Australian Government
Australian Institute of Health and Welfare

National Health Data Dictionary

Version 16.2

NATIONAL HEALTH DATA DICTIONARY SERIES NO. 18

Australian Government
Australian Institute of Health and Welfare

Authoritative information and statistics to promote better health and wellbeing

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

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Please note that there is the potential for minor revisions of data in this report. Please check the online version at <www.aihw.gov.au> for any amendments.

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Abbreviations

AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
ASGS	Australian Statistical Geography Standard
DSS	data set specification
ISO/IEC 11179	International Organization for Standardization and the International Electrotechnical Commission 11179 Metadata Registries (International Standard)
METeOR	Metadata Online Registry
NHDD	National Health Data Dictionary
NHIPPC	National Health Information and Performance Principal Committee
NHISSC	National Health Information Standards and Statistics Committee
NMDS	national minimum data set

Symbols

▲	new standard data elements
◊	revised standard data elements

1 Introduction

The National Health Data Dictionary (NHDD) is the authoritative source of information about endorsed national metadata standards for the health sector, and provides the basis for consistent national collection and reporting.

The NHDD version 16.2 contains national standards that were approved between July 2013 and the end of June 2014. It follows the publication of NHDD version 16.1 which reflected changes to the national health data standards between May 2012 and June 2013. The NHDD version 16.1 is available on the Australian Institute of Health and Welfare's (AIHW's) website, at <www.aihw.gov.au/publication-detail/?id=10737422826>.

Within the NHDD version 16.2, the national standards have been grouped into the following categories:

- data elements
- national minimum data set specifications
- data set specifications
- data element clusters
- supporting metadata items:
  - object classes
  - properties
  - classification schemes
  - glossary items.

The standards have been endorsed by the National Health Information and Performance Principal Committee (NHIPPC) for inclusion in the data dictionary. Further information about the committee governance process can be found in the 'Governance' section later in this chapter.

The standards are also available on METeOR, the AIHW's online metadata registry, at <www.meteor.aihw.gov.au>.

Structure of this publication

To support the use of this publication, the NHDD version 16.2 has been divided into 4 chapters:

- Chapter 1—a brief description of the NHDD, including how metadata are approved as national data standards and the future of the NHDD.
- Chapter 2—a summary of the changes to the national data standards since the previous version of the NHDD.
- Chapter 3—all new and revised national data standards. Data elements are alphabetised by their short names.
- Chapter 4—a list of all new and revised data elements within this publication, alphabetised by their technical names.

Data elements are assigned both a short name and a technical name. Both the short name and the technical name will be unique to the data element. The short name is the designation by which the data element is commonly known. The technical name reflects the metadata that combine to form the data element, and is based on the second edition of the international standard *International Organization for Standardization and the International Electrotechnical Commission 11179 Metadata Registries* (ISO/IEC 11179). For example, the data element technically named 'Person—date of birth, DDMMYYYY' is commonly referred to as 'Date of birth'. The data elements section of Chapter 3 is organised by short name, with Chapter 4 providing an alternative listing (with corresponding page numbers) by technical name.

1.1 What are the national data dictionaries?

National data dictionaries contain standard data definitions and data elements for use in a particular sector. The three national data dictionaries produced by the AIHW contain national standards for use in Australian health, community services, and housing and homelessness data collections respectively. The National Health Data Dictionary, the National Community Services Data Dictionary and the National Housing and Homelessness Data Dictionary are the authoritative sources of information about endorsed national metadata standards and provide the basis for consistent national collection and reporting. The NHDD has been produced under the auspices of the Australian Health Ministers' Advisory Council (AHMAC), with all standards endorsed by NHIPPC.

Where possible, metadata standards in the dictionary are consistent with other national standard classifications to ensure overall comparability of national data. Examples include the 'Australian Statistical Geography Standard', developed by the Australian Bureau of Statistics, and the 'Australian Classification of Health Interventions 8th edition', developed by the National Casemix and Classification Centre.

The national health, community services and housing and homelessness data dictionaries are available online at <www.aihw.gov.au>.

Governance

To date, the national health data dictionaries have been produced as initiatives under the National Health Information Agreement (NHIA). Under the NHIA, all parties commit to ensuring that collection, compilation and interpretation of national information are all appropriate and carried out efficiently. This requires agreement on definitions, standards and rules for collecting information, and on guidelines for coordinating the access, interpretation and publication of national health information. The NHIA is available online at <www.aihw.gov.au/nhissc/>.

The process of developing health metadata standards is overseen by the National Health Information Standards and Statistics Committee (NHISSC), a subcommittee of the NHIPPC. Once developed and agreed, the standards are endorsed by NHIPPC, which is one of several principal committees that report to AHMAC. AHMAC provides support to the Health Council (Australian, state and territory health ministers) under arrangements for the Council of Australian Governments. Further information about the national health information committees and the health data development process can be found in the publication *Creating nationally-consistent health information: Engaging with the national health information committees*, available on the AIHW website at <http://www.aihw.gov.au/publication-detail/?id=60129546545>.

Where to from here?

The NHDD was first published in 1989 as the publication *National Minimum Data Set – Institutional Health Care*. New versions of the NHDD have generally been published every 2 years as hard copies and/or as PDFs, with updates containing changes produced between major versions. With a shift in user preferences for how to access the information contained within the NHDD, this will be the last version published in PDF format.

The NHDD will continue to be maintained and will remain accessible via the NHDD Browser on the METeOR website at <http://meteor.aihw.gov.au/content/index.phtml/itemId/268110>.

1.2 METeOR

The NHDD version 16.2 is extracted from METeOR, the online metadata registry for developing, registering and disseminating metadata, which is based on ISO/IEC 11179. The international standard was applied to METeOR to provide a detailed registry architecture in which metadata standards can be better defined, navigated and managed throughout the data development lifecycle.

METeOR integrates and presents information about:

- the National Health Data Dictionary
- the National Community Services Data Dictionary
- the National Housing and Homelessness Data Dictionary
- national minimum data sets (NMDSs)
- data set specifications (DSSs)
- performance indicator specifications.

METeOR includes:

- data search and browse tools that allow navigation of data standards of varying levels of endorsement across the health, community services and housing and homelessness assistance sectors
- data view, collation and download tools
- data development tools, including areas in which multiple data developers may collaborate on the development of data standards
- data submission tools that enable data developers to submit draft metadata standards for consideration as national standards
- data management tools that allow the registrar to change the registration status of metadata standards under authorisation of one or more registration authorities
- comprehensive guidelines for developing and reviewing metadata.

2 Summary of updates to the National Health Data Dictionary since version 16.1

This chapter presents an overview of new and revised national standards that have been endorsed between July 2013 and June 2014.

Table 1: Summary of updates

Registration status	National minimum data sets	Data set specifications	Data element clusters	Data elements	Classifications	Glossary items
Standards (new)	1	8	9	107	12	13
Standards (revised)	7	4	7	67	1	0
Superseded	9	4	7	64	1	1
Retired	0	0	0	12	0	0

Table 2: New national minimum data sets

Name	Description
Non-admitted patient care hospital aggregate NMDS 2014–15	The scope of the Non-admitted patient care hospital aggregate NMDS is non-admitted patient service events involving non-admitted patients in public hospitals. The NMDS is intended to capture instances of service provision from the point of view of the patient. For the purpose of this NMDS, a non-admitted service is a specialty unit or organisational arrangement under which a hospital provides non-admitted services.

Table 3: Revised national minimum data sets

Name	Description of change
Admitted patient care NMDS 2014–15	Revisions made due to the introduction of the ASGS and changes to mental health-specific data elements.
Community mental health care NMDS 2014–15	Revisions made due to changes to mental health-specific data elements.
Mental health establishments NMDS 2014–15	Revisions mainly associated with updates to consumer- and carer-specific data elements.
Non-admitted patient emergency department care NMDS 2014–15	Revisions made to remove and update some diagnosis-specific data elements.
Perinatal NMDS 2014–	Revisions mainly associated with birth plurality and parity data elements.
Public hospital establishments NMDS 2014–15	Revisions made due to the removal of some data elements measuring non-admitted patient activity, gross capital expenditure and the introduction of data element clusters to measure staffing and recurrent expenditure.
Residential mental health care NMDS 2014–15	Revisions made due to changes to mental health-specific data elements.

Table 4: New data set specifications

Name	Description
Admitted subacute and non-acute hospital care DSS 2014–15	The Admitted subacute and non-acute hospital care DSS aims to ensure national consistency in relation to defining and collecting information about care provided to subacute and non-acute admitted public and private patients in activity based funded public hospitals.
Gynaecological cancer (clinical) DSS	The Gynaecological cancer (clinical) DSS is primarily directed at the clinical and clinical epidemiological use of cancer data. The data set specification can also be used by a wider range of health and health-related establishments that create, use or maintain records on health-care clients.
Hospital teaching and training activities DSS 2014–15	The purpose of the Hospital teaching and training activities DSS is to collect information about teaching and training activities, funded by the states and territories that are associated with Australian public hospitals.
Local Hospital Networks DSS 2014–15	The purpose of the Local Hospital Networks DSS is to collect information about: • Local Hospital Networks • all public hospital services that are managed by a state or territory health authority and are included in the *General list of In-scope Public Hospital Services*, which was developed under the *National Health Reform Agreement* (2011).
Lung cancer (clinical) DSS	The purpose of the Lung cancer (clinical) DSS is to define data standards for the national collection of lung cancer clinical data so that the data collected are consistent and reliable.
Non-admitted patient care Local Hospital Network aggregate DSS 2014–15	The Non-admitted patient care Local Hospital Network aggregate DSS is intended to capture instances of service provision from the point of view of the patient.
Non-admitted patient emergency department care DSS 2014–15	The Non-admitted patient emergency department care DSS captures patients registered for care in emergency departments in public hospitals where the emergency department meets the following criteria: • purposely designed and equipped area with designated assessment, treatment and resuscitation areas • ability to provide resuscitation, stabilisation and initial management of all emergencies • availability of medical staff in the hospital 24 hours a day • designated emergency department nursing staff 24 hours a day, 7 days a week, and a designated emergency department nursing unit manager.
Perinatal DSS 2014–15	The Perinatal DSS is designed to capture all births in Australia in hospitals, birth centres and the community. The data set includes information on all births, both live births and stillbirths, of at least 20 weeks gestation or 400g birth weight.

Table 5: Revised data set specifications

Name	Description of change
Cancer (clinical) DSS	Revisions made to clarify the intent of this DSS and support the introduction of other cancer-specific DSSs.
Indigenous primary health care DSS 2014–15	Revisions mainly associated with the introduction of Medicare Benefit Schedule-specific data elements.
Medical indemnity DSS 2014–	Revisions made due to the introduction of the ASGS and changes to medical indemnity claim payment data elements.
Non-admitted patient DSS 2014–15	Revisions mainly associated with updates to the data elements measuring the source of funding and the recording of identifier codes.

Table 6: New data element clusters

Name	Description
Full-time equivalent staffing data element cluster	The cluster is used to describe full-time equivalent staff in establishments.
Health professional graduate trainee cluster	The cluster is used to describe the volume of health professional graduate trainees within an establishment. For the purposes of this cluster, health professional graduate trainees include any person who has graduated from a course and gained a qualification to practice as a health professional in Australia, does not qualify as a new health professional graduate, and is commencing or undertaking postgraduate training in the health professional field.
New health professional graduate cluster	The cluster is used to describe the volume of new health professional graduates within an establishment. For the purposes of this cluster, new health professional graduates include any person who has graduated from a course and gained a qualification to practice as a health professional in Australia.
Professional entry health professional student cluster	The cluster is used to describe the hours of clinical placement activity undertaken within an establishment by professional entry health professional students. For the purposes of this cluster, professional entry health professional students include any person commencing or undertaking a course in a higher education facility where the course is required for initial registration for, or qualification to, practice as a health professional in Australia.
Recurrent contracted care expenditure data element cluster	The cluster is used to describe recurrent contracted care expenditure broken down by National Health Reform Agreement (2011) product streams in establishments.
Recurrent non-salary expenditure data element cluster	The cluster is used to describe recurrent non-salary expenditure by establishments. These data elements exclude expenditure relating to salaries and wages.
Recurrent salaries and wages expenditure data element cluster	The cluster is used to describe expenditure on recurrent salaries and wages for staff in establishments.
Revenue data element cluster	The cluster is used to describe the revenue received by establishments.
Total recurrent expenditure on National Health Reform Agreement product streams data element cluster	The cluster is used to describe total recurrent expenditure broken down by National Health Reform Agreement (2011) product streams in establishments.

Table 7: Revised data element clusters

Name	Description of change
Chemotherapy for cancer cluster	Revisions made to support changes to the Cancer (clinical) DSS and the introduction of other cancer-specific DSSs.
Elective surgery waiting times cluster	Revisions made due to the Indicator procedure data element being updated
Hormone therapy for cancer cluster	Revisions made to support changes to the Cancer (clinical) DSS and the introduction of other cancer-specific DSSs.
Immunotherapy for cancer cluster	Revisions made to support changes to the Cancer (clinical) DSS and the introduction of other cancer-specific DSSs.
Radiotherapy for cancer cluster	Revisions made to support changes to the Cancer (clinical) DSS and the introduction of other cancer-specific DSSs.
Surgery for cancer cluster	Revisions made to support changes to the Cancer (clinical) DSS and the introduction of other cancer-specific DSSs.
Systemic therapy procedure for cancer cluster	Revisions made to support changes to the Cancer (clinical) DSS and the introduction of other cancer-specific DSSs.

3 National health data standards—endorsed July 2013–June 2014

This chapter presents new and revised national health data standards, endorsed by NHIPPC between July 2013 and June 2014. These metadata have been grouped into categories for data elements (alphabetised using the data element's short name), national minimum data sets, data set specifications, data element clusters, classification schemes and glossary items.

Chapter 3—Table of contents

For ease of reference, all data elements have been assigned a ▲ or ◊ symbol. The ▲ symbol denotes the data element is a new data standard, and the ◊ symbol denotes that it has been revised from a previous version. All revised data standards include hyperlinks to previous versions, located on METeOR.

Data elements listed by short name

◊ Absolute cardiovascular disease risk assessment recorded indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—absolute cardiovascular disease risk assessment recorded indicator, yes/no code N
Synonymous names:	Absolute CVD risk assessment recorded indicator
METeOR identifier:	503024
Registration status:	Health, Standard 21/11/2013
Definition:	An indicator of whether a person has had an absolute cardiovascular disease risk (CVD) assessment recorded, as represented by a code.
Data Element Concept:	Person—absolute cardiovascular disease risk assessment recorded indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A person has had an absolute cardiovascular disease risk assessment recorded.

CODE 2 No

A person has not had an absolute cardiovascular disease risk assessment recorded.

Comments:

An absolute cardiovascular disease risk assessment is the numerical probability of an event occurring within a specified period, expressed as a percentage (e.g. 5-year absolute risk of 15% means there is a 15% probability that the individual will experience a cardiovascular event within 5 years). It reflects a person's overall risk of CVD, as opposed to

the traditional method that considers various risk factors, such as high cholesterol or high blood pressure, in isolation.

An assessment of CVD risk based on multiple risk factors is more accurate than an assessment of individual risk factors due to the cumulative effect of risk factors that may be additive or synergistic. Given that an absolute risk assessment provides a more accurate assessment of risk than individual risk factors, it is reasonable to expect that basing management decisions on this assessment will improve outcomes.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Vascular Disease Prevention Alliance, 2009. Guidelines for the assessment of absolute cardiovascular disease risk. National Vascular Disease Prevention Alliance. Viewed 21 January 2013, http://www.heartfoundation.org.au/SiteCollectionDocuments/absolute-risk-assessement.pdf

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS 2014-15 Health, Standard 21/11/2013
Indigenous, Endorsed 21/11/2013

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Implementation in Indicators: **Used as numerator**
Indigenous primary health care: PI20a-Number of regular clients aged 35 years and over who have had an absolute cardiovascular disease risk assessment recorded, 2014 Health, Standard 21/11/2013
Indigenous, Endorsed 21/11/2013
Indigenous primary health care: PI20b-Proportion of regular clients aged 35 years and over who have had an absolute cardiovascular disease risk assessment recorded, 2014 Health, Standard 21/11/2013
Indigenous, Endorsed 21/11/2013

◊ Additional body function or structure of patient affected

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—additional body function or structure affected, body function or structure code N[N]
METeOR identifier:	532509
Registration status:	Health, Standard 21/11/2013
Definition:	The body function or structure of the patient alleged to have been affected, in addition to the primary body function or structure affected, as represented by a code.
Data Element Concept:	Patient—additional body function or structure affected

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Permissible values:	Value	Meaning
	1	Mental functions or structures of the nervous system
	2	Sensory functions and pain of the eye, ear and related structures
	3	Voice and speech functions or structures involved in voice and speech
	4	Functions or structures of the cardiovascular, haematological, immunological and respiratory systems
	5	Functions or structures of the digestive, metabolic and endocrine systems
	6	Genitourinary or reproductive functions and structures
	7	Neuromusculoskeletal or movement-related functions and structures
	8	Functions and structures of the skin and related structures
	9	Death
Supplementary values:	97	Not applicable
	99	Not stated/inadequately described

Collection and usage attributes

Comments:	The coding categories for this value domain are based on the chapter headings for body functions and body structures in the

Body component of the World Health Organization's International Classification of Functioning, Disability and Health (ICF 2.1a) (WHO 2003).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

CODE 1 Mental functions or structures of the nervous system

'Mental functions or structures of the nervous system' should be recorded where psychological harm was an additional rather than the primary effect on the patient.

CODE 2 Sensory functions and pain of the eye, ear and related structures

'Sensory functions and pain of the eye, ear and related structures' should be recorded where the pain experienced as a result of the incident was an additional rather than the primary effect on the patient. Where the pain experienced by the patient is deemed to be more disabling than the associated physical or mental damage to the patient, record the body structure or structures with which the pain is closely associated as an additional body function or structure affected.

CODE 4 Functions or structures of the cardiovascular, haematological, immunological and respiratory systems

'Functions or structures of the cardiovascular, haematological, immunological and respiratory systems' should be recorded where an additional effect on the patient is a cancer that has progressed and affects major body systems. In the case of cancer primarily affecting a single organ or body part, the appropriate code for that organ or body part should be recorded. This rule should also be followed for other conditions affecting major body systems.

CODE 9 Death

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

CODE 97 Not applicable

'Not applicable' is an invalid code for this data element but is a

valid response for the data element: *Patient – primary body function or structure affected, body function or structure code N[N]*.

CODE 99 Not stated/Inadequately described

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Patient—additional body function or structure affected, body function or structure code N[N] Health, Superseded 21/11/2013

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

Implementation in Data Set Specifications: Medical indemnity DSS 2014- Health, Standard 21/11/2013

Implementation start date: 01/07/2014

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

DSS specific information:
This data element relates to additional body functions or structures of the patient alleged to have been affected as a result of a health-care incident. Up to three codes may be reported for this data element.

◊ Additional clinician specialty involved in health-care incident

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health-care incident—additional clinician specialty involved in health-care incident, clinical specialties code N[N]
METeOR identifier:	532135
Registration status:	Health, Standard 21/11/2013
Definition:	The clinical specialty of the health-care provider(s) who played a role in the health-care incident that gave rise to a medical indemnity claim, in addition to the principal clinician responsible, as represented by a code.
Data Element Concept:	Health-care incident—additional clinician specialty involved in health-care incident

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
3	Cardiology
4	Cardio-thoracic surgery
5	Chiropractics
6	Clinical genetics
7	Haematology (clinical)
8	Immunology and allergy (clinical)
9	Clinical pharmacology (excluding pharmacy)
11	Cosmetic surgery
13	Dentistry
14	Dermatology
15	Diagnostic radiology
16	Otolaryngology
17	Emergency medicine
18	Endocrinology
21	Gastroenterology and hepatology
22	General medicine
23	General practice–non-procedural
24	General practice–procedural

25	General surgery
26	Geriatric medicine
27	Gynaecology only
28	Infectious diseases
29	Intensive care medicine
30	Medical oncology
31	Midwifery
32	Neurology
33	Neurosurgery
34	Neonatal or perinatal medicine
35	Nuclear medicine
36	Nursing–general
37	Nursing–nurse practitioner
38	Nutrition or dietician
39	Obstetrics and gynaecology
40	Obstetrics only
41	Occupational and environmental medicine
42	Ophthalmology
44	Orthopaedic surgery
45	Osteopathy
46	Paediatrics (general)
47	Paediatric surgery
48	Paramedical and ambulance staff
49	Pathology
50	Pharmacy (excluding clinical pharmacology)
51	Physiotherapy
52	Plastic and reconstructive surgery
53	Podiatry
54	Psychiatry
55	Psychology
56	Public health medicine
57	Rehabilitation medicine
58	Nephrology
59	Respiratory and sleep medicine
60	Rheumatology
62	Sports and exercise medicine
63	Radiation oncology (therapeutic radiology)
65	Urology
66	Vascular surgery
67	Other allied health (including complementary medicine)

	68	Other hospital-based medical practitioner
	71	Anaesthesia
	72	Maternal-fetal medicine
	73	Medical administration
	75	Oral and maxillofacial surgery
	76	Palliative medicine
	77	Urogynaecology
	78	Reproductive endocrinology and infertility
	79	Addiction medicine
	80	Paediatric emergency medicine
	81	Sexual health medicine
	82	Pain medicine
	83	Community child health
	84	Gynaecological oncology
	85	Obstetrical and gynaecological ultrasound
Supplementary values:	97	Not applicable
	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 13 Dentistry

'Dentistry' excludes oral and maxillofacial surgery.

