would include the total number of days on all lists (less days not ready for care and days in lower urgency categories).

This is a critical elective surgery waiting times metadata item. It is used to determine whether patients were overdue, or had extended waits when they were removed from the waiting list. It is used to assist doctors and patients in making decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Waiting time at removal from elective surgery waiting list, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.97 KB)

Is formed using Elective care waiting list episode—category reassignment date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Elective surgery waiting list episode—waiting list removal date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Elective care waiting list episode—listing date for care, DDMMYYYY Health, Standard 01/03/2005

Is used in the formation of Elective surgery waiting list episode—overdue patient status, code N Health, Standard 01/03/2005

Is used in the formation of Elective surgery waiting list episode—extended wait patient indicator, code N Health, Standard 01/03/2005

Implementation in Data Set

Elective surgery waiting times (removals data) NMDS Health,

Specifications:

Standard 07/12/2005

Implementation start date: 01/07/2006

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Weight (self-reported)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—weight (self-reported), total kilograms NN[N]
METeOR identifier:	302365
Registration status:	Health, Standard 14/07/2005
Definition:	A person's self-reported weight (body mass).
Data Element Concept:	Person—weight

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
888	Unknown
999	Not stated

Unit of measure: Kilogram (Kg)

Collection and usage attributes

Guide for use:

CODE 888 Unknown

Use this code if self-reported body mass (weight) is unknown.

CODE 999 Not stated

Use this code if self-reported body mass (weight) is not responded to.

Data element attributes

Collection and usage attributes

Collection methods:

The method of data collection, e.g. face to face interview, telephone interview or self-completion questionnaire, can affect survey estimates and should be reported.

The data collection form should include a question asking the respondent what their weight is. For example, the ABS National Health Survey 1989-90 included the question 'How much do you weigh without clothes and shoes?'. The data collection form should allow for both metric (to the nearest 1 kg) and imperial (to the nearest 1 lb) units to be recorded.

If practical, it is preferable to enter the raw data into the data base before conversion of measures in imperial units to metric. However, if this is not possible, weight reported in imperial units can be converted to metric prior to data entry using a conversion factor of 0.454 kg to the lb.

Rounding to the nearest 1 kg will be required for measures converted to metric prior to data entry, and may be required for data reported in metric units to a greater level of precision than

the nearest 1 kg. The following rounding conventions are desirable to reduce systematic over reporting (Armitage and Berry 1994):

nnn.x where x

nnn.x where x > 5 - round up, e.g. 72.7 kg would be rounded to 73 kg.

nnn.x where x = 5 - round to the nearest even number, e.g. 72.5 kg would be rounded to 72 kg, while 73.5 kg would be rounded to 74 kg.

Comments:

This metadata item is recommended for persons aged 18 years or older. It is recommended for use in population surveys when it is not possible to measure weight.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables. Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

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

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

For some reporting purposes, it may be desirable to present weight data in categories. It is recommended that 5 kg groupings are used for this purpose. Weight data should not be rounded before categorisation. The following categories may be appropriate for describing the weights of Australian men and women, although the range will depend on the population. The World Health Organization's range for weight is 30-140 kg.

Weight

30 kg = Weight

35 kg = Weight

... in 5 kg categories

135 kg = Weight

Weight => 140 kg

On average, body mass (weight) tends to be underestimated when self-reported by respondents. Data for men and women aged 20-69 years in 1989 indicated that men underestimated by an average of 0.2 kg (sem of 0.05 kg) and women by an average of 0.4 kg (sem of 0.04 kg) (Waters 1993). The extent of underestimation varied with age.

Source and reference attributes

Origin:

National Centre for Monitoring Cardiovascular Disease

Australian Institute of Health and Welfare

National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Weight - self-reported, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (20.45 KB) Supersedes Adult—weight (self-reported), total kilograms NN[N] Health, Superseded 14/07/2005 Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005 Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Weight in grams (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—weight (measured), total grams NNNN
Synonymous names:	Infant weight, neonate, stillborn
METeOR identifier:	310245
Registration status:	Health, Standard 01/03/2005
Definition:	The weight (body mass) of a person measured in grams.
Data Element Concept:	Person—weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Gram (g)

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Standard 01/03/2005 Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Admitted patient care NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008 *Information specific to this data set:*

For the provision of state and territory hospital data to Commonwealth agencies this metadata item must be consistent with diagnoses and procedure codes for valid grouping.

Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000g and age is less than 365 days.

Weight in kilograms (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—weight (measured), total kilograms N[NN].N
Synonymous names:	Infant weight, neonate, stillborn
METeOR identifier:	270208
Registration status:	Health, Standard 01/03/2005
Definition:	The weight (body mass) of a person measured in kilograms.
Data Element Concept:	Person—weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4
Supplementary values:	Value: 999.9 — Meaning: Not collected
Unit of measure:	Kilogram (Kg)

Collection and usage attributes

Guide for use:	A continuous variable measured to the nearest 0.1 kg. CODE 999.9 Not collected Use this code if measured weight is not collected.