CODE 15 Diagnostic radiology

'Diagnostic radiology' includes diagnostic ultrasound.

CODE 16 Otolaryngology

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

CODE 22 General medicine

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

CODE 25 General surgery

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

CODE 27 Gynaecology only

'Gynaecology only' includes gynaecologists who only diagnose, treat and aid in the prevention of disorders of the female reproductive system (RANZCOG 2013).

CODE 31 Midwifery

'Midwifery' includes registered midwives only.

CODE 35 Nuclear medicine

'Nuclear medicine' includes radiotherapy and radiation oncology.

CODE 36 Nursing–general

'Nursing-general' includes enrolled and registered nurses.

CODE 37 Nursing–nurse practitioner

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

CODE 39 Obstetrics and gynaecology

'Obstetrics and gynaecology' includes specialists who carry out gynaecological examinations, diagnosis and operations on women; discuss suitable contraceptive methods with referred patients; provide medical care before, during and after childbirth; deliver babies through normal procedures or by caesarean section; examine mothers and babies after childbirth to check for complications; and treat infertility by chemical or operative measures (RANZCOG 2013).

CODE 40 Obstetrics only

'Obstetrics only' includes obstetricians who only provide medical care before, during and after childbirth (RANZCOG 2013).

CODE 41 Occupational and environmental medicine

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

CODE 46 Paediatrics

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

CODE 49 Pathology

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

CODE 59 Respiratory and sleep medicine

'Respiratory and sleep medicine' includes thoracic medicine.

CODE 67 Other allied health (including complementary medicine)

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

CODE 68 Other hospital-based medical practitioners

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

CODE 71 Anaesthesia

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

CODE 82 Pain medicine

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

CODE 97 Not applicable

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

CODE 99 Not stated/inadequately described

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

Comments:

The general aim of this list is to include all categories that might be of relevance to medical indemnity claims. The medical specialties included in this value domain are taken from the List of Australian Recognised Medical Specialties, a list approved by the Minister for Health and Ageing (AMC 2013) and from the lists of clinical specialties developed by various health authorities for use in their medical indemnity data collections.

The categories of medical specialists align well between the Australian Prudential Regulation Authority (2006) National Claims and Policies Database (NCPD) and the Medical Indemnity National Collection (MINC). The NCPD specifications have separate codes for several allied health and complementary fields which are subsumed within the MINC category 'Other allied health (including complementary medicine)'. In the NCPD, 'student practitioner or intern' is a separate category. The MINC codes students based on the speciality they are training in, and classifies interns with 'Other hospital-based medical practitioners' (AIHW 2013).

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents:

AIHW (Australian Institute of Health and Welfare) 2013. Australia's medical indemnity claims 2011–12. Safety and quality of health care series no.14. Cat. no. HSE 137. Canberra: AIHW

AMC (Australian Medical Council) 2013. The List of Australian Recognised Medical Specialties. Canberra. Viewed 17 July 2013, http://www.amc.org.au/images/Recognition/AMC-list-of-specialties.pdf

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

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

RANZCOG (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists) 2013. About the specialty. Viewed 17 July 2013, http://www.ranzcog.edu.au/the-ranzcog/about-specialty.html

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

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

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Health-care incident—additional clinician specialty involved in health-care incident, clinical specialties code N[N] Health, Superseded 21/11/2013

See also Health-care incident—principal clinician specialty involved in health-care incident, clinical specialties code N[N] Health, Standard 21/11/2013

Implementation in Data Set Specifications:

Medical indemnity DSS 2014- Health, Standard 21/11/2013

Implementation start date: 01/07/2014

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

DSS specific information:
This data element relates to more than one clinician being involved in the health-care incident that gave rise to a medical indemnity claim. Up to three codes may be reported for this data element.

▲ Additional indications for caesarean section

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—additional indications for caesarean section, code NN
Synonymous names:	Reasons for caesarean section
METeOR identifier:	522168
Registration status:	Health, Standard 07/03/2014
Definition:	Additional indications for why a caesarean section is performed during a birth event, as represented by a code.
Data Element Concept:	Birth event—additional indications for caesarean section

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Fetal compromise
02	Suspected fetal macrosomia
03	Malpresentation
04	Lack of progress; less than or equal to 3 cm cervical dilatation
05	Lack of progress in the first stage; 4 cm to less than 10 cm cervical dilatation
06	Lack of progress in the second stage
07	Placenta praevia
08	Placental abruption
09	Vasa praevia
10	Antepartum/intrapartum haemorrhage
11	Multiple pregnancy
12	Unsuccessful attempt at assisted delivery
13	Unsuccessful induction
14	Cord prolapse
15	Previous caesarean section
16	Previous shoulder dystocia
17	Previous perineal trauma/4th degree tear
18	Previous adverse fetal/neonatal outcome
19	Other obstetric, medical, surgical, psychological

		indications
	20	Maternal choice in the absence of any obstetric, medical, surgical, psychological indications
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 01 Fetal compromise

This includes suspected or actual fetal compromise and intra uterine growth restriction (IUGR).

CODE 04 Lack of progress; less than or equal to 3 cm cervical dilatation

Lack of progress includes slow or no progress.

If there has been an attempted induction of labour and then a lack of progress leading to a caesarean section use Code 13 as the main indication and Code 04 as an additional indication.

CODE 05 Lack of progress in the first stage; 4 cm to less than 10 cm cervical dilatation

Lack of progress includes slow or no progress.

If there has been an attempted induction of labour and then a lack of progress leading to a caesarean section use Code 13 as the main indication and Code 05 as an additional indication.

CODE 06 Lack of progress in the second stage

Lack of progress includes slow or no progress.

CODE 07 Placenta praevia

Record placenta praevia as the indication for caesarean section if there is ultrasound or clinical evidence that the edge of the placenta covers the internal cervical os, or encroaches into the lower segment less than 2 cm away from the internal cervical os.

CODE 08 Placental abruption

Record placental abruption as the indication for caesarean section if there is ultrasound or clinical evidence antenatally of abruption of the placenta prior to onset or during labour.

CODE 09 Vasa praevia

Record vasa praevia as the indication for caesarean section if there is ultrasound or visual evidence of exposed fetal blood vessels running across the fetal membrane below or at the level of the fetal presenting part in the lower segment of the uterus. This code is to be used when the caesarean section is planned or in the case of an emergency when the vessels may have ruptured.

CODE 10 Antepartum/intrapartum haemorrhage

Record antepartum/intrapartum haemorrhage as the indication for caesarean section if there has been any antenatal or intrapartum vaginal bleeding that leads to the immediate delivery of the baby by caesarean section. This code should only be used as a main indication if a more specific cause of the antepartum/intrapartum haemorrhage is not known.

Where there is a vasa praevia and an antepartum/intrapartum haemorrhage, Code 09 is to be recorded as the main indication and Code 10 as an additional indication.

CODE 19 Other obstetric, medical, surgical,

psychological indications

Where a woman has a psychopathological indication for caesarean section, e.g. extreme fear of natural childbirth, this code should be used. It is not to be used for psychosocial indications which should be coded under Code 19.

CODE 20 Maternal choice in the absence of any obstetric, medical, surgical, psychological indications

This includes psychosocial indications.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Collection methods: Additional indications for caesarean section are conditional on there being more than one reason for which a caesarean was performed. Additional indications for caesarean section are completed after the Birth event—main indication for caesarean section, code NN has been identified. Multiple codes can be selected. Up to two additional indications can be recorded as contributing to the need for a caesarean section. However Code 20 should not be used in conjunction with any other code.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Has been superseded by Birth event—additional indication for caesarean section, code N[N] Health, Standardisation pending 22/09/2014

See also Birth event—birth method, code N Health, Standard 06/09/2006

See also Birth event—main indication for caesarean section, code NN Health, Standard 07/03/2014

Implementation in Data Set Specifications: Perinatal DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
Conditional on birth method being coded as a caesarean section. Also conditional on main indication for caesarean section being completed.

▲ Asbestos exposure indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—asbestos exposure indicator, yes/no/unknown code N
METeOR identifier:	428199
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether a person is known to have been exposed to **asbestos**, as represented by a code.
Data Element Concept:	Person—asbestos exposure 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:	8	Unknown

Data element attributes

Collection and usage attributes

Guide for use:	Record whether a person has had known exposure to **asbestos** whether primary or secondary, occupational or domestic. Primary exposure relates to direct exposure to asbestos, and secondary exposure relates to indirect contact to asbestos (for example the spouse or children of someone who worked with asbestos).
Collection methods:	This information should be sought from the patient's medical record.
Comments:	Asbestos inhalation is implicated in serious respiratory diseases such as asbestosis and pleural fibrosis. Asbestos exposure may increase the risk of lung cancer or mesothelioma and is an important risk factor for survival. It is collected for analysis of survival adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Cancer Council Victoria 2010. Victorian Consensus Data Set: Lung Cancer Data Dictionary. Version 1.0. Melbourne: Cancer Council Victoria Tim Driscoll et al. 2004. Occupational carcinogens: assessing the environmental burden of disease at national and local levels.

(Environmental Burden of Disease Series, No. 6). Geneva: World Health Organisation

Stedman TL 2006. Stedman's Medical Dictionary. 28th edition. Maryland: Lippincott Williams & Wilkins

Fauci AS et al (Editors) 2008. Harrison's Principles of Internal Medicine, 17th edition, New York: McGraw-Hill Medical

Relational attributes

Implementation in Data Set Specifications:	Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Asbestos exposure setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—asbestos exposure setting, code N
METeOR identifier:	520724
Registration status:	Health, Standard 08/05/2014
Definition:	The setting in which a person's exposure to **asbestos** is known to have occurred, as represented by a code.
Data Element Concept:	Person—asbestos exposure setting

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Occupational exposure to asbestos
2	Domestic exposure to asbestos

Supplementary values:

Value	Meaning
9	Exposure to asbestos occurred but where not stated/inadequately described

Source and reference attributes

Submitting organisation:	Cancer Australia.
Reference documents:	Cancer Council Victoria 2010. Victorian Consensus Data Set: Lung Cancer Data Dictionary. Version 1.0. Melbourne, Victoria: Cancer Council Victoria.

Data element attributes

Collection and usage attributes

Guide for use:

Record the setting in which a person's exposure to asbestos is known to have occurred.

This data element should be recorded when Person—asbestos exposure indicator, yes/no/unknown code N indicates that a person has been exposed to asbestos (equals 1).

Relational attributes

Implementation in Data Set Specifications:

Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on the person having known exposure to asbestos.

▲ Average available beds for admitted contracted care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Available bed—admitted contracted care, average number of beds N[NNN.N]
METeOR identifier:	552334
Registration status:	Health, Standard 11/04/2014
Definition:	The number of beds available to care for admitted patients that an establishment provides via contractual arrangements with private hospitals.
Data Element Concept:	Available bed—admitted contracted care

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN.N]
Maximum character length:	5
Unit of measure:	Bed

Collection and usage attributes

Guide for use:	Average available beds, rounded to the nearest decimal or whole number.

Data element attributes

Collection and usage attributes

Guide for use:	Where available, actual data should be reported. Where actual data are not available, this measure can be calculated by dividing the total contracted patient days by the number of days in the period, e.g. in a normal year, a hospital records 4000 contracted care patient days – the average available contracted care beds would be 4000/365 = 11.0.
Collection methods:	Beds exclusively or predominantly for overnight-stay admitted care and same-day admitted care are collected and reported.
Comments:	This data element is necessary to provide an indicator of the availability of admitted patient care provided under contracted care arrangements by an establishment.

Source and reference attributes

Submitting organisation:	PHE NMDS Working Group

Relational attributes

Related metadata references:

See also Establishment—data estimated indicator, yes/no code N Health, Standard 11/04/2014

Implementation in Data Set Specifications:

Local Hospital Networks DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
This data element is used in conjunction with Establishment—data estimate indicator, yes/no code N.

Public hospital establishments NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
This data element is reported in conjunction with Establishment—data estimate indicator, yes/no code N

▲ Average number of full-time equivalent staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff, average N[NNN{.N}]
METeOR identifier:	542006
Registration status:	Health, Standard 11/04/2014
Definition:	The average number of full-time equivalent staff units for staffing categories within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Relational attributes

Related metadata references:	See also Establishment—staffing categories, health code N[N] Health, Standard 11/04/2014
Implementation in Data Set Specifications:	Full-time equivalent staffing data element cluster Health, Standard 11/04/2014

▲ Basis of diagnostic investigation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—basis of diagnostic investigation, code N
METeOR identifier:	431369
Registration status:	Health, Standard 08/05/2014
Definition:	The basis of diagnostic investigation of a person with cancer at the time of first presentation, as represented by a code.
Data Element Concept:	Person with cancer—basis of diagnostic investigation

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Symptomatic
2	Asymptomatic - diagnosis incidental
3	Asymptomatic - diagnosis via opportunistic screening
4	Asymptomatic - diagnosis via organised screening
5	Asymptomatic - investigations leading to diagnosis not stated/inadequately described

Supplementary values:

8	Unknown whether patient symptomatic or asymptomatic

Collection and usage attributes

Guide for use:

CODE 1 Symptomatic

When an individual was diagnosed after seeking examination or treatment for a symptom related to the disease.

CODE 2 Asymptomatic - diagnosis incidental

The diagnosis of a disease during examinations, tests or other procedures for a purpose other than diagnosis of the specific disease.

CODE 3 Asymptomatic - diagnosis via opportunistic screening:

When the disease is diagnosed using screening tests that are offered to people who are being examined for other reasons. This is generally the detection of specific diseases that can be controlled better when detected early in their natural history in individuals or groups who may be predisposed to that disease, for example, individuals with particular risk factors.

CODE 4 Asymptomatic - diagnosis via organised screening:

The detection of unrecognised diseases or conditions in a specific population of people by using reliable tests, examinations or other

procedures which can be applied rapidly as part of an organised screening program.

CODE 5 Asymptomatic - investigations leading to diagnosis not stated/inadequately described

If the patient is described as asymptomatic, but the event that first initiated the process of investigations leading to diagnosis is unknown.

Data element attributes

Collection and usage attributes

Guide for use: Record the basis of diagnostic investigations for a person with cancer at the time of first presentation to a clinician for investigations.

Outline whether the patient was symptomatic, and if the patient was asymptomatic, record the event that first initiated the process of investigations leading to diagnosis.

Collection methods: This information should be sought from the patient's medical record.

Comments: This information is used in clinical and population health research.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Stedman TL 2006. Stedman's Medical Dictionary. 28th edition. Maryland: Lippincott Williams & Wilkins

The Royal Australian College of General Practitioners 2009. Guidelines for preventive activities in general practice (7th edition). South Melbourne: The Royal Australian College of General Practitioners

Relational attributes

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Birth plurality

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—birth plurality, code N
Synonymous names:	Multiple birth
METeOR identifier:	482409
Registration status:	Health, Standard 07/03/2014
Definition:	The number of babies resulting from a single pregnancy, as represented by a code.
Data Element Concept:	Birth event—birth plurality

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

9	Not stated

Data element attributes

Collection and usage attributes

Guide for use:	Plurality at birth is determined by the total number of live births and stillbirths that result from the pregnancy. Stillbirths, including those where the fetus was likely to have died before 20 weeks gestation, should be included in the count of plurality. To be included, they should be recognisable as a fetus and have been expelled or extracted with other products of conception when pregnancy ended at 20 or more weeks gestation.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Birth event—birth plurality, code N Health, Superseded 07/03/2014
Implementation in Data Set Specifications:	Perinatal NMDS 2014- Health, Standard 07/03/2014 *Implementation start date:* 01/07/2014 *Implementation end date:* 30/06/2015 *DSS specific information:* This item is collected for the mother only.

▲ Blood transfusion for primary PPH

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—blood transfusion due to primary postpartum haemorrhage indicator, yes/no/not stated/inadequately described code N
METeOR identifier:	522211
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a female received a blood transfusion as a result of a **primary postpartum haemorrhage**, as represented by a code.
Data Element Concept:	Female—blood transfusion due to primary postpartum haemorrhage 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:	Blood transfusion refers to the administration (including autologous blood via a cell salvage procedure), of blood, blood products or blood substitutes, but excludes volume expanders. CODE 1 Yes To be reported if the woman received a blood transfusion. CODE 2 No To be reported if a woman did not receive a blood transfusion (including cases where one is offered but refused). CODE 9 Not stated/inadequately described To be recorded by data entry personnel (state/territory health authority) if the data field is left blank or is inadequately

completed in the perinatal data collection form or extract. Clinicians should not record code 9.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references:

See also Female—estimated blood loss indicating primary postpartum haemorrhage, estimated blood loss volume category, code N Health, Standard 07/03/2014

See also Female—primary postpartum haemorrhage indicator, yes/no/not stated/inadequately described code N Health, Standard 07/03/2014

Implementation in Data Set Specifications:

Perinatal DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
Conditional on primary postpartum haemorrhage indicator being coded as yes.

Perinatal DSS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

Conditional obligation:
This data element is conditional on Female—primary postpartum haemorrhage indicator, yes/no/not stated/inadequately described code N being coded to Yes.

◊ Caesarean section at most recent previous birth indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—caesarean section at most recent previous birth indicator, code N
METeOR identifier:	422187
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a caesarean section was performed for the most recent previous pregnancy that resulted in a birth, as represented by a code.
Data Element Concept:	Female—caesarean section at most recent previous birth 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:	7	Not applicable
	9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	This item should be completed for all women who give birth. CODE 7 Not applicable This code should be applied if the woman has not had a previous pregnancy that resulted in a birth at or after 20 weeks gestation or of a baby weighing 400g or more.
Comments:	Previous caesarean sections are associated with a higher risk of complications, and when used with other Data elements provides important information on the risk of obstetric care. This item can be used to determine vaginal births occurring after a caesarean section delivery (VBAC).

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Female—caesarean section indicator (last previous birth) code N Health, Superseded 07/03/2014

Implementation in Data Set Specifications: Perinatal NMDS 2014- Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
This item is collected for the mother only.

◊ Cancer treatment type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—cancer treatment type, code N[N]
METeOR identifier:	561618
Registration status:	Health, Standard 08/05/2014
Definition:	The type of treatment administered during the course of treatment for cancer, as represented by a code.
Data Element Concept:	Cancer treatment—cancer treatment type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Surgery only
2	Radiotherapy only
3	Systemic agent therapy only
4	Surgery and radiotherapy
5	Surgery and systemic agent therapy
6	Radiotherapy and systemic agent therapy
7	Surgery, radiotherapy and systemic agent therapy

Supplementary values:

Value	Meaning
97	Not applicable—treatment was not administered
98	Unknown whether treatment was administered
99	Treatment was administered but the type was not stated/inadequately described

Collection and usage attributes

Guide for use:

More than one treatment type may be administered during a course of cancer treatment; select the appropriate code value.

Systemic agent therapy refers to:

- **chemotherapy**
- hormone therapy
- immunotherapy

Surgery includes:

- surgical procedure for cancer
- systemic therapy procedure involving surgery

A systemic therapy procedure is a medical, surgical or radiation

procedure that has an effect on the hormonal or immunologic balance of the patient.

Treatments other than surgery, radiotherapy or systemic agent therapy administered as part of the treatment are recorded separately.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer, 28E

Data element attributes

Collection and usage attributes

Guide for use: All treatments administered to the patient during the course of cancer treatment should be recorded.

When the patient has received treatment for cancer and codes 1 to 7 are recorded, the relevant treatment information for each treatment modality should also be collected.

Cancer-directed treatments administered to the patient during the course of treatment that cannot be characterised as surgery, radiotherapy or systemic therapy according to the definitions in this data set specification, are recorded separately in the data element *Cancer treatment – other cancer treatment, text [X(150)].*

Collection methods: This information should be obtained from the patient's medical record.

Comments: The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Origin: Commission on Cancer, American College of Surgeons

New South Wales Health Department

Reference documents: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Public Health Division 2001. NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1. Sydney: NSW Health Department

Relational attributes

Related metadata references: Supersedes Cancer treatment—cancer treatment type, code N[N] Health, Superseded 08/05/2014

See also Cancer treatment—other cancer treatment, text X[X(149)] Health, Standard 08/05/2014

See also Chemotherapy for cancer cluster Health, Standard 08/05/2014

See also Hormone therapy for cancer cluster Health, Standard

08/05/2014

See also Immunotherapy for cancer cluster Health, Standard 08/05/2014

See also Radiotherapy for cancer cluster Health, Standard 08/05/2014

See also Surgery for cancer cluster Health, Standard 08/05/2014

See also Systemic therapy procedure for cancer cluster Health, Standard 08/05/2014

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Standard 08/05/2014

Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is to be recorded for a patient having a first recurrence of cancer. All treatments administered to the patient during the first recurrence of cancer should be recorded.

DSS specific information:
This data element is to be recorded separately for the primary course of treatment and treatment for the first recurrence of cancer. All treatments administered to the patient as part of the primary course of treatment for the first recurrence of cancer should be recorded.

▲ Care type, derived

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—care type, (derived) code N
Synonymous names:	Care type
METeOR identifier:	548212
Registration status:	Health, Standard 07/03/2014
Definition:	A descriptor of the overall nature of care delivered during a non-admitted patient service event, derived from other service characteristics, as represented by a code.
Data Element Concept:	Non-admitted patient service event—care type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Rehabilitation care
2	Palliative care
3	Geriatric evaluation and management (GEM)
4	Psychogeriatric care
5	Mental health care
8	Other care

Collection and usage attributes

Guide for use:

CODE 1 Rehabilitation care

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating.

Rehabilitation care is always:

- delivered under the management of or informed by a clinician with specialised expertise in rehabilitation; and
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record, that includes negotiated goals within specified time frames and formal assessment of functional ability.

CODE 2 Palliative care

Palliative care is care in which the primary clinical purpose or

treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

Palliative care is always:

- delivered under the management of or informed by a clinician with specialised expertise in palliative care; and
- evidenced by an individualised multidisciplinary assessment and management plan, which is documented in the patient's medical record, that covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals.

CODE 3 Geriatric evaluation and management (GEM)

Geriatric evaluation and management is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions related to ageing, such as tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.

Geriatric evaluation and management is always:

- delivered under the management of or informed by a clinician with specialised expertise in geriatric evaluation and management; and
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.

CODE 4 Psychogeriatric care

Psychogeriatric care is care in which the primary clinical purpose or treatment goal is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance, caused by mental illness, an age-related organic brain impairment or a physical condition.

Psychogeriatric care is always:

- delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care; and
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record, that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.

Psychogeriatric care is not applicable if the primary focus of care is acute symptom control.

CODE 5 Mental health care

Mental health care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to

a patient's mental disorder.

Mental health care is:

- delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health;
- evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan; and
- may include significant psychosocial components, including family and carer support.

CODE 8 Other care

Any care provided that does not fall within the categories above, e.g. maintenance care, and acute care.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Data element attributes

Collection and usage attributes

Guide for use:

Subacute care is specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction.

Subacute care comprises the defined care types of rehabilitation, palliative care, geriatric evaluation and management (GEM) and psychogeriatric care.

A multidisciplinary management plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions and timeframes) which has been established through multidisciplinary consultation and consultation with the patient and/or carers.

Palliative care episodes can include grief and bereavement support for the family and carers of the patient where it is documented in the patient's medical record.

Collection methods:

Classification depends on an assessment of the overall nature of care provided, based on other service event characteristics collected at the jurisdiction level such as clinic type, provider type and/or referral details. The method used to derive the care type should be submitted with the dataset.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references:

Has been superseded by Non-admitted patient service event—care type, (derived) code N Health, Standardisation pending 23/09/2014

	Supersedes Non-admitted patient service event—care type, subacute (derived) code N Health, Superseded 07/03/2014
Implementation in Data Set Specifications:	Non-admitted patient DSS 2014-15 Health, Standard 07/03/2014 *Implementation start date:* 01/07/2014 *Implementation end date:* 30/06/2015

▲ Carer representation arrangements indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer representation arrangements indicator, code N
METeOR identifier:	529383
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a specialised mental health service organisation has formal **mental health carer** representation at the highest level of governance to include the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer representation arrangements 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

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Standardisation pending 23/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

▲ Cervical lymphovascular invasion location

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—location of lymphovascular invasion of cervix, code N
Synonymous names:	Cervical LVI location; LVI of cervix
METeOR identifier:	424175
Registration status:	Health, Standard 08/05/2014
Definition:	The location of cancer cells invasion into the lymphatic and/or vascular spaces for a person with cervical cancer, as represented by a code.
Context:	Invasion of lymphatic vascular space is a predictor of lymph node metastasis and recurrence. Collect this information for women with cervical cancer.
Data Element Concept:	Person with cancer—location of lymphovascular invasion

Value domain attributes

Representational attributes

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

Permissible values: / *Supplementary values:*

Value	Meaning
1	Lymphovascular invasion present and at tumour interface
2	Lymphovascular invasion present and within cervix remote from tumour interface
3	Lymphovascular invasion present (location unknown)
7	Not applicable-pathology specimen not obtained or no lymphovascular invasion present
8	Unknown whether pathology specimen obtained
9	Pathology specimen obtained but lymphovascular invasion not stated/inadequately described

Source and reference attributes

Submitting organisation:	Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use:	Record the one digit code indicating the location of lymphovascular

invasion in a woman with cervical cancer.

Collection methods: Collect from pathology reports or databases.

Source and reference attributes

Submitting organisation: Cancer Australia

Relational attributes

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is only to be recorded for patients with cervical cancer, as indicated by Person with cancer—primary site of cancer, topography code (ICD-O-3) ANN.N, and when Person with cancer—lymphovascular invasion indicator, yes/no code N indicates the presence of lymphovascular invasion.

◊ Chemotherapy completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—chemotherapy completion date, DDMMYYYY
METeOR identifier:	561215
Registration status:	Health, Standard 08/05/2014
Definition:	The completion date of **chemotherapy** administered during treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—chemotherapy completion date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Chemotherapy is cancer treatment that achieves its antitumour effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis. The completion date of chemotherapy is the date the last dose was administered during the course of treatment. The completion date of chemotherapy is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of the chemotherapy. Multiple entries are not permitted. Dates relating to targeted therapies using a chemotherapy agent are included. Targeted therapies are treatments that use drugs or other substances to identify and attack specific cancer cells. Dates of surgery, radiotherapy and other systemic treatments are collected as separate items. However, if a patient receives treatment with a protocol that includes different types of systemic therapy agents, for example, a chemotherapy agent and a hormone therapy agent, record the completion date of treatment in both relevant data items.
Collection methods:	The information should be obtained from the patient's medical record.
Comments:	Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation:	Cancer Australia
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references:	Supersedes Cancer treatment—chemotherapy completion date, DDMMYYYY Health, Superseded 08/05/2014 See also Cancer treatment—chemotherapy cycles administered, number of cycles N[NN] Health, Standard 08/05/2014 See also Cancer treatment—chemotherapy start date, DDMMYYYY Health, Standard 08/05/2014 See also Cancer treatment—systemic therapy agent or protocol, text X[X(149)] Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Chemotherapy for cancer cluster Health, Standard 08/05/2014

◊ Chemotherapy cycles administered

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—chemotherapy cycles administered, number of cycles N[NN]
METeOR identifier:	561248
Registration status:	Health, Standard 08/05/2014
Definition:	The total number of cycles of **chemotherapy** administered during the course of treatment for cancer.
Data Element Concept:	Cancer treatment—chemotherapy cycles administered

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
997	Not applicable-no chemotherapy was administered
998	Unknown whether chemotherapy was administered
999	Chemotherapy was administered but the number of cycles was not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Chemotherapy is a type of cancer treatment that achieves its antitumour effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Chemotherapy may be administered as single-agent treatment or as a combination of drugs administered according to a prespecified regimen or protocol.

The number of cycles of each course of single agent chemotherapy, regimen or protocol administered to the patient during the treatment of cancer should be recorded separately.

The number of cycles of chemotherapy received is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of the chemotherapy.

If any part of a cycle is administered but the cycle is not completed, record as one cycle.

	Oral chemotherapy normally given on an outpatient basis should also be included. The number of cycles of targeted therapies using a chemotherapy agent is included. Targeted therapies are treatments that use drugs or other substances to identify and attack specific cancer cells. If a patient receives treatment with a protocol including both a chemotherapy agent and another systemic agent such as an immunotherapy or hormone therapy agent, record the number of cycles here.
Collection methods:	This information should be collected from the patient's medical record.
Comments:	The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Cancer Institute NSW 2006. NSW Clinical Cancer Registration: Minimum Data Set Data Dictionary, version 1.9 draft

Relational attributes

Related metadata references:	See also Cancer treatment—chemotherapy completion date, DDMMYYYY Health, Standard 08/05/2014 Supersedes Cancer treatment—chemotherapy cycles administered, number of cycles N[NN] Health, Superseded 08/05/2014 See also Cancer treatment—chemotherapy start date, DDMMYYYY Health, Standard 08/05/2014 See also Cancer treatment—systemic therapy agent or protocol, text X[X(149)] Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Chemotherapy for cancer cluster Health, Standard 08/05/2014

◊ Chemotherapy start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—chemotherapy start date, DDMMYYYY
METeOR identifier:	561273
Registration status:	Health, Standard 08/05/2014
Definition:	The start date of **chemotherapy** administered during the course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—chemotherapy start date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Chemotherapy is cancer treatment that achieves its antitumour effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis. Record the first or earliest date chemotherapy was administered during the course of treatment. The start date of the chemotherapy is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of chemotherapy. Multiple entries are not permitted. Dates relating to targeted therapies using a chemotherapy agent are included. Targeted therapies are treatments that use drugs or other substances to identify and attack specific cancer cells. Dates of surgery, radiotherapy and other systemic treatments are collected as separate items. However, if a patient receives treatment with a protocol that includes different types of systemic therapy agents, for example, a chemotherapy agent and a hormone therapy agent, record the start date of treatment in both relevant data items.
Collection methods:	The information should be obtained from the patient's medical record.
Comments:	Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation:	Cancer Australia
Origin:	American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references:	See also Cancer treatment—chemotherapy completion date, DDMMYYYY Health, Standard 08/05/2014 See also Cancer treatment—chemotherapy cycles administered, number of cycles N[NN] Health, Standard 08/05/2014 Supersedes Cancer treatment—chemotherapy start date, DDMMYYYY Health, Superseded 08/05/2014 See also Cancer treatment—systemic therapy agent or protocol, text X[X(149)] Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Chemotherapy for cancer cluster Health, Standard 08/05/2014

◊ Clinical assessment only indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—clinical assessment only indicator, yes/no/unknown/not stated/inadequately described code N
Synonymous names:	Assessment only indicator
METeOR identifier:	550492
Registration status:	Health, Standard 11/04/2014
Definition:	An indicator of whether an episode of admitted patient care resulted in the patient undergoing a clinical assessment only, as represented by a code.
Data Element Concept:	Episode of admitted patient care—clinical assessment only indicator

Value domain attributes

Representational attributes

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

Permissible values: / *Supplementary values:*

Value	Meaning
1	Yes
2	No
8	Unknown
9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

An episode of care is regarded as 'assessment only' if a patient was seen for clinical assessment only and no treatment or further intervention was planned by the assessing clinical team.

CODE 1 Yes

This code is used when the patient was assessed by a clinical team but received no treatment during an episode. These episodes are usually of short duration, normally less than 3 days.

CODE 2 No

This code is used when the patient was assessed and then goes on to receive treatment.

CODE 8 Unknown

This code is used when it is unknown whether the patient was seen for assessment only.

CODE 9 Not stated/inadequately described

This code is used when it is has not been reported whether the patient was seen for assessment only.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references: Supersedes Episode of admitted patient care—clinical assessment only indicator, yes/no/unknown code N Independent Hospital Pricing Authority, Standard 31/10/2012

Implementation in Data Set Specifications: Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

Only required to be reported for episodes of admitted patient care with Hospital service—care type, code N[N] recorded as:

- Code 2, Rehabilitation care;
- Code 3, Palliative care;
- Code 4, Geriatric evaluation and management;
- Code 5, Psychogeriatric care; or
- Code 6, Maintenance care.

Not required to be reported for patients aged 16 years and under at admission.

◊ Clinical placement hours (students)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—student clinical placement hours, total hours N(7)
METeOR identifier:	534808
Registration status:	Health, Standard 07/03/2014
Definition:	The total number of student **clinical placement** hours within an establishment.
Data Element Concept:	Establishment—student clinical placement hours

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N(7)
Maximum character length:	7

Supplementary values:

Value	Meaning
9999997	Not applicable
9999998	Unknown
9999999	Not stated/inadequately described

Unit of measure:	Hour (h)

Collection and usage attributes

Guide for use:	Total hours expressed as 0000001, 0000002 etc.

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority

Data element attributes

Collection and usage attributes

Guide for use:	Where students undertake clinical placements in more than one establishment, clinical placement hours should be apportioned between establishments on the basis of hours of clinical placement in each.

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority

Relational attributes

Implementation in Data Set Specifications:	Professional entry health professional student cluster Health, Standard 07/03/2014

DSS specific information:
If a legitimate data value cannot be provided by a jurisdiction for a particular category, such an occurrence should be handled via the use of a supplementary value of 9999997.

Professional entry health professional student cluster Health, Standardisation pending 19/09/2014

DSS specific information:
If a legitimate data value cannot be provided by a jurisdiction for a particular category, such an occurrence should be handled via the use of a supplementary value of 9999997.

▲ Clinical trial entry status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—clinical trial entry status, code N
Synonymous names:	Clinical trial use
METeOR identifier:	430028
Registration status:	Health, Standard 08/05/2014
Definition:	The status of **clinical trial** acceptance for the person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—clinical trial entry status

Value domain attributes

Representational attributes

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

Permissible values: / *Supplementary values:*

Value	Meaning
1	Clinical trial entry not offered
2	Clinical trial entry offered and accepted
3	Clinical trial entry offered and declined
4	Clinical trial not available
8	Unknown whether clinical trial entry offered
9	Clinical trial entry offered but patient response not stated/inadequately described

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Royal College of Physicians of London 1999. Lung cancer: a core data set. London: Royal College of Physicians of London

Data element attributes

Collection and usage attributes

Guide for use:	Record the appropriate code number for **clinical trial** proposed or entered throughout the course of treatment for cancer. If this data item is coded as 2 Clinical trial entry offered and accepted, Person with cancer—clinical trial identification, text [X(399)] must also be completed.
Collection methods:	This information should be sought from the patient's medical record.
Comments:	A measurement of the percentage of patients entering clinical

trials may have implications for access to, and the provision of, cancer services.

The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Royal College of Physicians of London 1999. Lung cancer: a core data set. London: Royal College of Physicians of London

Stedman TL 2006. Stedman's Medical Dictionary. 28th edition. Maryland: Lippincott Williams & Wilkins

Relational attributes

Related metadata references: See also Person with cancer—clinical trial identifier, text X[X(399)] Health, Standard 08/05/2014

See also Person with cancer—date clinical trial entered, DDMMYYYY Health, Standard 08/05/2014

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Clinical trial name and number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—clinical trial identifier, text X[X(399)]
METeOR identifier:	430953
Registration status:	Health, Standard 08/05/2014
Definition:	The scientific/public title and/or registration number of the **clinical trial**(s) in which the person with cancer is enrolled, as represented by text.
Data Element Concept:	Person with cancer—clinical trial identifier

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(399)]
Maximum character length:	400

Data element attributes

Collection and usage attributes

Guide for use:	Record the scientific/public title and/or registration number of the **clinical trial**(s) in which the person with cancer is enrolled. This item is completed when a person with cancer has been offered and accepted clinical trial entry. Where available record the title in line with the Australian New Zealand Clinical Trials Register (ANZCTR) public title and universal trial number (UTN).
Collection methods:	This information should be sought from the patient's medical record.
Comments:	Information regarding the types of clinical trials patients are enrolled in may have implications for access to, and the provision of, cancer services. The collection of specific treatment information may also be useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	National Breast and Ovarian Cancer Centre 2009. Breast cancer specific data items for clinical cancer registration. Surry Hills, NSW: National Breast and Ovarian Cancer Centre

Relational attributes

Related metadata references:	See also Person with cancer—clinical trial entry status, code N Health, Standard 08/05/2014 See also Person with cancer—date clinical trial entered, DDMMYYYY Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Lung cancer (clinical) DSS Health, Standard 08/05/2014 *Conditional obligation:* Conditional on a person with cancer being accepted into a clinical trial.

▲ Closest surgical margin

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—distance of closest surgical margin, total millimetres N[N]
METeOR identifier:	430295
Registration status:	Health, Standard 08/05/2014
Definition:	The distance of the closest surgical margin from the invasive or in situ carcinoma after surgical cancer treatment, measured in millimetres.
Data Element Concept:	Cancer treatment—distance of closest surgical margin

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
97	Not applicable
98	Unknown
99	Not stated/inadequately described

Unit of measure: Millimetre (mm)

Collection and usage attributes

Guide for use: Size in millimetres with valid values from 1 to 96.

Source and reference attributes

Submitting organisation: Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use:

Surgical margins represent sites that have either been cut or bluntly dissected by the surgeon to resect the specimen.

Record the distance of the closest surgical margin to the invasive or in situ carcinoma as described in the pathology report. Where two or more margins are reported, only the closest should be recorded.

Record only for the most definitive surgical procedure performed. For instance, if a surgical procedure to remove a portion of tumour at the primary site is followed by additional surgery to remove the remainder of the tumour at that site, code

the distance of the margin for the final surgical procedure.

Record for the primary tumour site only, not for metastatic sites.

When the margin is described as positive (i.e. cancer cells come to the edge of the removed tissue) record "00".

When surgery was not performed record "97", when it is unknown whether surgery was performed record "98", and when surgery was performed but the margin was not described record "99".

Collection methods: This information should be sought from the patient's pathology report under microscopic findings.

Comments: The distance of the closest margin is useful for surgical audit and for assessing the completeness of surgical resection. Margin involvement may influence treatment decisions and is a prognostic indicator.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Royal College of Pathologists of Australasia 2010. Lung cancer structured reporting protocol. 1st Edition (Version 1.0). Surry Hills, NSW: Royal College of Pathologists of Australasia

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2011 revision. Commission on Cancer, page 211

Relational attributes

Related metadata references: See also Cancer treatment—lung cancer surgical margin qualifier, code N[N] Health, Standard 08/05/2014

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Collect when a person with cancer has undergone surgery during their initial course of cancer treatment for the purpose of removing cancer (either invasive or in situ).

▲ Colinet comorbidities

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—comorbidities, Colinet defined comorbidities code N[N]
METeOR identifier:	432994
Registration status:	Health, Standard 08/05/2014
Definition:	Diseases or conditions present at diagnosis and defined as comorbidities relevant to non-small cell lung cancer by Colinet et al 2005, as represented by a code.
Data Element Concept:	Person with cancer—comorbidities

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Cardiovascular
2	Respiratory
3	Neoplastic
4	Renal insufficiency
5	Diabetes
6	Alcoholism
7	Tobacco consumption

Supplementary values:

Value	Meaning
97	Not applicable-no comorbidities present
98	Unknown whether comorbidities are present
99	Comorbidities are present but type not stated/inadequately described

Collection and usage attributes

Guide for use:

Record each comorbid condition, as defined by the Colinet criteria, present in the patient at the time of diagnosis for lung cancer.

The criteria were developed specifically for non-small cell lung cancer where comorbidities may be an important variable in treatment decisions and prognosis, however, record each comorbid condition for all lung cancers.