Data element attributes

Collection and usage attributes

Guide for use:	In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.
Collection methods:	The collection of anthropometric measurements, particularly in those who are overweight or obese or who are concerned about their weight, should be performed with great sensitivity and without drawing attention to an individual's weight. The measurement protocol described below is that recommended by the WHO Expert Committee (1995). Measurement protocol: Equipment used should be described and reported. Scales should have a resolution of at least 0.1kg and should have the capacity to weigh up to at least 200 kg. Measurement intervals and labels should be clearly readable under all conditions of use of the instrument. Scales should be capable of being calibrated across the entire range of measurements. Precision error should be no more than 0.1kg. Scales should be calibrated on each day of use. Manufacturers' guidelines should be followed with regard to the transportation of the scales.

Adults and children who can stand:

The subject stands over the centre of the weighing instrument, with the body weight evenly distributed between both feet.

Heavy jewellery should be removed and pockets emptied. Light indoor clothing can be worn, excluding shoes, belts, and sweater. Any variations from light indoor clothing (e.g. heavy clothing, such as kaftans or coats worn because of cultural practices) should be noted on the data collection form. Adjustments for non-standard clothing (i.e. other than light indoor clothing) should only be made in the data checking/cleaning stage prior to data analysis.

If the subject has had one or more limbs amputated, record this on the data collection form and weigh them as they are. If they are wearing an artificial limb, record this on the data collection form but do not ask them to remove it. Similarly, if they are not wearing the limb, record this but do not ask them to put it on.

The measurement is recorded to the nearest 0.1 kg. If the scales do not have a digital readout, take a repeat measurement. If the two measurements disagree by more than 0.5 kg, then take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured weight is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 kg. If so, rounding should be to the nearest even digit to reduce systematic over reporting (Armitage and Berry 1994). For example, a mean value of 72.25 kg would be rounded to 72.2 kg, while a mean value of 72.35 kg would be rounded to 72.4 kg.

Infants:

Birth weight and gender should be recorded with gestational age. During infancy a levelled pan scale with a bean and movable weights or digital scales capable of measuring to two decimal places of a kilogram are acceptable. Birth weight should be determined within 12 hours of birth. The infant, with or without a nappy or diaper is placed on the scales so that the weight is distributed equally about the centre of the pan. When the infant is lying or suspended quietly, weight is recorded to the nearest 10 grams. If the nappy or diaper is worn, its weight is subtracted from the observed weight i.e. reference data for infants are based on nude weights.

Validation and quality control measures:

If practical, equipment should be checked daily using one or more objects of known weight in the range to be measured. It is recommended that the scale be calibrated at the extremes and in the mid range of the expected weight of the population being studied.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within -) or different (between-) observers repeating the measurement of weight, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement) between

observers should not exceed 0.5 kg and be less than 0.5 kg within observers.

Extreme values at the lower and upper end of the distribution of measured height should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Comments:

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

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

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

Presentation of data:

Means and 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

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

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

Weight

10 kg = Weight

15 kg = Weight

... in 5 kg categories

135 kg = Weight

Weight => 140 kg

Source and reference attributes

Submitting organisation:

World Health Organization The consortium to develop standard methods for the collection and collation of anthropometric data in children as part of the National Food and Nutrition Monitoring and Surveillance Project, funded by the Commonwealth Department of Health and Ageing

Reference documents:

Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults (US National Heart, Lung and Blood Institute (NHLBI) in cooperation with the National Institute of Diabetes and Digestive and Kidney Diseases).
Chronic Diseases and Associated Risk Factors in Australia 2001 (AIHW).

Relational attributes

Related metadata references:

Supersedes Weight - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (29.31 KB)

Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Adult—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

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

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

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

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

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

Information specific to this data set:

Following Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, body mass index (BMI) should be below 27 kg/m 2 for men and women. For adults who suffer from diabetes, the recommendation is to measure weight and calculate BMI on the initial visit and then measure weight every 3 months. If the patient is on a weight reduction program, weight is to be measured more frequently.

Strong evidence exists that weight loss reduces blood pressure in both overweight hypertensive and non-hypertensive individuals; reduces serum triglycerides and increases high-density lipoprotein (HDL)-cholesterol; and generally produces some reduction in total serum cholesterol and low-density lipoprotein (LDL)-cholesterol.

The risk of developing diabetes rises continuously with increasing obesity (DHAC & AIHW 1999:13). An increased central distribution of body fat (when fatness is concentrated in the abdomen) also appears to be associated more often with Type 2 diabetes (Bishop et al. 1998:430-1).

Weight loss reduces blood glucose levels in overweight and obese persons with and without diabetes; and weight loss also reduces blood glucose levels and HbA1c in some patients with type 2 diabetes. Although there have been no prospective trials to show changes in mortality with weight loss in obese patients, reductions in risk factors would suggest that development of type 2 diabetes and

CVD would be reduced with weight loss.