Colinet criteria for comorbidities

CODE 1 Cardiovascular

Defined as the presence of one or more of the following:

- congestive heart failure,

- ischaemic cardiopathy with/without myocardial infarction,
- severe valvular cardiopathy,
- arrhythmia requiring chronic treatment,
- history of cerebrovascular disease,
- hypertension, and/or
- peripheral vascular disease

CODE 2 Respiratory

Defined as the presence of one or more of the following:

- history of tuberculosis,
- history of pleural effusion or pneumonia,
- asthma,
- pulmonary embolism,
- chronic pulmonary insufficiency (as defined by a chronic hypoxemia less than 60 mmHg, and/or
- chronic obstructive pulmonary disease (COPD) inducing a FEV1 less than 1.5l)

CODE 3 Neoplastic

Defined as a previous personal history of cancer excluding basal cell carcinoma of the skin and in situ carcinoma of the cervix.

CODE 4 Renal insufficiency

Defined as a creatinine clearance lower than 60 ml/min-.

CODE 5 Diabetes mellitus

Defined as diabetes treated with either oral hypoglycaemics or insulin.

CODE 6 Alcoholism

Defined as a daily consumption of:

- more than 80g of alcohol (8 standard drinks) for men
- more than 40g of alcohol (4 standard drinks) for women

CODE 7 Tobacco consumption

Defined as a lifelong consumption of an equivalent of at least 100 cigarettes.

Comments: The Colinet system provides criteria to define comorbidities and a scoring system whereby each comorbidity is weighted and assigned a score, then scores are added to provide the Simplified Comorbidity Score (SCS). For instance, Colinet et al. 2005 found that an SCS greater than 9 was found to be an independent prognostic factor of poor outcome in NSCLC (non-small-cell lung cancer).

For the purpose of this data item, record each comorbidity as defined by the Colinet criteria but do not score them.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Colinet, B; Jacot, W et al 2005. A new simplified comorbidity score as a prognostic factor in non-small-cell lung cancer patients: description and comparison with the Charlson's index. British Journal of Cancer 93:1098-1105

Data element attributes

Collection and usage attributes

Collection methods: This information should be sought from the patient's medical record.

Comments: Comorbidities may influence treatment decisions and patient outcomes; they may be used to adjust outcome statistics when evaluating patient survival and other outcomes.

Comorbidities are generally used with cancer patients to refer to conditions not related to the cancer, and in epidemiology to indicate the coexistence of two or more disease processes.

The presence of comorbidities in a patient may affect treatment decisions and be an important prognostic determinant. For example, they may be used to adjust outcome statistics when evaluating patient survival and other outcomes.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Colinet, B; Jacot, W et al 2005. A new simplified comorbidity score as a prognostic factor in non-small-cell lung cancer patients: description and comparison with the Charlson's index. British Journal of Cancer 93:1098-1105

Relational attributes

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Consumer representation arrangements indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer representation arrangements indicator, code N
METeOR identifier:	529103
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a specialised mental health service organisation has formal **mental health consumer** representation at the highest level of governance to include the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer representation arrangements 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

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Standardisation pending 23/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Corpus uteri lymphovascular invasion location

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—location of lymphovascular invasion of corpus uteri, code N
Synonymous names:	LVI of corpus uteri
METeOR identifier:	424445
Registration status:	Health, Standard 08/05/2014
Definition:	The location of cancer cells invasion into the lymphatic and/or vascular spaces for a person with cancer of the corpus uteri, as represented by a code.
Context:	Invasion of lymphatic vascular space is a predictor of lymph node metastasis and recurrence. Collect this item for women with cancer of the corpus uteri.
Data Element Concept:	Person with cancer—location of lymphovascular invasion

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Lymphovascular invasion present and at tumour interface
2	Lymphovascular invasion present and within the myometrium remote to the tumour interface
3	Lymphovascular invasion present (location unknown)

Supplementary values:

Value	Meaning
7	Not applicable-pathology specimen not obtained or no lymphovascular invasion present
8	Unknown whether pathology specimen obtained
9	Pathology specimen obtained but lymphovascular invasion not stated/inadequately described

Source and reference attributes

Submitting organisation:	Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use:	Record the 1 digit code indicating the location of lymphovascular

invasion of neoplastic (cancer) cells. Lymphovascular invasion of neoplastic cells, both at the interface of the tumour, with the normal myometrium and more distantly, relates partly to tumour invasive depth and partly to tumour type.

Collection methods: Collect from pathology reports or databases.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: RCPA (2011), Endometrial Cancer Structured Reporting Protocol (1st Edition 2011)

Relational attributes

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is only to be recorded for patients with endometrial cancer, as indicated by Person with cancer—primary site of cancer, topography code (ICD-O-3) ANN.N, and when Person with cancer—lymphovascular invasion indicator, yes/no code N indicates the presence of lymphovascular invasion.

▲ Cytopathology result

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—cytopathology result, code N
Synonymous names:	Cytology result
METeOR identifier:	422463
Registration status:	Health, Standard 08/05/2014
Definition:	The result of a cytopathology test to verify cancer diagnosis and morphology in a person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—cytopathology result

Value domain attributes

Representational attributes

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

Permissible values: / *Supplementary values:*

Value	Meaning
1	Positive
2	Negative
3	Equivocal
7	Not applicable
9	Not available

Collection and usage attributes

Guide for use:

CODE 1 Positive

A positive result indicates that the cellular abnormality tested for was found. In the case of cancer diagnosis, a positive result indicates malignancy.

CODE 2 Negative

A negative result indicates that the cellular abnormality tested for was not found.

CODE 3 Equivocal

This code should be recorded when the cellular abnormality status could not be determined by the test.

CODE 9 Not available

This code should be recorded when the test results have not been received or could not be accessed.

Source and reference attributes

Submitting organisation:	Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use:	Record the code specifying the positivity or negativity of cytology or cytopathology test results as outlined in the pathology report. Where multiple tests have been undertaken record each test result separately. A negative result indicates that no abnormal cells were found in the sample tested. A positive result indicates that there were abnormal cells found in the sample tested. This includes results of peritoneal washings.
Collection methods:	Collected for people with cancer who have undergone a cytology or cytopathology test to help define the proportion of cancer morphologically verified.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Gynaecological Cancer DSS Working Group, Cancer Australia. 2010

Relational attributes

Implementation in Data Set Specifications:	Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

▲ Date clinical trial entered

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—date clinical trial entered, DDMMYYYY
METeOR identifier:	447247
Registration status:	Health, Standard 08/05/2014
Definition:	The date on which a person with cancer registers for a **clinical trial**, expressed as DDMMYYYY.
Data Element Concept:	Person with cancer—date clinical trial entered

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Record the date when the patient registers for a **clinical trial** for the treatment of cancer. This refers to the date in which they sign and submit required consent forms. A patient may be offered entry into a clinical trial at any time during the course of illness; record the date for each trial the patient entered.
Collection methods:	This information should be sought from the patient's medical record.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Royal College of Physicians of London 1999. Lung cancer: a core data set. London: Royal College of Physicians of London Stedman TL 2006. Stedman's Medical Dictionary. 28th edition. Maryland: Lippincott Williams & Wilkins

Relational attributes

Related metadata references:	See also Person with cancer—clinical trial entry status, code N Health, Standard 08/05/2014 See also Person with cancer—clinical trial identifier, text X[X(399)] Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Date of referral to palliative care services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—date of referral to palliative care services, DDMMYYYY
Synonymous names:	Supportive care; Symptomatic care
METeOR identifier:	447391
Registration status:	Health, Standard 08/05/2014
Definition:	The date on which a person with cancer was referred to **palliative care** services, expressed as DDMMYYYY.
Data Element Concept:	Person with cancer—date of referral to palliative care services

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Record the date on which a person with cancer was referred to **palliative care** services. Referral to palliative care will generally come from a person with cancer's primary treatment clinician or GP. If the patient is receiving palliative care but no referral date can be identified, record the date of the first account of receipt of palliative care as the date of referral. Referral to palliative care services is referral to palliative care administered by palliative care specialists such as a palliative care team or palliative physician. Palliative care may be administered in a community setting, for example, the patient's home or a nursing home, in the palliative care unit of an acute hospital, or a hospice. The date of referral must be: • greater than or equal to the date of diagnosis; • greater than the date of birth; and • less than or equal to the date of death.
Collection methods:	This information should be sought from the patient's medical record.
Comments:	This information is used to evaluate the quality of care for patients with cancer, and may have implications for access to,

and the provision of, cancer services.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: National Breast and Ovarian Cancer Centre (NBOCC) and National Cancer Control Initiative (NCCI) 2003. Clinical practice guidelines for the psychosocial care of adults with cancer. Camperdown, NSW: National Breast and Ovarian Cancer Centre & National Cancer Control Initiative

Cancer Institute NSW 2006. NSW clinical cancer registration: minimum data set data dictionary, Version 1.9. Everleigh: Cancer Institute NSW

Relational attributes

Related metadata references: See also Person with cancer—referral to palliative care services indicator, yes/no/unknown code N Health, Standard 08/05/2014

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on patient referral to palliative care services.

▲ Date of referral to psychosocial services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—date of referral to psychosocial services, DDMMYYYY
METeOR identifier:	448664
Registration status:	Health, Standard 08/05/2014
Definition:	The date on which a person with cancer is referred to **psychosocial services**, expressed as DDMMYYYY.
Data Element Concept:	Person with cancer—date of referral to psychosocial services

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Record the date the patient was first referred to psychosocial services.

If the patient is receiving psychosocial care but no referral date can be identified, record the date of the first account of receipt of psychosocial care as the date of referral.

Psychosocial services provide emotional and social support for patients and may, for example:

- provide information
- minimise the social and psychological impact of cancer on the patient and their family
- integrate quality-of-life issues into the care of patients with cancer
- develop strategies for the identification and management of patients experiencing significant emotional distress

Psychosocial care may be provided by the following individuals, programs or services:

- Psychiatrist
- Psychologist
- Social worker
- Specialist nurse or nurse counsellor
- Cancer or volunteer support group
- Individual peer support

- Counsellor or bereavement counsellor
- Pastoral care (refers to counselling provided by pastors, chaplains, clergy and other religious leaders or spiritual advisors)
- Community services

The opportunity to access psychosocial services may be limited for some patients by local circumstances and the availability of resources such as access to psychiatrists, clinical psychologists or specialist oncology nurses.

Collection methods: This information should be sought from the patient's medical record.

Comments: This information is used to evaluate the quality of psychosocial care for patients with cancer, and may have implications for access to, and the provision of, cancer services.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: National Breast and Ovarian Cancer Centre and National Cancer Control Initiative 2003. Clinical practice guidelines for the psychosocial care of adults with cancer. Camperdown, NSW: National Breast and Ovarian Cancer Centre

Cancer Institute NSW 2006. NSW clinical cancer registration: minimum data set data dictionary, version 1.9. Sydney: Cancer Institute NSW

Relational attributes

Related metadata references: See also Person with cancer—psychosocial services type, code N[N] Health, Standard 08/05/2014

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on patient referral to psychosocial services.

▲ Delay in primary course of chemotherapy indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—primary course of chemotherapy delay indicator, yes/no/unknown code N
METeOR identifier:	542950
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether the primary course of **chemotherapy** for cancer treatment has been delayed, as represented by a code.
Data Element Concept:	Cancer treatment—primary course of chemotherapy delay 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:	8	Unknown

Data element attributes

Collection and usage attributes

Guide for use:	Record if the planned course of primary chemotherapy has been delayed.
Collection methods:	Collect from patient medical records. Record for a person undergoing chemotherapy as part of their cancer treatment.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Cancer Australia Working Group, 2010.

Relational attributes

Implementation in Data Set Specifications:	Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014 *Conditional obligation:* This data element is to be recorded for patients who have undergone chemotherapy as part of their cancer treatment.

▲ Depth of cervical cancer invasion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—depth of cervical cancer invasion, total millimetres N[N]
METeOR identifier:	424275
Registration status:	Health, Standard 08/05/2014
Definition:	The depth of invasion of a cervical cancer tumour into the cervical wall for a person with cervical cancer, expressed in millimetres.
Data Element Concept:	Person with cancer—depth of cervical cancer invasion

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
97	Not applicable
98	Unknown
99	Not stated/inadequately described

Unit of measure: Millimetre (mm)

Collection and usage attributes

Guide for use: Size in millimetres with valid values from 1 to 96.

Source and reference attributes

Submitting organisation: Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use: Record the depth of invasion of cervical cancer into the cervical wall in millimetres (mm), where available from a pathology report. The depth of cervical wall invasion ranges from 0 to 30 mm.

The depth of tumour invasion is an important prognostic indicator for cervical cancer. All macroscopically visible lesions, even with superficial invasion, are allocated to Stage Ib carcinomas.

Collection methods: Collect from pathology reports or databases.

Source and reference attributes

Submitting organisation: The Australian e-Health Research Centre/CSIRO

Reference documents:

Pecorelli S 2003. 25th Annual Report on the Results of Treatment in Gynecological Cancer. International Journal of Gynecology & Obstetrics 83(Supp 1): 1-230

Bertrand M Lickrish GM, Colgan TJ 1987. The anatomic distribution of cervical adenocarcinoma in situ: Implications for the treatment. American Journal of Obstetrics & Gynecology 157: 21-28

Wei J 2009. Pathology of Cervical Carcinoma. Global library of women's medicine.

Relational attributes

Implementation in Data Set Specifications:

Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is only to be recorded for patients with cervical cancer, as indicated by Person with cancer—primary site of cancer, topography code (ICD-O-3) ANN.N.

▲ Depth of myometrial invasion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—depth of myometrial invasion, total millimetres N[N]
Synonymous names:	Depth of myometrial involvement
METeOR identifier:	545243
Registration status:	Health, Standard 08/05/2014
Definition:	The depth of tumour invasion into the myometrium for a person with endometrial cancer, expressed in millimetres.
Data Element Concept:	Person with cancer—depth of myometrial invasion

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
97	Not applicable
98	Unknown
99	Not stated/inadequately described

Unit of measure: Millimetre (mm)

Collection and usage attributes

Guide for use: Size in millimetres with valid values from 1 to 96.

Source and reference attributes

Submitting organisation: Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use: Record the depth of myometrial invasion in millimetres (mm).

The depth of myometrial invasion is assessed on microscopic examination and is measured from the normal endometrium-myometrium interface (not the surface of the intracavity or exophytic tumour) to the deepest tumour infiltrative focus. The depth of myometrial invasion cannot exceed the myometrial thickness. Myometrial thickness ranges from 2 to 40 mm. A myometrial thickness of 5 mm or less is considered to be normal.

Depth of myometrial invasion is a prognostic factor for endometrial cancer. The fractional myometrial invasion by

tumour cells, i.e. the ratio of myometrial invasive depth to total normal myometrial thickness, is predictive of lymph node metastases in high risk endometrial cancers.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents:

Hauth EA, Jaeger HJ, Libera H, Lange S, Forsting M 2007. MR imaging of the uterus and cervix in healthy women: determination of normal values. European Radiology 17:734

O'Connell LO, Fries MH, Zeringue E, Brehm W 1998. Triage of Abnormal Postmenopausal Bleeding: A comparison of endometrial biopsy and transvaginal sonohysterography versus fractional curettage with hysteroscopy. American Journal of Obstetrics & Gynecology 178:956-61

RCPA 2011. Endometrial Cancer Structured Reporting Protocol (1st Edition 2011). Sydney: Royal College of Pathologists of Australasia

Weber AM, Belinson JL, Bradley LD, Piedmonte MR 1997. Vaginal ultrasonography versus endometrial biopsy in women with postmenopausal bleeding. American Journal of Obstetrics & Gynecology 177:924-9

Relational attributes

Related metadata references: See also Person with cancer—myometrial thickness, total millimetres N[N] Health, Standard 08/05/2014

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is only to be recorded for patients with endometrial cancer, as indicated by Person with cancer—primary site of cancer, topography code (ICD-O-3) ANN.N.

▲ Diabetes during pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—diabetes mellitus during pregnancy indicator, yes/no/not stated/inadequately described code N
METeOR identifier:	504291
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a female has diabetes mellitus during pregnancy, based on a current or previous diagnosis, as represented by a code.
Data Element Concept:	Female—diabetes mellitus during pregnancy 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

To be reported if the woman has pre-existing, **gestational** or other diabetes during this pregnancy.

CODE 2 No

To be reported if the woman does not have any form of diabetes during this pregnancy.

CODE 9 Not stated/inadequately described

To be recorded by data entry personnel (state/territory health authority) if the data field is left blank or is inadequately completed in the perinatal data collection form or extract. Clinicians should not record code 9.

Collection methods:

The diagnosis is preferably derived from, and substantiated by clinical documentation, which would be reviewed at the time of

delivery. However, this information may not be available, in which case the patient may self-report to the clinician that they have been diagnosed with diabetes mellitus.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also Female—type of diabetes mellitus during pregnancy, code N Health, Standard 07/03/2014

See also Female—type of diabetes mellitus therapy during pregnancy, code N Health, Standard 07/03/2014

Implementation in Data Set Specifications: Perinatal DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
It is acceptable for jurisdictions to report only Codes 1 and 9 against this item.

Perinatal DSS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

DSS specific information:
It is acceptable for jurisdictions to report only Code 1, Yes and Code 9, Not stated/inadequately described against this item.

▲ Diabetes mellitus type during pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—type of diabetes mellitus during pregnancy, code N
METeOR identifier:	516668
Registration status:	Health, Standard 07/03/2014
Definition:	The type of diabetes mellitus a female has during pregnancy, based on a current or previous diagnosis, as represented by a code.
Data Element Concept:	Female—type of diabetes mellitus during pregnancy

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Pre-existing Type 1 diabetes
2	Pre-existing Type 2 diabetes
3	Gestational diabetes mellitus (GDM)
8	Other type of diabetes mellitus
9	Not stated/inadequately described

Supplementary values:

Collection and usage attributes

Guide for use:

Note that where there is a Gestational diabetes mellitus (GDM) and a current history of Pre-existing Type 2 diabetes then record Code 2 Pre-existing Type 2 diabetes.

While most women will know what type of diabetes they have, where their type of diabetes is unknown the clinician should leave the collection form/system blank. This will be coded as a '9' by the data custodian.

CODE 1 Pre-existing Type 1 diabetes

Beta-cell destruction, usually leading to absolute insulin deficiency. Includes those cases attributed to an autoimmune process, as well as those with beta-cell destruction and who are prone to ketoacidosis for which neither an aetiology nor pathogenesis is known (idiopathic). It does not include those forms of beta-cell destruction or failure to which specific causes can be assigned (e.g. cystic fibrosis, mitochondrial defects). Some subjects with Type 1 diabetes can be identified at earlier clinical stages than 'diabetes mellitus'.

CODE 2 Pre-existing Type 2 diabetes

Type 2 includes the common major form of diabetes, which

results from defect(s) in insulin secretion, almost always with a major contribution from insulin resistance.

CODE 3 Gestational diabetes mellitus (GDM)

GDM is a carbohydrate intolerance resulting in hyperglycaemia of variable severity with onset or first recognition during pregnancy. The definition applies irrespective of whether or not insulin is used for treatment or if the condition persists after pregnancy.

Diagnosis is to be based on the Australian Diabetes in Pregnancy Society (ADIPS) Guidelines. If the clinician does not have information as to whether these guidelines have been used, available information about diagnosis of GDM is still to be reported.

CODE 8 Other type of diabetes mellitus

This categorisation include less common causes of diabetes mellitus, but are those in which the underlying defect or disease process can be identified in a relatively specific manner. They include, for example, genetic defects of beta-cell function, genetic defects in insulin action, diseases of the exocrine pancreas, endocrinopathies, drug or chemical-induced, infections, uncommon forms of immune-mediated diabetes, other genetic syndromes sometimes associated with diabetes. Impaired glucose regulation is not to be included here.

CODE 9 Not stated/inadequately described

To be recorded by data entry personnel (state/territory health authority) if the data field is left blank or is inadequately completed in the perinatal data collection form or extract. Clinicians should not record Code 9.

Source and reference attributes

Origin: Nankervis A, McIntyre HD, Moses R, Ross GP, Callaway L, Porter C et al. 2013. Australasian Diabetes In Pregnancy Society (ADIPS) Consensus Guidelines for the Testing and Diagnosis of Gestational Diabetes Mellitus in Australia. Australasian Diabetes In Pregnancy Society (ADIPS).

Data element attributes

Collection and usage attributes

Collection methods: The diagnosis is preferably derived from, and substantiated by, clinical documentation which should be reviewed at the time of delivery. However, this information may not be available, in which case the patient may self-report to the clinician that they have been diagnosed with a particular type of diabetes mellitus.

Jurisdictions that record perinatal data using the ICD-10-AM should apply the following codes:

'Code 1 Pre-existing Type 1 diabetes' is equivalent to O24.0 in the ICD-10-AM

'Code 2 Pre-existing Type 2 diabetes' is equivalent to O24.1 in the ICD-10-AM

'Code 3 Gestational diabetes mellitus (GDM)' is equivalent to O24.4 in the ICD-10-AM

'Code 8 Other type of diabetes mellitus' is equivalent to O24.2 in the ICD-10-AM

See also related data element Female—type of diabetes therapy in pregnancy, code NN where the following fifth character subdivisions are for use with categories O24.1–O24.9:

- 2 Insulin treated
- 3 Oral hypoglycaemic therapy
- 4 Other: diet, exercise, lifestyle management
- 9 Unspecified.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Reference documents: National Casemix and Classification Centre 2013. The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM), Australian Classification of Health Interventions (ACHI) and Australian Coding Standards (ACS), Eighth edition. National Casemix and Classification Centre, Australian Health Services Research Institute: University of Wollongong

Relational attributes

Related metadata references: See also Female—diabetes mellitus during pregnancy indicator, yes/no/not stated/inadequately described code N Health, Standard 07/03/2014

See also Female—type of diabetes mellitus therapy during pregnancy, code N Health, Standard 07/03/2014

Implementation in Data Set Specifications: Perinatal DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
Conditional on diabetes mellitus during pregnancy indicator being coded as yes.

Perinatal DSS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

Conditional obligation:
This data element is conditional on Female—diabetes mellitus during pregnancy indicator, yes/no/not stated/inadequately described code N being coded to Yes.

▲ Diabetes therapy type during pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—type of diabetes mellitus therapy during pregnancy, code N
METeOR identifier:	516185
Registration status:	Health, Standard 07/03/2014
Definition:	The type of diabetes mellitus treatment which a female is prescribed during pregnancy, as represented by a code.
Data Element Concept:	Female—type of diabetes mellitus therapy during pregnancy

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Insulin
2	Oral hypoglycaemic
3	Diet and exercise

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

All therapies prescribed during pregnancy should be recorded. Therefore more than one code can be selected when reporting this item.

CODE 1 Insulin

CODE 2 Oral hypoglycaemic

This code includes the options of sulphonylurea, biguanide (e.g. metformin), alpha-glucosidase inhibitor, thiazolidinedione, meglitinide, combination (e.g. biguanide & sulphonylurea), or other.

CODE 3 Diet and exercise

This code includes the options of generalised prescribed diet; avoid added sugar/simple carbohydrates (CHOs); low joule diet; portion exchange diet and uses glycaemic index and a recommendation for increased exercise.

CODE 9 Not stated/inadequately described

To be recorded by data entry personnel (state/territory health authority) if the data field is left blank or is inadequately completed in the perinatal data collection form or extract. Clinicians should not record Code 9.

Data element attributes

Collection and usage attributes

Collection methods:

Jurisdictions that record perinatal data using the ICD-10-AM should apply the following codes:

'Code 1 Insulin' is equivalent in the ICD-10-AM to a code in the range O24.1–24.9 used in conjunction with the fifth character '2' (insulin treated).

'Code 2 Oral hypoglycaemic' is equivalent in the ICD-10-AM to a code in the range O24.1–24.9 used in conjunction with the fifth character '3' (oral hypoglycaemic therapy).

'Code 3 Diet and exercise' is equivalent in the ICD-10-AM to a code in the range O24.1–24.9 used in conjunction with the fifth character '4' (other; diet; exercise; lifestyle management).

For example, for a mother who has pre-existing Type 2 diabetes mellitus and uses oral hypoglycaemic therapy and insulin, this would be coded in the ICD-10-AM as O2412 and O2413 and would be reported against this data item using Codes 1 and 2.

Source and reference attributes

Reference documents:

National Casemix and Classification Centre 2013. The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM), Australian Classification of Health Interventions (ACHI) and Australian Coding Standards (ACS), Eighth edition. National Casemix and Classification Centre, Australian Health Services Research Institute: University of Wollongong

Relational attributes

Related metadata references:

See also Female—diabetes mellitus during pregnancy indicator, yes/no/not stated/inadequately described code N Health, Standard 07/03/2014

See also Female—type of diabetes mellitus during pregnancy, code N Health, Standard 07/03/2014

See also Person—diabetes therapy type, code NN Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Perinatal DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
Conditional on diabetes mellitus during pregnancy indicator being coded as yes.

Perinatal DSS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

Conditional obligation:
This data element is conditional on Female—diabetes

mellitus during pregnancy indicator, yes/no/not stated/inadequately described code N being coded to Yes.

▲ Diagnostic imaging type (lung cancer)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—diagnostic imaging type, lung cancer code N[N]
METeOR identifier:	431754
Registration status:	Health, Standard 08/05/2014
Definition:	The type of **medical imaging** performed to confirm the diagnosis and determine the stage of lung cancer, as represented by a code.
Data Element Concept:	Person—diagnostic imaging type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Chest x-ray (spiral)
2	Computed tomography (CT) abdomen/upper abdomen
3	CT adrenals
4	CT brain
5	CT chest
6	CT liver
7	CT mediastinal nodes
8	CT pelvis
9	Magnetic resonance imaging (MRI) brain
10	MRI chest
11	Positron emission tomography (PET) scan
12	Radioisotope bone scan
13	Ultrasound chest
14	Ventilation/perfusion scan
88	Other

Supplementary values:

Value	Meaning
97	Not applicable-imaging not performed
98	Unknown whether imaging performed
99	Imaging performed but type not stated/inadequately described

Collection and usage attributes

Guide for use: Record the code for each diagnostic imaging modality performed to confirm

the diagnosis and determine the stage of lung cancer.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: The NHS Information Centre, National Health Service (UK) 11 August 2003. Cancer data manual-lung cancer appendix version 4. Viewed 22 February 2011, http://www.ic.nhs.uk/webfiles/Services/Datasets/cANCER/applung.doc

Data element attributes

Collection and usage attributes

Guide for use: Record the types of **medical imaging** performed to confirm the diagnosis and determine the stage of lung cancer. This item may be recorded multiple times where multiple types of imaging were used for diagnostic purposes.

Collection methods: This information should be sought from the patient's medical record.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: The NHS Information Centre, National Health Service (UK) 11 August 2003. Cancer data manual-lung cancer appendix, version 4. Viewed 22 February 2011, http://www.ic.nhs.uk/webfiles/Services/Datasets/cANCER/applung.doc

The Free Dictionary 2003. McGraw-Hill Dictionary of Scientific & Technical Terms, 6th edition. The McGraw-Hill Companies, Inc. Viewed 15 August 2011, http://encyclopedia2.thefreedictionary.com/medical+imaging

Relational attributes

Related metadata references: See also Person—lung cancer diagnostic procedure type, code N[N] Health, Standard 08/05/2014

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Diagnostic procedure type (lung cancer)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—lung cancer diagnostic procedure type, code N[N]
Synonymous names:	Investigations
METeOR identifier:	431734
Registration status:	Health, Standard 08/05/2014
Definition:	The type of medical procedure performed to confirm the diagnosis and determine the stage of lung cancer, as represented by a code.
Data Element Concept:	Person—diagnostic procedure type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Biopsy-bone marrow
2	Biopsy-liver
3	Biopsy-mediastinal lymph node
4	Biopsy-pleural (closed)
5	Biopsy-pleural (open)
6	Biopsy-skin
7	Biopsy-supraclavicular/cervical lymph nodes
8	Biopsy-thorascopic (endoscopic) pleural biopsy
9	Biopsy-video-assisted thorascopic surgical (VATS) lung biopsy
10	Bronchoscopy (fibreoptic)
11	Bronchoscopy (rigid)
12	Bronchoscopic washings/brushing/biopsy
13	Endobronchial ultrasound (EBUS)
14	EBUS guided transbronchial lung biopsy (TBBx)
15	EBUS guided transbronchial needle aspiration (TBNA)
16	EUS guided transoesophageal FNA
17	Fine needle aspirate (FNA)-computed tomography (CT) guided
18	Mediastinoscopy/mediastinotomy
19	Pleural aspirate

	20	Sputum cytology
	21	Thoracoscopy
	22	Thoracotomy
	88	Other
Supplementary values:	97	Not applicable-diagnostic procedure not performed
	98	Unknown whether diagnostic procedure performed
	99	Diagnostic procedure performed but type not stated/inadequately described

Collection and usage attributes

Guide for use: Record the code for each diagnostic procedure performed for the diagnosis and staging of lung cancer.

Source and reference attributes

Submitting organisation: Cancer Australia.

Reference documents: The NHS Information Centre, National Health Service (UK) 11 August 2003. Cancer data manual-lung cancer appendix version 4. Viewed 22 February 2011, http://www.ic.nhs.uk/webfiles/Services/Datasets/cANCER/applung.doc

Data element attributes

Collection and usage attributes

Guide for use: Record the type of medical procedures performed to confirm the diagnosis and determine the stage of lung cancer. This includes different forms of tissue biopsy and internal examinations and excludes medical imaging.

Where applicable this item can be recorded multiple times.

Collection methods: This information should be sought from the patient's medical record.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: The NHS Information Centre, National Health Service (UK) 11 August 2003. Cancer data manual-lung cancer appendix version 4. Viewed 22 February 2011, http://www.ic.nhs.uk/webfiles/Services/Datasets/cANCER/applung.doc

Relational attributes

Related metadata references: See also Person—diagnostic imaging type, lung cancer code N[N] Health, Standard 08/05/2014

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Distant metastatic site

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—distant metastatic site(s) at diagnosis, code N[N]
METeOR identifier:	424239
Registration status:	Health, Standard 08/05/2014
Definition:	The anatomical position (topography) of the secondary or distant metastatic site(s) identified in the person with cancer at diagnosis, as represented by a code.
Data Element Concept:	Person with cancer—distant metastatic site(s) at diagnosis

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Lung
2	Liver
3	Bowel
4	Bone
5	Brain
88	Other

Supplementary values:

Value	Meaning
99	Metastatic spread indicated but site not stated/inadequately described

Collection and usage attributes

Guide for use: This code set represents common sites of cancer metastasis. Where multiple sites occur, all should be recorded.

Source and reference attributes

Reference documents:

Pecorelli, S. 25th Annual Report on the Results of Treatment in Gynecological Cancer. International Journal of Gynecology & Obstetrics 2003, 83 (Supp 1): 1-230

Endometrial Cancer Structured Reporting Protocol (1st Edition 2010) © RCPA 2010

The new FIGO staging system for cancers of the vulva, cervix, endometrium and sarcomas; Gynecologic Oncology 115 (2009) 325–328

Data element attributes

Collection and usage attributes

Guide for use: Record sites of metastases. Where multiple sites occur, all should be recorded.

Collection methods: Collect from patient medical records.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Pecorelli, S. 25th Annual Report on the Results of Treatment in Gynecological Cancer. International Journal of Gynecology & Obstetrics 2003, 83 (Supp 1): 1-230.
RCPA (2011). Endometrial Cancer Structured Reporting Protocol (1st Edition 2011)
Mutch, D G (2009). The new FIGO staging system for cancers of the vulva, cervix, endometrium and sarcomas. Gynecologic Oncology. 115: 325–328

Relational attributes

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is to be completed if Person with cancer—distant metastatic cancer indicator, yes/no/not stated/inadequately described code N indicates the presence of metastatic cancer.

▲ Distant metastatic site indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—distant metastatic cancer indicator, yes/no/not stated/inadequately described code N
METeOR identifier:	545189
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether a primary cancer has spread to a distant site in the person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—distant metastatic cancer 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:	Record whether a primary cancer has spread to a distant site or sites. This may be determined through diagnostic or other imaging or procedures. What is determined as a distant site will vary depending on the primary cancer type.
Collection methods:	Collect from patient medical records.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Pecorelli, S. 25th Annual Report on the Results of Treatment in Gynecological Cancer. International Journal of Gynecology & Obstetrics 2003, 83 (Supp 1): 1-230. RCPA (2011). Endometrial Cancer Structured Reporting Protocol (1st Edition 2011)

Mutch, D G (2009). The new FIGO staging system for cancers of the vulva, cervix, endometrium and sarcomas. Gynecologic Oncology. 115: 325–328

Relational attributes

Implementation in Data Set Specifications:	Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

▲ Distant metastatic site(s)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—distant metastatic site(s) at diagnosis, topography code (ICD-O-3) ANN.N
METeOR identifier:	433232
Registration status:	Health, Standard 08/05/2014
Definition:	The anatomical position (topography) of the secondary or distant metastatic site(s) identified in the person with cancer at the time of diagnosis of cancer, as represented by a code.
Data Element Concept:	Person with cancer—distant metastatic site(s) at diagnosis

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	String
Format:	ANN.N
Maximum character length:	5

Collection and usage attributes

Guide for use:	Record all four alphanumeric characters of the topography code. The number after the decimal point represents the subsite or subcategory.

Data element attributes

Collection and usage attributes

Guide for use:	Record all distant metastatic site(s) identified at the time of diagnosis of the cancer. Site refers to the anatomical position of the distant metastatic disease. Use the latest edition of the *AJCC Cancer Staging Manual* or *UICC TNM Classification of Malignant Tumours* to distinguish between regional involvement and distant metastatic sites. Cases with sites of distant metastasis would be coded M1. Do not code sites of regional or local metastasis as defined in the "T" field. Do not update this record with the sites of distant metastasis diagnosed subsequent to the initial diagnosis.
Collection methods:	This information should be sought from the patient's medical record.
Comments:	The presence of distant metastatic disease at diagnosis is an independent prognostic indicator and may influence treatment decisions.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Implementation in Data Set Specifications:	Lung cancer (clinical) DSS Health, Standard 08/05/2014 *Conditional obligation:* Conditional on the identification of distant metastasis at the time of diagnosis of cancer.

▲ ECOG score

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—performance status score at diagnosis, Eastern Cooperative Oncology Group code N
Synonymous names:	Zubrod score; WHO performance status score
METeOR identifier:	412327
Registration status:	Health, Standard 08/05/2014
Definition:	A score given at the time of diagnosis outlining the extent to which a person with cancer's disease affects their daily living abilities, as represented by a code.
Data Element Concept:	Person with cancer—performance status score at diagnosis

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
0	Fully active, able to carry on all pre-disease performance without restriction.
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours.
3	Capable of only limited selfcare, confined to bed or chair more than 50% of working hours.
4	Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair.

Supplementary values:

8	Unknown
9	Not stated

Collection and usage attributes

Guide for use:	The criteria was developed by the Eastern Cooperative Oncology Group (ECOG).

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Oken MM et al. 1982. Toxicity and response criteria of the Eastern Cooperative Oncology Group. Am J Clin Oncol 5:649-655

Data element attributes

Collection and usage attributes

Guide for use:

The Eastern Cooperative Oncology Group (ECOG) performance score was developed to consistently assess the impact of a person's disease on their daily living abilities.

Record the ECOG performance status score recorded at diagnosis and before the implementation of treatment.

Performance status should be based on assessment by a clinician at the time of initial presentation.

Only record performance status when expressed as an ECOG score by the clinician; do not attempt to determine the ECOG score from patient notes.

Collection methods:

This information should be obtained from the patient's medical record at the time of diagnosis. It may be available in the admission notes, outpatient notes or referral letters.

Comments:

Performance status at diagnosis is an important prognostic indicator and is used to determine appropriate treatment, assess how the disease is progressing, and for the statistical analyses of outcome adjusted by performance status.

Previous attempts to collect this information has revealed that ECOG scores are not routinely recorded at the time of diagnosis. However, performance status is an important prognostic indicator and used to determine and evaluate treatment decisions so recording the ECOG score in patient notes at the time of diagnosis is strongly recommended.

Source and reference attributes

Submitting organisation:

Cancer Australia

Reference documents:

Oken MM et al. 1982. Toxicity and response criteria of the Eastern Cooperative Oncology Group. Am J Clin Oncol 5:649-655

National Cancer Control Initiative 2004. NCCI Clinical Cancer Core Data Set and Data Dictionary, Version 5. Melbourne: National Cancer Control Initiative

Relational attributes

Implementation in Data Set Specifications:

Lung cancer (clinical) DSS Health, Standard 08/05/2014

◊ Episode end status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—episode end status, code N
Synonymous names:	Departure status
METeOR identifier:	551305
Registration status:	Health, Standard 11/04/2014
Definition:	The status of the patient at the end of the non-admitted patient emergency department service episode, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode—episode end status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Transferred for admitted patient care in this hospital (either short stay unit, hospital-in-the-home or other admitted patient care unit)
2	Emergency department stay completed - departed without being transferred to a short stay unit, hospital-in-the-home or other admitted patient care unit in this hospital or referred to another hospital
3	Emergency department stay completed - referred to another hospital for admission
4	Did not wait to be attended by a health care professional
5	Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed
6	Died in emergency department
7	Dead on arrival

Collection and usage attributes

Guide for use:	CODE 1 Transferred for admitted patient care in this hospital (either short stay unit, hospital-in-the-home or other admitted patient care unit)

This code should only be used for patients who physically depart the emergency department because they are admitted to a short stay unit, hospital-in-the-home or other admitted patient care unit.

Patients for whom the intention is to admit to a short stay unit, hospital-in-the-home or other admitted patient care unit, but who die or otherwise leave the emergency department should not be recorded as Code 1.

This code excludes patients who died in the emergency department. Such instances should be coded to Code 6.

CODE 2 Emergency department stay completed - departed without being transferred to a short stay unit, hospital-in-the-home or other admitted patient care unit in this hospital or referred to another hospital

This code includes patients who either departed under their own care, under police custody, under the care of a residential aged care facility or under the care of another carer.

This code excludes patients who died in the emergency department. Such instances should be coded to Code 6.

CODE 6 Died in emergency department

This code should only be used for patients who die while physically located within the emergency department.

CODE 7 Dead on arrival

This code should only be used for patients who are dead on arrival and an emergency department clinician certifies the death of the patient. This includes where the clinician certifies the death outside the emergency department (e.g. in an ambulance outside the emergency department).

Exclusion: When resuscitation or any other clinical care for the patient is attempted, Code 7 should not be used.

Note: Where Code 7 is recorded for a patient, a Type of visit to emergency department Code 5 (Dead on arrival) should also be recorded.

Source and reference attributes

Submitting organisation: National Health Information Standards and Statistics Committee - Emergency Data Development Working Group

Data element attributes

Collection and usage attributes

Guide for use: When recording the episode end status of a patient, Codes 6 and 7 should first be considered for use. If Codes 6 and 7 are inappropriate, select the most suitable code for the patient from Codes 1-5.

Collection methods: Some data systems may refer to this data element as 'Departure status'.

Source and reference attributes

Submitting organisation: National Health Information Standards and Statistics Committee

- Emergency Data Development Working Group

Relational attributes

Related metadata references:

Supersedes Non-admitted patient emergency department service episode—episode end status, code N Health, Superseded 11/04/2014, Independent Hospital Pricing Authority, Standard 31/10/2012, National Health Performance Authority, Standard 28/05/2014

Implementation in Data Set Specifications:

Activity based funding: Emergency service care DSS 2014-2015 Independent Hospital Pricing Authority, Candidate 02/01/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Non-admitted patient emergency department care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

◊ Episode of residential care end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode end date, DDMMYYYY
METeOR identifier:	534037
Registration status:	Health, Standard 07/03/2014
Definition:	The date on which a **resident** formally or statistically **ends an episode of residential care,** expressed as DDMMYYYY.
Data Element Concept:	Episode of residential care—episode end date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

Related metadata references:

Supersedes Episode of residential care—episode end date, DDMMYYYY Health, Superseded 07/03/2014

Implementation in Data Set Specifications:

Residential mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:

Data in this field must:

be ≤ last day of reference period
be ≥ first day of reference period
be ≥ Episode of residential care start date

Residential mental health care NMDS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

DSS specific information:

Data in this field must:

be ≤ last day of reference period
be ≥ first day of reference period
be ≥ Episode of residential care start date

◊ Episode of residential care end mode

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode end mode, code N
METeOR identifier:	524966
Registration status:	Health, Standard 07/03/2014
Definition:	The reason for **ending an episode of residential care**, as represented by a code.
Data Element Concept:	Episode of residential care—episode end mode

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Died
2	Left against clinical advice / at own risk
3	Did not return from leave
4	Formal discharge from residential care at this establishment
5	End of reference period
6	Return to other residential mental health service

Supplementary values:

9	Unknown/not stated/inadequately described

Collection and usage attributes

Guide for use:

CODES 1–4 These codes refer to the formal end of a residential care episode.