Weight is an overall measure of body size that does not distinguish between fat and muscle. Weight is an indicator of nutritional and health status. Low pre-pregnancy weight is an indicator of poorer gestational outcome in women (Kramer 1988). Low weight is also associated with osteoporosis. In general, change in weight in adults is of interest because it is an indicator of changing health status, and in children as it indicates changing health status and growth and development. Self-reported or parentally-reported weight for children and adolescents should be used cautiously if at all. It enables the calculation of body mass index (BMI) which requires the measurement of height and weight for adults as well as sex and date of birth for children and adolescents.

Working partnership indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—working partnership indicator, yes/no code N
METeOR identifier:	290696
Registration status:	Health, Standard 05/12/2007
Definition:	Whether a service provider organisation has formal working partnership(s) with other service provider(s) or organisation(s), as represented by a code.
Data Element Concept:	Service provider organisation—working partnership indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

A formal working partnership involves arrangements between a service provider organisation and another service provider or organisation, aimed at providing integrated and seamless care, so that clients are able to move smoothly between services and service settings.

A formal working partnership is a verbal or written agreement between two or more parties. It specifies the roles and responsibilities of each party, including the expected outcomes of the agreement.

Key elements of a formal working partnership are that it is organised, routine, collaborative, and systematic. It excludes ad hoc arrangements. Examples of formal working partnerships include the existence of: written service agreements; formal liaison; referral and discharge planning processes; formal and routine consultation; protocols; partnership working groups; memoranda of understanding with other providers; and case conferencing.

CODE 1 Yes
The service provider organisation has formal working partnership(s) with other service provider(s) or organisation(s) in place.

CODE 2 No
The service provider organisation has no formal working

partnership(s) with other service provider(s) or organisation(s) in place.

Collection methods: Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

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

Information specific to this data set:
This information is required for the calculation of palliative care performance indicator number 4: 'The proportion of palliative care agencies, within their setting of care, that have formal working partnerships with other service provider(s) and organisation(s)'.

Year insulin started

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—insulin start date, YYYY
METeOR identifier:	269928
Registration status:	Health, Standard 01/03/2005
Definition:	The year the patient started insulin injections.
Context:	Public health, health care and clinical settings.
Data Element Concept:	Patient—insulin start date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Record the year that insulin injections were started. This data element has to be completed for all patients who use insulin. It is used to cross check diabetes type assignment.
Collection methods:	Ask the individual the year when he/ she started to use insulin. Alternatively obtain this information from appropriate documentation, if available.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Year insulin started, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.15 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005 *Information specific to this data set:* This data element provides information about the duration of diabetes in individual patients. Insulin is a regulating hormone secreted into the blood in response to a rise in concentration of blood glucose or amino acids. It is a double-chain protein hormone formed from proinsulin in the beta cells of the pancreatic islets of Langerhans. Insulin promotes the storage of glucose and the uptake of amino acids, increases protein and lipid synthesis, and inhibits lipolysis and gluconeogenesis.

Commercially prepared insulin is available in various types, which differ in the speed they act and in the duration of their effectiveness.

Year of arrival in Australia

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (overseas born)—year of first arrival in Australia, date YYYY
METeOR identifier:	269929
Registration status:	Health, Standard 04/05/2005 Community services, Standard 01/03/2005
Definition:	The year a person (born outside of Australia) first arrived in Australia, from another country, with the intention of staying in Australia for one year or more.
Data Element Concept:	Person (overseas born)—year of first arrival in Australia

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Collection methods:

Actual year of arrival in Australia.

Recommended question:

In what year did you/the person first arrive in Australia to live here for one year or more?

(Write in the calendar year of arrival or mark the box if here less than one year)

Calendar year of arrival

Will be here less than one year

It is anticipated that for the majority of people their response to the question will be the year of their only arrival in Australia. However, some respondents may have multiple arrivals in Australia. To deal with these cases in self-enumerated collections, an instruction such as 'Please indicate the year of first arrival only' should be included with the question.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, the recommended question should be used wherever practically possible.

Source and reference attributes

Origin: The Australian Bureau of Statistics Standard for Year of Arrival in Australia. (last viewed 05/12/2006)

Reference documents:	The ABS standard for the collection of Year of arrival in Australia appears on the ABS Website http://www.abs.gov.au/ausstats/abs@.nsf/StatsLibrary select Other ABS Statistical Standards/Standards for Social, Labour and Demographic Variables/Cultural Diversity Variable.

Relational attributes

Related metadata references:	Supersedes Year of arrival in Australia, version 2, DE, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (15.52 KB)
Implementation in Data Set Specifications:	Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Year of diagnosis of diabetes mellitus

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date (diabetes mellitus), YYYY
METeOR identifier:	269930
Registration status:	Health, Standard 01/03/2005
Definition:	The year a patient was first diagnosed as having diabetes
Context:	Public health, health care and clinical settings.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Record the year that the patient was first diagnosed as having diabetes.
Collection methods:	Ask the individual the year when he/ she was diagnosed with diabetes. Alternatively obtain this information from appropriate documentation, if available.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Year of diagnosis of diabetes mellitus, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.06 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:
Long-term complications of diabetes mellitus affect the eyes, kidneys, nerves, and blood vessels.