CODE 5 refers to the statistical end of a residential care episode.

CODE 6 refers to the end of a concurrent short intervention stay when a resident returns to the original residential mental health service after a period of leave days.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 6 Return to other residential mental health service

This code should only occur in instances where Code 4, 'Start of expected short concurrent residential stay (on leave from other residential mental health service)', is reported for Episode start mode.

Relational attributes

Related metadata references:

Supersedes Episode of residential care—episode end mode, code N Health, Superseded 07/03/2014

See also Episode of residential care—episode start mode, code N Health, Standard 07/03/2014

Implementation in Data Set Specifications:

Residential mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
Episodes with an episode end mode of 1 (died) should be coded as 8 (not applicable) for referral destination.

Residential mental health care NMDS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

DSS specific information:
Episodes with an episode end mode of 1 (died) should be coded as 8 (not applicable) for referral destination.

◊ Episode of residential care start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode start date, DDMMYYYY
METeOR identifier:	534048
Registration status:	Health, Standard 07/03/2014
Definition:	The date on which the **resident** formally or statistically **starts an episode of residential care,** expressed as DDMMYYYY.
Data Element Concept:	Episode of residential care—episode start date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

Related metadata references:

Supersedes Episode of residential care—episode start date, DDMMYYYY Health, Superseded 07/03/2014

Implementation in Data Set Specifications:

Residential mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:

Right justified and zero filled.

episode of residential care start date ≤ episode of residential care end date.

episode of residential care start date ≥ date of birth.

Residential mental health care NMDS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

DSS specific information:

Right justified and zero filled.

episode of residential care start date ≤ episode of residential care end date.

episode of residential care start date ≥ date of birth.

◊ Episode of residential care start mode

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode start mode, code N
METeOR identifier:	525026
Registration status:	Health, Standard 07/03/2014
Definition:	The reason for **starting an episode of residential care**, as represented by a code.
Data Element Concept:	Episode of residential care—episode start mode

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
2	Start of a new residential stay
3	Start of a new reference period
4	Start of expected short concurrent residential stay (on leave from other residential mental health service)

Supplementary values:

9	Unknown/not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 2 refers to the formal start of a residential care episode.

CODE 3 refers to the statistical start of a residential care episode.

CODE 4 refers to the start of an expected short concurrent residential stay when a resident is on leave from the original residential mental health service with the intention of return.

Data element attributes

Relational attributes

Related metadata references:

See also Episode of residential care—episode end mode, code N Health, Standard 07/03/2014

Supersedes Episode of residential care—episode start mode, code N Health, Superseded 07/03/2014

Implementation in Data Set Specifications:

Residential mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Residential mental health care NMDS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

▲ Establishment staffing categories

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—staffing categories, health code N[N]
METeOR identifier:	542001
Registration status:	Health, Standard 11/04/2014
Definition:	The categories of staffing used types by an establishment, as represented by a code.
Data Element Concept:	Establishment—staffing categories

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Administrative and clerical staff
2	Diagnostic and health professionals
3	Domestic and other staff
4	Enrolled nurses
5	Other personal care staff
6	Registered nurses
7	Specialist salaried medical officers (SMOs)
8	Other salaried medical officers (SMOs)
9	Student nurses
10	Trainee/pupil nurses

Collection and usage attributes

Guide for use:

CODE 1 Administrative and clerical staff

Administrative and clerical staff are staff engaged in administrative and clerical duties. Medical staff and nursing staff, diagnostic and health professionals and any domestic staff primarily or partly engaged in administrative and clerical duties are excluded. Civil engineers and computing staff are included in this category.

CODE 2 Diagnostic and health professionals

Diagnostic and health professionals are qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature (but also including diagnostic and health professionals whose duties are primarily or partly of an administrative nature). This category includes all

allied health professionals and laboratory technicians (but excludes civil engineers and computing staff).

CODE 3 Domestic and other staff

Domestic staff are staff engaged in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded. This category also includes all staff not elsewhere included (primarily maintenance staff, trades people and gardening staff).

CODE 4 Enrolled nurses

Enrolled nurses are registered with the national registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses).

CODE 5 Other personal care staff

This category includes attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions.

CODE 6 Registered nurses

Registered nurses include persons with at least a three year training certificate and nurses holding post graduate qualifications. Registered nurses must be registered with the national registration board. This is a comprehensive category and includes community mental health, general nurse, intellectual disability nurse, midwife (including pupil midwife), psychiatric nurse, senior nurse, charge nurse (now unit manager), supervisory nurse and nurse educator. This category also includes nurses engaged in administrative duties no matter what the extent of their engagement, for example, directors of nursing and assistant directors of nursing.

CODE 7 Specialist salaried medical officers (SMOs)

Specialist medical officers employed by the establishment on a full-time or part-time salaried basis. This excludes visiting medical officers engaged on an honorary, sessional or fee for service basis.

This metadata item includes specialist salaried medical officers who are engaged in administrative duties regardless of the extent of that engagement (for example, clinical superintendent and medical superintendent).

CODE 8 Other salaried medical officers (SMOs)

Non-specialist medical officers employed by the establishment on a full-time or part-time salaried basis. This excludes visiting medical offices engaged on an honorary, sessional or fee for service basis. This category includes non-specialist salaried medical officers who are engaged in administrative duties regardless of the extent of that engagement (for example, clinical superintendent and medical superintendent).

CODE 9 Student nurses

Student nurses are persons employed by the establishment currently studying in years one to three of a three year certificate

course. This includes any person commencing or undertaking a three year course of training leading to registration as a nurse by the national registration board. This includes full-time general student nurse and specialist student nurse, such as mental deficiency nurse, but excludes practising nurses enrolled in post basic training courses.

CODE 10 Trainee/pupil nurses

Trainee/pupil nurse includes any person commencing or undertaking a 1-year course of training leading to registration as an enrolled nurse on the national registration board (includes all trainee nurses).

Data element attributes

Relational attributes

Related metadata references:

See also Establishment—full-time equivalent staff, average N[NNN{.N}] Health, Standard 11/04/2014

Implementation in Data Set Specifications:

Full-time equivalent staffing data element cluster Health, Standard 11/04/2014

Recurrent salaries and wages expenditure data element cluster Health, Standard 11/04/2014

▲ Estimated data indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—data estimated indicator, yes/no code N
METeOR identifier:	548891
Registration status:	Health, Standard 11/04/2014
Definition:	An indicator of whether data relating to an establishment have been estimated, as represented by a code.
Data Element Concept:	Establishment—data estimated indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: This data element is used to indicate where data have been estimated rather than directly sourced.

Source and reference attributes

Submitting organisation: PHE NMDS Working Group

Relational attributes

Related metadata references: See also Available bed—admitted contracted care, average number of beds N[NNN.N] Health, Standard 11/04/2014

Implementation in Data Set Specifications: Local Hospital Networks DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
This data element is used in conjunction with Available bed—admitted contracted care, average number of beds N[NNN.N].

Public hospital establishments NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
This data element is reported in conjunction with Available bed—admitted contracted care, average number of beds N[NNN.N]

Recurrent non-salary expenditure data element cluster Health, Standard 11/04/2014

DSS specific information:

This data element is used to indicate where financial data have been estimated rather than directly sourced from the general ledger, audited accounts or other financial systems.

The PHE NMDS Working Group strongly supported the inclusion of a data element to indicate where data had been estimated or apportioned, as a way of informing data users of situations where the data do not reflect the actual items in the general ledger.

Recurrent salaries and wages expenditure data element cluster Health, Standard 11/04/2014

DSS specific information:

This data element is used to indicate where financial data have been estimated rather than directly sourced from the general ledger, audited accounts or other financial systems.

The PHE NMDS Working Group strongly supported the inclusion of a data element to indicate where data had been estimated or apportioned, as a way of informing data users of situations where the data do not reflect the actual items in the general ledger.

Revenue data element cluster Health, Standard 11/04/2014

DSS specific information:

This data element is used to indicate where financial data have been estimated rather than directly sourced from the general ledger, audited accounts or other financial systems.

The PHE NMDS Working Group strongly supported the inclusion of a data element to indicate where data had been estimated or apportioned, as a way of informing data users of situations where the data do not reflect the actual items in the general ledger.

▲ Estimated glomerular filtration rate result

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—estimated glomerular filtration rate (eGFR) result, code N[A]
Synonymous names:	eGFR result
METeOR identifier:	503010
Registration status:	Health, Standard 21/11/2013
Definition:	A person's estimated glomerular filtration rate (eGFR) result, as represented by a code.
Data Element Concept:	Person—estimated glomerular filtration rate (eGFR) result

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Kidney function stage 1
2	Kidney function stage 2
3a	Kidney function stage 3a
3b	Kidney function stage 3b
4	Kidney function stage 4
5	Kidney function stage 5

Collection and usage attributes

Guide for use:

CODE 1 Kidney function stage 1

Use this code when the estimated glomerular filtration rate (eGFR) is greater than or equal to 90 (ml/min/1.73m²).

CODE 2 Kidney function stage 2

Use this code when the estimated glomerular filtration rate (eGFR) is greater than or equal to 60 but less than 90 (ml/min/1.73m²).

CODE 3a Kidney function stage 3a

Use this code when the estimated glomerular filtration rate (eGFR) is greater than or equal to 45 but less than 60 (ml/min/1.73m²).

CODE 3a Kidney function stage 3b

Use this code when the estimated glomerular filtration rate (eGFR) is greater than or equal to 30 but less than 45 (ml/min/1.73m²).

CODE 4 Kidney function stage 4

Use this code when the estimated glomerular filtration rate (eGFR) is greater than or equal to 15 but less than 30 (ml/min/1.73m²).

CODE 5 Kidney function stage 5

Use this code when the estimated glomerular filtration rate (eGFR) is less than 15 (ml/min/1.73m²).

Comments: The estimated glomerular filtration rate (eGFR) is a measure of the amount of fluid that passes through the kidneys per unit time.

Source and reference attributes

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

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Indigenous primary health care DSS 2014-15 Health, Standard 21/11/2013
Indigenous, Endorsed 21/11/2013

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
Reporting of this data element is conditional on a 'yes' answer to 'Person—estimated glomerular filtration rate (eGFR) recorded indicator, yes/no code N'.

Implementation in Indicators: **Used as numerator**
Indigenous primary health care: PI19a-Number of regular clients with a selected chronic disease who have had an eGFR recorded with results within specified levels, 2014 Health, Standardisation pending 22/09/2014
Indigenous, Endorsed 21/11/2013
Indigenous primary health care: PI19b-Proportion of regular clients with a selected chronic disease who have had an eGFR recorded with results within specified levels, 2014 Health, Standardisation pending 22/09/2014
Indigenous, Endorsed 21/11/2013

▲ FIGO cervical cancer stage

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—extent of primary cancer, cervical cancer staging (FIGO) code N[N]
METeOR identifier:	424190
Registration status:	Health, Standard 08/05/2014
Definition:	The extent of a primary cervical cancer as outlined by International Federation of Gynecology and Obstetrics (FIGO), represented by a code.
Context:	Collect for women with cervical cancer.
Data Element Concept:	Person with cancer—extent of primary cancer

Value domain attributes

Representational attributes

Classification scheme:	International Federation of Gynecology and Obstetrics cancer staging system
Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Stage IA1
2	Stage IA2
3	Stage IB1
4	Stage IB2
5	Stage IIA1
6	Stage IIA2
7	Stage IIB
8	Stage IIIA
9	Stage IIIB
10	Stage IVA
11	Stage IVB

Supplementary values:

Value	Meaning
99	Not available/inadequately described

Collection and usage attributes

Guide for use:

International Federation of Gynecology and Obstetrics (FIGO) stage according to 2009 definitions. Data on patients affected by Stage 0 disease is not collected.

Stage I: the carcinoma is strictly confined to the cervix (extension to the corpus would be disregarded).

Stage IA: invasive carcinoma that can be diagnosed only by microscopy, with deepest invasion less than or equal to 5 mm and largest extension less than or equal to 7 mm.

CODE 1 Stage IA1

Measured stromal invasion of less than or equal to 3.0 mm in depth and extension of less than or equal to 7.0 mm.

CODE 2 Stage IA2

Measured stromal invasion of greater than 3.0 mm and less than 5.0 mm with an extension of not more than 7.0 mm.

Stage IB: clinically visible lesions limited to the cervix uteri or preclinical cancers greater than stage IA.

CODE 3 Stage IB1

Clinically visible lesion less than or equal to 4.0 cm in greatest dimension.

CODE 4 Stage IB2

Clinically visible lesion greater than 4.0 cm in greatest dimension.

Stage II: cervical carcinoma invades beyond the uterus, but not to the pelvic wall or to the lower third of the vagina.

Stage IIA: without parametrial invasion.

CODE 5 Stage IIA1

Clinically visible lesion less than or equal to 4.0 cm in greatest dimension.

CODE 6 Stage IIA2

Clinically visible lesion greater than 4.0 cm in greatest dimension.

CODE 7 Stage IIB

With obvious parametrial invasion.

Stage III: the tumour extends to the pelvic wall and/or involves lower third of the vagina and/or causes hydronephrosis or non-functioning kidney.

CODE 8 Stage IIIA

Tumour involves lower third of the vagina, with no extension to the pelvic wall.

CODE 9 Stage IIIB

Extension to the pelvic wall and/or hydronephrosis or non-functioning kidney.

Stage IV: the carcinoma has extended beyond the true pelvis or has involved (biopsy proven) the mucosa of the bladder or rectum. A bullous oedema, as such, does not permit a case to be allotted to Stage IV.

CODE 10 Stage IVA

Spread of the growth to adjacent organs.

CODE 11 Stage IVB

Spread to distant organs.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Mutch, D G (2009). The new FIGO staging system for cancers of the vulva, cervix, endometrium and sarcomas. Gynecologic Oncology. 115: 325–328

Data element attributes

Collection and usage attributes

Guide for use: Record the extent of the primary cervical cancer as outlined by the International Federation of Gynecology and Obstetrics (FIGO) stage. This should be filled out according to 2009 definitions. Data on patients affected by Stage 0 disease is not collected.

Collection methods: To be sought from pathology reports or patient medical records.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Mutch, D G (2009). The new FIGO staging system for cancers of the vulva, cervix, endometrium and sarcomas. *Gynecologic Oncology.* 115: 325–328

Relational attributes

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is only to be recorded for patients with cervical cancer, as indicated by Person with cancer—primary site of cancer, topography code (ICD-O-3) ANN.N.

▲ FIGO endometrial cancer stage

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—extent of primary cancer, endometrial cancer staging (FIGO) code N[N]
METeOR identifier:	424209
Registration status:	Health, Standard 08/05/2014
Definition:	The extent of a primary endometrial cancer as outlined by International Federation of Gynecology and Obstetrics (FIGO), represented by a code.
Data Element Concept:	Person with cancer—extent of primary cancer

Value domain attributes

Representational attributes

Classification scheme:	International Federation of Gynecology and Obstetrics cancer staging system
Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Stage IA
2	Stage IB
3	Stage II
4	Stage IIIA
5	Stage IIIB
6	Stage IIIC1
7	Stage IIIC2
8	Stage IVA
9	Stage IVB

Supplementary values:

Value	Meaning
99	Not available/inadequately described

Collection and usage attributes

Guide for use:

The International Federation of Gynecology and Obstetrics (FIGO) endometrial cancer stage according to 2009 definitions.

Stage I: tumour confined to the corpus uteri.

CODE 1 Stage IA

No invasion or less than half myometrial invasion.

CODE 2 Stage IB

Invasion equal to or greater than half of the myometrium.

Stage II

CODE 3 Stage II

Tumour invades cervical stroma, but does not extend beyond the uterus.

Note: In situ involvement of the endocervix that does not invade the stroma is not a Stage II lesion.

Stage III: local and/or regional spread of the tumour.

CODE 4 Stage IIIA

Tumour invades the serosa of the corpus uteri and/or the adnexa.

CODE 5 Stage IIIB

Involvement of the vagina, parametrium and/or the pelvic peritoneum.

Stage IIIC: retroperitoneal node involvement

CODE 6 Stage IIIC1

Pelvic node involvement.

CODE 7 Stage IIIC2

Paraaortic involvement.

Stage IV: tumour invades bladder and/or bowel mucosa, and/or distant metastases.

CODE 8 Stage IVA

Tumour invasion of bladder and/or bowel mucosa.

CODE 9 Stage IVB

Distant metastases, including intra-abdominal metastases and/or inguinal lymph nodes.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Mutch, D G (2009). The new FIGO staging system for cancers of the vulva, cervix, endometrium and sarcomas. Gynecologic Oncology. 115: 325–328

Data element attributes

Collection and usage attributes

Guide for use: Record the extent of the primary endometrial cancer as outlined by the International Federation of Gynecology and Obstetrics (FIGO) stage. This should be filled out according to 2009 definitions.

Collection methods: To be sought from pathology reports or patient medical records.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Mutch, D G (2009). The new FIGO staging system for cancers of the vulva, cervix, endometrium and sarcomas. Gynecologic Oncology. 115: 325–328

Relational attributes

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is only to be recorded for patients with

endometrial cancer, as indicated by Person with cancer—primary site of cancer, topography code (ICD-O-3) ANN.N.

▲ FIGO ovarian cancer stage

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—extent of primary cancer, ovarian cancer staging (FIGO) code N[N]
METeOR identifier:	424212
Registration status:	Health, Standard 08/05/2014
Definition:	The extent of a primary ovarian cancer as outlined by International Federation of Gynecology and Obstetrics (FIGO), as represented by a code.
Data Element Concept:	Person with cancer—extent of primary cancer

Value domain attributes

Representational attributes

Classification scheme:	International Federation of Gynecology and Obstetrics cancer staging system
Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Stage IA
2	Stage IB
3	Stage IC1
4	Stage IC2
5	Stage IC3
6	Stage IIA
7	Stage IIB
8	Stage IIIA1
9	Stage IIIA1(i)
10	Stage IIIA1(ii)
11	Stage IIIA2
12	Stage IIIB
13	Stage IIIC
14	Stage IV
15	Stage IVA
16	Stage IVB

Supplementary values:

99	Not available/inadequately described

Collection and usage attributes

Guide for use:

The FIGO stage section should be filled out according to the 2013 definitions.

Stage I Growth limited to the ovaries

CODE 1 Stage IA

Tumour limited to one ovary; no malignant cells in ascites or peritoneal washings. No tumour present on ovarian surface; capsule intact.

CODE 2 Stage IB

Tumour limited to both ovaries, capsule intact, no tumour on ovarian surface; no malignant cells in ascites or peritoneal washings.

CODE 3 Stage IC1

Tumour limited to one or both ovaries or fallopian tubes with surgical spill.

Stage II Tumour involving one or both ovaries with pelvic extension

CODE 4 Stage IC2

Tumour limited to one or both ovaries or fallopian tubes, with capsule ruptured before surgery or tumour on ovarian surface.

CODE 5 Stage IC3

Tumour limited to one or both ovaries or fallopian tubes, with malignant cells in the ascites or peritoneal washings.

Stage II Tumour involving one or both ovaries with pelvic extension (below pelvic brim)

CODE 6 Stage IIA

Extension and/or implants on uterus and/or fallopian tubes.

CODE 7 Stage IIB

Extension to other pelvic intraperitoneal tissues.

Stage III Tumour involving one or both ovaries with cytologically or histologically confirmed spread to the peritoneum outside the pelvis and/or metastasis to the retroperitoneal lymph nodes.

CODE 8 Stage IIIA1

Positive retroperitoneal lymph nodes only (cytologically or histologically proven).

CODE 9 Stage IIIA1(i)

Positive retroperitoneal lymph nodes only (cytologically or histologically proven), with metastasis up to 10 mm in greatest dimension.

CODE 10 Stage IIIA1(ii)

Positive retroperitoneal lymph nodes only (cytologically or histologically proven), with metastasis more than 10 mm in greatest dimension.

CODE 11 Stage IIIA2

Microscopic extrapelvic (above the pelvic brim) peritoneal involvement with or without positive retroperitoneal lymph nodes.

CODE 12 Stage IIIB

Macroscopic peritoneal metastasis beyond the pelvis up to 2 cm in greatest dimension, with or without metastasis to the retroperitoneal lymph nodes.

CODE 13 Stage IIIC

Macroscopic peritoneal metastasis beyond the pelvis more than 2 cm

in greatest dimension, with or without metastasis to the retroperitoneal lymph nodes (includes extension of tumour to capsule of liver and spleen without parenchymal involvement of either organ).

CODE 14 Stage IV

Distant metastases, excluding peritoneal metastases.

CODE 15 Stage IVA

Distant metastases, excluding peritoneal metastases, with pleural effusion with positive cytology.

CODE 16 Stage IVB

Distant metastases, excluding peritoneal metastases, including parenchymal metastases and metastases to extra-abdominal organs (including inguinal lymph nodes and lymph nodes outside of the abdominal cavity).

Source and reference attributes

Reference documents: Prat, J. Staging classification for cancer of the ovary, fallopian tube and peritoneum. International Journal of Gynecology and Obstetrics 2014, 124: 1-5.

Data element attributes

Collection and usage attributes

Guide for use: Record the extent of the primary endometrial cancer as outlined by the International Federation of Gynecology and Obstetrics (FIGO) stage. This should be filled out according to 1988 definitions.

Collection methods: To be sought from pathology reports or patient medical records.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Prat, J. Staging classification for cancer of the ovary, fallopian tube and peritoneum. International Journal of Gynecology and Obstetrics 2014, 124: 1-5.

Relational attributes

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is only to be recorded for patients with ovarian cancer, as indicated by Person with cancer—primary site of cancer, topography code (ICD-O-3) ANN.N.

◊ Funding source for hospital patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—source of funding, patient funding source code NN
METeOR identifier:	553314
Registration status:	Health, Standard 07/03/2014
Definition:	The source of funds for an admitted patient episode or non-admitted patient service event, as represented by a code.
Context:	Admitted patient care. Hospital non-admitted patient care.
Data Element Concept:	Episode of care—source of funding

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Health service budget (not covered elsewhere)
02	Health service budget (due to eligibility for Reciprocal Health Care Agreement)
03	Health service budget (no charge raised due to hospital decision)
04	Department of Veterans' Affairs
05	Department of Defence
06	Correctional facility
07	Medicare Benefits Scheme
08	Other hospital or public authority (contracted care)
09	Private health insurance
10	Worker's compensation
11	Motor vehicle third party personal claim
12	Other compensation (e.g. public liability, common law, medical negligence)
13	Self-funded
88	Other funding source

Supplementary values:

98	Not known

Collection and usage attributes

Guide for use:

CODE 01 Health service budget (not covered elsewhere)

Health service budget (not covered elsewhere) should be recorded as the funding source for Medicare eligible patients for whom there is no other funding arrangement.

CODE 02 Health service budget (due to eligibility for Reciprocal Health Care Agreement)

Patients who are overseas visitors from countries covered by Reciprocal Health Care Agreements.

Australia has Reciprocal Health Care Agreements with the United Kingdom, the Netherlands, Italy, Malta, Sweden, Finland, Norway, Belgium, Slovenia, New Zealand and Ireland. The Agreements provide for free accommodation and treatment as public hospital services, but do not cover treatment as a private patient in any kind of hospital.

The Agreements with Finland, Italy, Malta, the Netherlands, Norway, Sweden, Belgium, Slovenia and the United Kingdom provide free care as a public patient in public hospitals, subsidised out-of-hospital medical treatment under Medicare, and subsidised medicines under the Pharmaceutical Benefits Scheme.

The Agreements with New Zealand and Ireland provide free care as a public patient in public hospitals and subsidised medicines under the Pharmaceutical Benefits Scheme, but do not cover out-of-hospital medical treatment.

Visitors from Italy and Malta are covered for a period of six months from the date of arrival in Australia only.

Visitors from Belgium, the Netherlands and Slovenia require their European Health Insurance card to enrol in Medicare. They are eligible for treatment in public hospitals until the expiry date indicated on the card, or to the length of their authorised stay in Australia if earlier.

Excludes: Overseas visitors who elect to be treated as private patients or under travel insurance.

CODE 03 Health service budget (no charge raised due to hospital decision)

Patients who are Medicare ineligible and receive public hospital services free of charge at the discretion of the hospital or the state/territory. Also includes patients who receive private hospital services for whom no accommodation or facility charge is raised (for example, when the only charges are for medical services bulk-billed to Medicare) and patients for whom a charge is raised but is subsequently waived.

CODE 07 Medicare Benefits Scheme

Medicare eligible patients in scope of collection for whom services are billed to Medicare. Includes both bulk-billed patients and patients with out-of-pocket expenses. This value is not applicable for admitted patients.

CODE 08 Other hospital or public authority (contracted care)

Patients receiving treatment under contracted arrangements with another hospital (inter-hospital contracted patient) or a public authority (e.g. a state or territory government).

CODE 09 Private health insurance

Patients who are funded by private health insurance, including travel insurance for Medicare eligible patients. If patients receive any funding from private health insurance, choose Code 09, regardless of whether it is the majority source of funds.

Excludes: Overseas visitors for whom travel insurance is the major funding source.

CODE 13 Self-funded

This code includes funded by the patient, by the patient's family or friends, or by other benefactors.

CODE 88 Other funding source

This code includes overseas visitors for whom travel insurance is the major funding source.

Data element attributes

Collection and usage attributes

Guide for use:

The source of funding should be assigned based on a best estimate of where the majority of funds come from, except for private health insurance, which should be assigned wherever there is a private health insurance contribution to the cost. This data element is not designed to capture information on out-of-pocket expenses to patients (for example, fees only partly covered by the Medicare Benefits Schedule).

If a charge is raised for accommodation or facility fees for the episode/service event, the intent of this data element is to collect information on who is expected to pay, provided that the charge would cover most of the expenditure that would be estimated for the episode/service event. If the charge raised would cover less than half of the expenditure, then the funding source that represents the majority of the expenditure should be reported.

If there is an expected funding source followed by a finalised actual funding source (for example, in relation to compensation claims), then the actual funding source known at the end of the reporting period should be recorded.

The expected funding source should be reported if the fee has not been paid but is not to be waived.

The major source of funding should be reported for nursing-home type patients.

Relational attributes

Related metadata references:

Supersedes Episode of care—source of funding, patient funding source code NN Health, Superseded 07/03/2014

Implementation in Data Set Specifications:

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Admitted patient palliative care NMDS 2014-15 Health, Standardisation pending 18/07/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Non-admitted patient care hospital aggregate NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

Only required to report Establishment—number of group sessions, total N[NNNNN], Establishment—number of group session non-admitted patient service events, total service events N[NNNNNN] and Establishment—number of individual session non-admitted patient service events, total service events N[NNNNNN] using the following two funding source categories:

- Medicare Benefits Scheme (07)
- All other funding sources (01, 02, 03, 04, 05, 06, 08, 09, 10, 11, 12, 13, 88 and 98)

Non-admitted patient care Local Hospital Network aggregate DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:

Only required to report Establishment—number of group sessions, total N[NNNNN], Establishment—number of group session non-admitted patient service events, total service events N[NNNNNN] and Establishment—number of individual session non-admitted patient service events, total service events N[NNNNNN] using the following two funding source categories:

- Medicare Benefits Scheme (07)
- All other funding sources (01, 02, 03, 04, 05, 06, 08, 09, 10, 11, 12, 13, 14 and 99)

Non-admitted patient DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Non-admitted patient DSS 2015-16 Health, Candidate 24/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Geographic remoteness

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health-care incident—geographic remoteness, remoteness classification (ASGS-RA) code N
Synonymous names:	Geographic remoteness of health-care incident
METeOR identifier:	531677
Registration status:	Health, Standard 21/11/2013
Definition:	The remoteness of the location at which a health-care incident took place, based on the physical road distance to the nearest urban centre and its population size, as represented by a code.
Data Element Concept:	Health-care incident—geographic remoteness

Value domain attributes

Representational attributes

Classification scheme:	Australian Statistical Geography Standard 2011
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Major cities of Australia
2	Inner regional Australia
3	Outer regional Australia
4	Remote Australia
5	Very remote Australia
6	Migratory

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Major cities of Australia

'Major cities of Australia' includes Statistical Area Level 1s (SA1s) with an average Accessibility/Remoteness Index of Australia (ARIA+) index value of 0 to 0.2.

CODE 2 Inner regional Australia

'Inner regional Australia' includes SA1s with an average ARIA+ index value greater than 0.2 and less than or equal to 2.4.

CODE 3 Outer regional Australia

'Outer regional Australia' includes SA1s with an average ARIA+ index value greater than 2.4 and less than or equal to 5.92.

CODE 4 Remote Australia

'Remote Australia' includes SA1s with an average ARIA+ index

value greater than 5.92 and less than or equal to 10.53.

CODE 5 Very remote Australia

'Very remote Australia' includes SA1s with an average ARIA+ index value greater than 10.53.

CODE 6 Migratory

'Migratory' is composed of off-shore, shipping and migratory SA1s.

Collection methods:

In this value domain, physical distance is defined in terms of ARIA+ codes, rather than a simple linear distance between points.

The list of permissible values for this value domain, i.e. codes 1 to 6, is intended to be directly mappable to the values used by the ABS to describe remoteness areas, i.e. codes 0 to 5.

Comments:

In its initial form, as developed by the National Centre for Social Applications of Geographic Information Centres (now located within the Australian Population and Migration Research Centre) and the then Department of Health and Aged Care in 1999, ARIA scores ranged from 0 to 12 and were based on proximity to 4 points of reference.

A new version, ARIA+, was introduced in 2003, with ARIA+ scores now based on proximity to 5 points of reference. Also, changes were made to account for Tasmania's unique status as an island state, and to increase accuracy for locations at the urban fringe.

Prior to 2011, ARIA+ scores were calculated for individual Census Collection Districts (CCDs). Following the phasing out of the Australian Standard Geographical Classification (ASGC) and the introduction of the Australian Statistical Geography Standard (ASGS) by the ABS in 2011, ARIA+ scores are now calculated for individual Statistical Area Level 1s (SA1s).

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Steward:

Australian Institute of Health and Welfare

Origin:

Publications detailing the ASGS remoteness classification are available free of charge from the ABS website:

Australian Bureau of Statistics 2013. 1270.055.005 - Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure, July 2011. Viewed 15 July 2013, http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1270.0.55.005July%202011?OpenDocument

Reference documents:

Information relating to the development of the ARIA and ARIA+ scores by the National Centre for Social Applications of Geographic Information Systems (GISCA) is available from the APMRC website:

Australian Population and Migration Research Centre (APMRC) 2013. ARIA (Accessibility/Remoteness Index of Australia). Viewed 15 July 2013, http://www.adelaide.edu.au/apmrc/research/projects/

category/about_aria.html

Data element attributes

Collection and usage attributes

Guide for use:

The remoteness classification of an entity can be derived using characteristics of its physical location, e.g. its map location or its Statistical Area Level 1 (SA1).

The remoteness classification (RA1 to RA5) can be found with knowledge of the map location or SA1 of the hospital or other health service provider at which the health-care incident occurred. State/territory maps displaying remoteness areas are available from 'ASGS Remoteness Structure Edition 2011 PDF Maps'. Mapping between SA1 and remoteness area is detailed in the 'Statistical Area Level 1 (SA1) to Remoteness Area (RA) ASGS Edition 2011 in csv. Format' data cube. The website with these and other aids for remoteness classification can be accessed via the following link:

http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1270.0.55.005July%202011?OpenDocument

The SA1 ('Region code') of a region, along with other relevant information, can be found on the interactive map of Australia accessible via the following link:

http://betaworks.abs.gov.au/betaworks/betaworks.nsf/projects/ASGSBoundariesOnline/frame.htm

When the health-care incident that gave rise to a medical indemnity claim involved a series of events that occurred in more than one location, the code recorded should reflect the location at which the primary incident or allegation type occurred.

Where a missed diagnosis was the main, dominant or primary cause giving rise to a medical indemnity claim, the code recorded should be the remoteness category of the place where the diagnosis should have been made, but was not, for example the general practitioner's surgery.

Code 9, 'Not stated/Inadequately described', should be used only when the information is not currently available, but is expected to become available as the medical indemnity claim progresses.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Reference documents:

Australian Bureau of Statistics. 1270.0.55.005 - ASGS Remoteness Structure Edition 2011 PDF Maps. Viewed 15 July 2013.

http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1270.0.55.005July%202011?OpenDocument

Australian Bureau of Statistics. Statistical Area Level 1 (SA1) to Remoteness Area (RA) ASGS Edition 2011 in csv format. Viewed 15 July 2013.

http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1270.0.55.005July%202011?OpenDocument

Australian Bureau of Statistics. Australia's ASGS statistical

boundaries. Viewed 15 July 2013.
http://betaworks.abs.gov.au/betaworks/betaworks.nsf/projects/ASGSBoundariesOnline/frame.htm

Relational attributes

Related metadata references:

Supersedes Health-care incident—geographic remoteness, remoteness classification (ASGC-RA) N Health, Superseded 21/11/2013

Implementation in Data Set Specifications:

Medical indemnity DSS 2014- Health, Standard 21/11/2013

Implementation start date: 01/07/2014

DSS specific information:
Code 6, 'Migratory', is not a valid code in this data set specification.

▲ Geographic remoteness—admitted patient care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—geographic remoteness, admitted patient care remoteness classification (ASGS-RA) N
Synonymous names:	Geographic remoteness of establishment
METeOR identifier:	539871
Registration status:	Health, Standard 11/04/2014
Definition:	The remoteness of an establishment providing admitted patient care, based on the physical road distance to the nearest urban centre and its population size, as represented by a code.
Data Element Concept:	Establishment—geographic remoteness

Value domain attributes

Representational attributes

Classification scheme:	Australian Statistical Geography Standard 2011
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	Major cities of Australia
1	Inner regional Australia
2	Outer regional Australia
3	Remote Australia
4	Very remote Australia
5	Migratory

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

This value domain is intended exclusively for use when collecting data relating to admitted patient care.

CODE 0 Major cities of Australia

'Major cities of Australia' includes Statistical Area Level 1s (SA1s) with an average Accessibility/Remoteness Index of Australia (ARIA+) index value of 0 to 0.2.

CODE 1 Inner regional Australia

'Inner regional Australia' includes SA1s with an average ARIA+ index value greater than 0.2 and less than or equal to 2.4.

CODE 2 Outer regional Australia

'Outer regional Australia' includes SA1s with an average ARIA+ index value greater than 2.4 and less than or equal to 5.92.

CODE 3 Remote Australia

'Remote Australia' includes SA1s with an average ARIA+ index value greater than 5.92 and less than or equal to 10.53.

CODE 4 Very remote Australia

'Very remote Australia' includes SA1s with an average ARIA+ index value greater than 10.53.

CODE 5 Migratory

'Migratory' is composed of off-shore, shipping and migratory SA1s.

This value domain allows for the allocation of remoteness codes in accordance with those used by the ABS remoteness structure. It is intended exclusively for use in the collection of admitted patient care data, where historically data has been remoteness coded to the value range 0-5. The similarly structured value domain, using the value range 1-6 for remoteness, should be used wherever possible (see the 'Related metadata references' section below).

Collection methods:

In this value domain, physical distance is defined in terms of ARIA+ codes, rather than a simple linear distance between points.

The list of permissible values for this value domain, i.e. codes 0 to 5, is the same as that used by the ABS to describe remoteness areas, i.e. codes 0 to 5, and is directly mappable to the range of codes used (codes 1-6) in the related value domain linked below (see the 'Related metadata references' section).

Comments:

In its initial form, as developed by GISCA and the then Department of Health and Aged Care in 1999, ARIA scores ranged from 0 to 12 and were based on proximity to 4 points of reference.

A new version, ARIA+, was introduced in 2003, with ARIA+ scores now based on proximity to 5 points of reference. Also, changes were made to allow for more accurate estimation of the cost of travelling from Tasmania to the mainland, and to increase accuracy for locations at the urban fringe.

Prior to 2011, ARIA+ scores were calculated for individual Census Collection Districts (CCDs). Following the phasing out of the Australian Standard Geographical Classification (ASGC) and the introduction of the Australian Statistical Geography Standard (ASGS) by the ABS in 2011, ARIA+ scores are now calculated for individual Statistical Area Level 1s (SA1s).

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Origin:

Information relating to remoteness and other aspects of statistical geography is available from the Statistical Geography portal on the ABS website:

Australian Bureau of Statistics 2011. ABS Geography. Viewed 19 November 2013, http://www.abs.gov.au/websitedbs/D3310114.nsf/home/Geography

Information relating to the development of the ARIA and ARIA+ scores by the Australian Population and Migration Research Centre (APMRC) within the National Centre for Social Applications of Geographic Information Systems (GISCA) at the University of Adelaide is available from the APMRC website:

Australian Population and Migration Research Centre 2013. ARIA -

Accessibility/Remoteness Index of Australia. Viewed 19 November 2013, http://www.adelaide.edu.au/apmrc/research/projects/category/about_aria.html

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

◊ GP Management Plan indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—GP Management Plan (MBS Item 721) indicator, yes/no code N
Synonymous names:	GPMP indicator
METeOR identifier:	504966
Registration status:	Health, Standard 21/11/2013
Definition:	An indicator of whether a GP Management Plan (MBS Item 721) has been claimed for a person, as represented by a code.
Data Element Concept:	Person—GP Management Plan (MBS Item 721) indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A GP Management Plan has been claimed for a person.

CODE 2 No

A GP Management Plan has not been claimed for a person.

Comments:

The Chronic Disease Management Medicare items on the Medicare Benefits Schedule enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions. This item is designed for patients who require a structured approach to their care. To be eligible for a GP Management Plan (GPMP) a patient must have a chronic (or terminal) medical condition; one that has been or is likely to be present for 6 months or longer, including, but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus and musculoskeletal conditions (Department of Health and Ageing 2011a).

A GPMP is required by legislation to be a comprehensive written plan that describes:

- the patient's health care needs, health problems and relevant

conditions

- management goals with which the patient agrees
- actions to be taken by the patient
- treatment and services the patient is likely to need
- arrangements for providing these treatment and services
- a date to review these matters (Department of Health and Ageing 2011b).

This chronic disease management service is for a patient who has at least one medical condition that:

(a) has been (or is likely to be) present for at least six months; or

(b) is terminal (Department of Health and Ageing 2011c).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Department of Health and Ageing 2011a. Department of Health and Ageing, Canberra. Viewed 27 May 2011, http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement

Department of Health and Ageing 2011b. GP Management Plans (Medicare item 721). Department of Health and Ageing, Canberra. Viewed 27 May 2011, http://www.health.gov.au/internet/main/publishing.nsf/Content/81BB2DB118217838CA2576710015F3B3/$File/Important%20Reminders%20About%20GPMPs%20Nov%2009.pdf

Department of Health and Ageing 2011c. Medicare Benefits Schedule – Item 721. Department of Health and Ageing, Canberra. Viewed 27 May 2011, http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=721

Relational attributes

Related metadata references: Supersedes Person—GP Management Plan (MBS Item 721) indicator, yes/no code N Health, Superseded 21/11/2013

Implementation in Data Set Specifications: Indigenous primary health care DSS 2014-15 Health, Standard 21/11/2013
Indigenous, Endorsed 21/11/2013

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
This item is only collected for persons who have Type II diabetes.

Implementation in Indicators: **Used as numerator**
Indigenous primary health care: PI07a-Number of regular clients with a chronic disease for whom a GP Management Plan (MBS Item 721) was claimed, 2014 Health, Standard 21/11/2013
Indigenous, Endorsed 21/11/2013
Indigenous primary health care: PI07b-Proportion of regular clients with a chronic disease for whom a GP Management Plan (MBS Item 721) was claimed, 2014 Health, Standard 21/11/2013

◊ Hormone therapy completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—hormone therapy completion date, DDMMYYYY
METeOR identifier:	561329
Registration status:	Health, Standard 08/05/2014
Definition:	The completion date of the **hormone therapy** administered during the course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—hormone therapy completion date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Hormone therapy is cancer treatment that achieves its antitumour effect through changes in hormonal balance. This includes the administration of hormones, agents acting via hormonal mechanisms, antihormones and steroids.

The completion date of hormone treatment is the date of the last dose administered during the course of treatment.

The completion date of hormone therapy is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of immunotherapy.

Do not record the dates for prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment. Only record prednisone as hormone therapy when it is administered in combination with chemotherapy such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

Tumour involvement or cancer treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of the initial course of treatment.

A patient may undergo hormone therapy for an extended period of time.

	Multiple entries are not permitted. Dates of surgery, radiotherapy and other systemic treatments are collected as separate items. However, if a patient receives treatment with a protocol that includes different types of systemic therapy agents, for example, a chemotherapy agent and a hormone therapy agent, record the completion date of treatment in both relevant data items.
Collection methods:	The information should be obtained from the patient's medical record.
Comments:	Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation:	Cancer Australia
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references:	Supersedes Cancer treatment—hormone therapy completion date, DDMMYYYY Health, Superseded 08/05/2014 See also Cancer treatment—hormone therapy start date, DDMMYYYY Health, Standard 08/05/2014 See also Cancer treatment—systemic therapy agent or protocol, text X[X(149)] Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Hormone therapy for cancer cluster Health, Standard 08/05/2014

◊ Hormone therapy start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—hormone therapy start date, DDMMYYYY
METeOR identifier:	561335
Registration status:	Health, Standard 08/05/2014
Definition:	The start date of **hormone therapy** administered during the course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—hormone therapy start date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Hormone therapy is cancer treatment that achieves its antitumour effect through changes in hormonal balance. This includes the administration of hormones, agents acting via hormonal mechanisms, antihormones and steroids.

Record the first or earliest date hormone therapy was administered during the course of treatment.

The start date of hormone therapy is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of hormone therapy.

Do not record the dates for prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment. Only record prednisone as hormone therapy when it is administered in combination with chemotherapy such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

Tumour involvement or cancer treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Hormone replacement therapy should only be recorded as part of a subsequent course of treatment and not the initial course of treatment.

A patient may undergo hormone therapy for an extended period of time.

Multiple entries are not permitted.

	Dates of surgery, radiotherapy and other systemic treatments are collected as separate items. However, if a patient receives treatment with a protocol that includes different types of systemic therapy agents, for example, a chemotherapy agent and a hormone therapy agent, record the start date of treatment in both relevant data items.
Collection methods:	The information should be obtained from the patient's medical record.
Comments:	Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation:	Cancer Australia
Origin:	American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references:	See also Cancer treatment—hormone therapy completion date, DDMMYYYY Health, Standard 08/05/2014 Supersedes Cancer treatment—hormone therapy start date, DDMMYYYY Health, Superseded 08/05/2014 See also Cancer treatment—systemic therapy agent or protocol, text X[X(149)] Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Hormone therapy for cancer cluster Health, Standard 08/05/2014

▲ Hypertension during pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—hypertensive disorder during pregnancy indicator, yes/no/not stated/inadequately described code N
METeOR identifier:	516807
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a female has a **hypertensive disorder during pregnancy**, based on a current or previous diagnosis, as represented by a code.
Data Element Concept:	Female—hypertensive disorder during pregnancy 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 To be reported if the woman has a hypertensive disorder during this pregnancy, including where a woman's hypertensive disorder is controlled through treatment during this pregnancy. CODE 2 No To be reported if the woman does not have a hypertensive disorder during this pregnancy. CODE 9 Not stated/inadequately described To be recorded by data entry personnel (state/territory health authority) if the data field is left blank or is inadequately completed in the perinatal data collection form or extract. Clinicians should not record code 9.
Collection methods:	Based on SOMANZ Guidelines 2008, normal pregnancy is

characterised by a fall in blood pressure, detectable in the first trimester and usually reaching a nadir in the second trimester. Blood pressure rises towards pre-conception levels towards the end of the third trimester.

Hypertension in pregnancy is defined as:

1. Systolic blood pressure greater than or equal to 140 mmHg and/or

2. Diastolic blood pressure greater than or equal to 90 mmHg.

Measurements should be confirmed by repeated readings over several hours.

The diagnosis is preferably derived from and substantiated by clinical documentation which should be reviewed at the time of delivery. However this information may not be available in which case the patient may self-report to the clinician that they have been diagnosed with a hypertensive disorder.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Reference documents: Lowe SA, Brown MA, Dekker G, Gatt S, McLintock C, McMahon L et al. 2008. Guidelines for the Management of Hypertension in Pregnancy. Society of Obstetric Medicine of Australia and New Zealand

Relational attributes

Related metadata references: See also Female—type of hypertensive disorder during pregnancy, code N Health, Standard 07/03/2014

Implementation in Data Set Specifications: Perinatal DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
It is acceptable for jurisdictions to report only Codes 1 and 9 against this item.

Perinatal DSS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

DSS specific information:
It is acceptable for jurisdictions to report only Code 1, Yes and Code 9, Not stated/inadequately described against this item.

▲ Hypertension type during pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—type of hypertensive disorder during pregnancy, code N
METeOR identifier:	504548
Registration status:	Health, Standard 07/03/2014
Definition:	The type of **hypertensive disorder during pregnancy** which a female has been diagnosed with, as represented by a code.
Context:	Perinatal statistics
Data Element Concept:	Female—type of hypertensive disorder during pregnancy

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Eclampsia
2	Preeclampsia
3	Gestational hypertension
4	Chronic hypertension

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

More than one code can be selected when reporting on this item. For example, for a woman who has preeclampsia superimposed on chronic hypertension, select both code 2 and code 4. For a woman who develops gestational hypertension which progresses to eclampsia, select codes 1 and 3.

CODE 1 Eclampsia

Eclampsia is characterised by grand mal seizures, hypertension, proteinuria, oedema and may progress to coma. Before a seizure, a patient may experience a body temperature of over 40°C, anxiety, epigastric pain, severe headache and blurred vision. Complications of eclampsia may include cerebral haemorrhage, pulmonary oedema, renal failure, abruptio placentae and temporary blindness (National Centre for Classification in Health, 2010).

CODE 2 Preeclampsia

Preeclampsia is a multi-system disorder unique to human

pregnancy characterised by hypertension and involvement of one or more other organ systems and/or the fetus. Proteinuria is the most commonly recognised additional feature after hypertension but should not be considered mandatory to make the clinical diagnosis.

A diagnosis of preeclampsia can be made when hypertension arises after 20 weeks gestation and is accompanied by one or more of the following: Renal involvement, Haematological involvement, Liver involvement, Neurological involvement, Pulmonary oedema, Fetal growth restriction, Placental abruption.

Women with HELLP syndrome (which stands for Haemolysis, Elevated Liver Enzymes, Low Platelet count and is a variant of preeclampsia) are to be included under this code for preeclampsia.

CODE 3 Gestational hypertension

Gestational hypertension is characterised by the new onset of hypertension after 20 weeks gestation without any maternal or fetal features of preeclampsia, followed by return of blood pressure to normal within 3 months post-partum.

CODE 4 Chronic hypertension

This may include essential or secondary hypertension. Essential hypertension is defined by a blood pressure > 140 mmHg systolic and/or > 90mm diastolic confirmed before pregnancy or before 20 completed weeks gestation without a known cause. It may also be diagnosed in women presenting early in pregnancy taking antihypertensive medications where no secondary cause for hypertension has been determined.

Important secondary causes of chronic hypertension in pregnancy include:

- Chronic kidney disease, e.g. glomerulonephritis, reflux nephropathy, and adult polycystic kidney disease.
- Renal artery stenosis
- Systemic disease with renal involvement, e.g. diabetes mellitus, systemic lupus erythematosus.
- Endocrine disorders, e.g. phaeochromocytoma, Cushing syndrome and primary hyperaldosteronism.
- Coarctation of the aorta.

In the absence of any of the above conditions it is likely that a woman with high blood pressure in the first half of pregnancy has essential hypertension.

Collection methods:

Diagnosis for eclampsia is to be based on the ICD-10-AM/ACHI/ACS (National Centre for Classification in Health, 2010).

For all other value domains, diagnosis is to be based on Society of Obstetric Medicine of Australia and New Zealand (SOMANZ) Guidelines for the Management of Hypertensive Disorders of Pregnancy. If the clinician does not have information as to whether the above guidelines have been used, available information about diagnosis of hypertensive disorder is still to be reported.

The diagnosis is preferably derived from and substantiated by

clinical documentation, which should be reviewed at the time of delivery. However this information may not be available in which case the patient may self-report to the clinician that they have been diagnosed with a hypertensive disorder.

Source and reference attributes

Reference documents:

Lowe SA, Brown MA, Dekker G, Gatt S, McLintock C, McMahon L et al. 2008. Guidelines for the management of hypertension in pregnancy. Society of Obstetric Medicine of Australia and New Zealand

The 10-AM Commandments (Coding Matters) in NCCH (National Centre for Classification in Health) 2010. The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM), Australian Classification of Health Interventions (ACHI) and Australian Coding Standards (ACS), Seventh edition. Sydney: University of Sydney.

Data element attributes

Relational attributes

Related metadata references:

See also Female—hypertensive disorder during pregnancy indicator, yes/no/not stated/inadequately described code N Health, Standard 07/03/2014

Implementation in Data Set Specifications:

Perinatal DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
Conditional on hypertensive disorder during pregnancy indicator being coded as yes.

Perinatal DSS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

Conditional obligation:
This data element is conditional on Female—hypertensive disorder during pregnancy indicator, yes/no/not stated/inadequately described code N being coded to Yes.

◊ Immunohistochemistry type description

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—immunohistochemistry type, text X[X(49)]
METeOR identifier:	447300
Registration status:	Health, Standard 08/05/2014
Definition:	Describes the type of **immunohistochemistry** stains used to assist in the identification of abnormal cells and hence the diagnosis of a person with cancer, as represented by text.
Context:	This should be collected for people with cancer where pathology data is available.
Data Element Concept:	Person with cancer—immunohistochemistry type

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(49)]
Maximum character length:	50

Data element attributes

Collection and usage attributes

Guide for use:	Record each immunohistochemical profile obtained to assist in the diagnosis of cancer other than those already specified in the data item for immunohistochemistry profiles of the cancer of interest.
Collection methods:	This information should be sought from the patient's medical record and may be included as a supplementary report in the original pathology report, or a stand-alone pathology report if a different laboratory performs the test.
Comments:	Immunohistochemistry may be helpful in some instances for precise histological subclassification of the tumour and the exclusion of metastasis.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Royal College of Pathologists of Australasia 2010. Lung cancer structured reporting protocol. 1st Edition (Version 1.0). Surry Hills, NSW: Royal College of Pathologists of Australasia

Relational attributes

Related metadata references:	See also Person with cancer—lung cancer immunohistochemistry type, code N[N] Health, Standard 08/05/2014

Implementation in Data Set Specifications:

Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on immunohistochemistry type being coded as Other (88).

▲ Immunotherapy completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—immunotherapy completion date, DDMMYYYY
METeOR identifier:	561360
Registration status:	Health, Standard 08/05/2014
Definition:	The completion date of **immunotherapy** administered during the course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—immunotherapy completion date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	The completion date of immunotherapy treatment is the date of the last dose administered during the course of treatment. The completion date of immunotherapy treatment is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of the immunotherapy. A patient may undergo immunotherapy for an extended period of time. The completion date of the immunotherapy treatment is recorded even if the agent is experimental. Multiple entries are not permitted. Dates of surgical, radiotherapy and other systemic treatments are collected as separate items. However, if a patient receives treatment with a protocol that includes different types of systemic therapy agents, for example, a chemotherapy agent and an immunotherapy agent, record the completion date of treatment in both relevant data items.
Collection methods:	The information should be obtained from the patient's medical record.
Comments:	Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation:	Cancer Australia
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer
	American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer
	Johnson CH & Adamo M (Editors) 2007. SEER Program Coding and Staging Manual 2007, MD 2008 revision. Bethesda:National Cancer Institute, NIH Publication number 07-5581

Relational attributes

Related metadata references:	Supersedes Cancer treatment—immunotherapy completion date, DDMMYYYY Health, Superseded 08/05/2014
	See also Cancer treatment—immunotherapy start date, DDMMYYYY Health, Standard 08/05/2014
	See also Cancer treatment—systemic therapy agent or protocol, text X[X(149)] Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Immunotherapy for cancer cluster Health, Standard 08/05/2014

▲ Immunotherapy start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—immunotherapy start date, DDMMYYYY
METeOR identifier:	561366
Registration status:	Health, Standard 08/05/2014
Definition:	The start date of **immunotherapy** administered during the course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—immunotherapy start date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Record the first or earliest date on which immunotherapy was administered during the course of treatment. The start date of immunotherapy treatment is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of the immunotherapy. A patient may undergo immunotherapy for an extended period of time. The start date of the immunotherapy treatment is recorded even if the agent is experimental. Multiple entries are not permitted. Dates of surgery, radiotherapy and other systemic treatments are collected as separate items. However, if a patient receives treatment with a protocol that includes different types of systemic therapy agents, for example, a chemotherapy agent and an immunotherapy agent, record the completion date of treatment in both relevant data items.
Collection methods:	The information should be obtained from the patient's medical record.
Comments:	Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation:	Cancer Australia

Origin:	American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer Johnson CH & Adamo M (Editors) 2007. SEER Program Coding and Staging Manual 2007, MD 2008 revision. Bethesda:National Cancer Institute, NIH Publication number 07-5581

Relational attributes

Related metadata references:	See also Cancer treatment—immunotherapy completion date, DDMMYYYY Health, Standard 08/05/2014 Supersedes Cancer treatment—immunotherapy start date, DDMMYYYY Health, Superseded 08/05/2014 See also Cancer treatment—systemic therapy agent or protocol, text X[X(149)] Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Immunotherapy for cancer cluster Health, Standard 08/05/2014

◊ Independent Hospital Pricing Authority funding designation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—Independent Hospital Pricing Authority funding designation, code N
Synonymous names:	IHPA funding designation
METeOR identifier:	548713
Registration status:	Health, Standard 11/04/2014
Definition:	The designation given to an establishment by the Independent Hospital Pricing Authority relating to a type of funding the establishment receives, as represented by a code.
Data Element Concept:	Establishment—Independent Hospital Pricing Authority funding designation

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Activity based funded
2	Block funded
8	Not designated

Collection and usage attributes

Guide for use:

CODE 1 Activity based funded

Means that the hospital has been designated by the Independent Hospital Pricing Authority as an **Activity based funded** (ABF) hospital.

CODE 2 Block funded

Means that the hospital has been designated by the Independent Hospital Pricing Authority as a block funded hospital.

CODE 8 Not designated

Means that the hospital is not designated by Independent Hospital Pricing Authority as receiving funding.

Source and reference attributes

Submitting organisation:	PHE NMDS Working Group

Data element attributes

Collection and usage attributes

Guide for use:

The designation given by the IHPA may not reflect the full extent of the funding received by the hospital. For example, in some circumstances a hospital may receive both activity based funding and block funding. It is the designation that is intended to be collected.

The IHPA lists those hospitals designated to be block funded hospitals on its website - http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/nec-determination-2013-14~appendix-A

Relational attributes

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

▲ Individual Healthcare Identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—Individual Healthcare Identifier, N(16)
Synonymous names:	IHI
METeOR identifier:	432495
Registration status:	Health, Standard 08/05/2014
Definition:	The numerical identifier that uniquely identifies each individual in the Australian healthcare system.
Data Element Concept:	Person—Individual Healthcare Identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	N(16)
Maximum character length:	16

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	National E-Health Transition Authority 2010. HI service: concept of operations. Version 2.0-final release. Sydney: National E-Health Transition Authority

Data element attributes

Collection and usage attributes

Guide for use:	Each person's Individual Healthcare Identifier (IHI) is unique within the Australian health care system. Record the full Individual Healthcare Identifier for an individual. The IHI is part of the government's e-health initiative developed to enhance the way information is exchanged, shared and managed in the Australian health sector. Electronic identifiers and the systems underpinning them were developed and are maintained by Medicare Australia. Individual Healthcare Identifiers are automatically assigned to all individuals registered with Medicare Australia or enrolled in the Department of Veterans' Affairs (DVA) programs. Those not enrolled in Medicare Australia or with the Department of Veterans' Affairs are assigned a temporary number when they next seek healthcare; this is then validated by the Healthcare Identifiers (HI) Service Operator and becomes their unique IHI. Only the individual, authorised healthcare providers and their authorised staff can access an individual's IHI number.

Each Individual Healthcare Identifier has an Identifier Status; this describes whether verification of the identifier of the individual has occurred and is based on the evidence available of a person's identity:

- Verified: All individuals eligible for Medicare or DVA benefits are assigned a verified IHI automatically.
- Unverified: For individuals whose identifier cannot be retrieved and who have an IHI created for them at the point of care. This caters, for instance, for newborns and overseas visitors.
- Provisional: Individuals who present at the point of care unconscious or unknown may be assigned a provisional IHI by the healthcare provider. This IHI expires after 90 days of inactivity on the assumption the patient will become known and a verified IHI obtained for them, or their IHI will be converted to an unverified IHI.

The IHI number does not change regardless of the person's Identifier Status.

All healthcare identifiers use the International Standard ISO 7812-1:2006 that specifies the numbering system for identification cards.

The format of the number is as follows:

Digits N1-N6: The issuer identification number, which in turn is made up of:

N1-N2, Major industry identifier: 80 = health
N3-N5, Country code: 036 = Australia
N6, Number type: 0 = IHI

Digits N7-N15: Individual account identification (9 digits for the unique identifier)

Digit N16: Check digit

Collection methods: Authorised healthcare providers and their authorised staff can access an individual's IHI online through the HI Service at the Medicare website.

Comments: The Individual Healthcare Identifier is an initiative of e-health and supports the accurate retrieval, discovery and recording of an individual's electronic health information, as part of the delivery of healthcare in Australia.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: National E-Health Transition Authority 2010. HI service: concept of operations. Version 2.0-final release. Sydney: National E-Health Transition Authority

Relational attributes

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Intended profession (professional entry health professional student)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Professional entry health professional student—intended profession type, code N[N].N
METeOR identifier:	534833
Registration status:	Health, Standard 07/03/2014
Definition:	The type of profession for which a professional entry health professional student is studying to qualify, as represented by a code.
Data Element Concept:	Professional entry health professional student—intended profession type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1.0	Aboriginal and Torres Strait Islander health worker
2.0	Audiology
3.0	Chiropractic
4.0	Dentistry
5.0	Dietetics
6.0	Exercise physiology
7.0	Medical laboratory science
8.0	Medicine
8.1	Medicine - prevocational postgraduate year 1
8.2	Medicine - prevocational postgraduate year 2
8.3	Medicine - prevocational postgraduate year 3+
9.0	Midwifery
10.0	Nursing
10.1	Nursing - enrolled nurse
10.2	Nursing - registered nurse
10.3	Nursing - nurse practitioner
10.8	Nursing - other nursing profession
11.0	Occupational therapy

	12.0	Optometry
	13.0	Oral health
	14.0	Orthoptics
	15.0	Orthotics and prosthetics
	16.0	Osteopathy
	17.0	Paramedicine
	18.0	Pharmacy
	19.0	Physiotherapy
	20.0	Podiatry
	21.0	Psychology
	22.0	Radiation science
	23.0	Social work
	24.0	Sonography
	25.0	Speech pathology
Supplementary values:	99.9	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Data element attributes

Collection and usage attributes

Guide for use:

CODES 8.1, 8.2 and 8.3 Medicine - prevocational postgraduates years 1, 2 and 3+

These codes are not applicable when reporting professional entry student clinical placement hours.

CODE 10.3 Nursing - nurse practitioner

This code is not applicable when reporting professional entry student clinical placement hours.

CODE 10.8 Nursing - other nursing profession

This code is not applicable when reporting professional entry student clinical placement hours.

CODE 13.0 Oral health

Includes dental hygienist, dental therapist, dental prosthetist and oral health therapist.

CODE 22.0 Radiation science

Includes medical diagnostic radiographer, medical radiation therapist, nuclear medicine technologist.

Where students undertake clinical placements related to a double degree, clinical placement hours should be apportioned between qualifying profession type according to the qualification applicable to the clinical placement. For example, a student studying for a combined nursing/psychology degree undertaking a clinical placement required for the nursing qualification should have the hours apportioned to nursing.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references: Has been superseded by Professional entry health professional student—intended profession type, code N[N].N Health, Standardisation pending 18/09/2014

Implementation in Data Set Specifications: Professional entry health professional student cluster Health, Standard 07/03/2014

◊ Labour onset type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—labour onset type, code N
Synonymous names:	Onset of labour
METeOR identifier:	495690
Registration status:	Health, Standard 07/03/2014
Definition:	The manner in which labour started in a birth event, as represented by a code.
Data Element Concept:	Birth event—labour onset type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Spontaneous
2	Induced
3	No labour

Supplementary values:

9	Not stated

Collection and usage attributes

Guide for use:

Labour commences at the onset of regular uterine contractions, which act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes.

If prostaglandins were given to induce labour and there is no resulting labour until after 24 hours, then code the onset of labour as spontaneous.

CODE 3 No labour
Can only be associated with a caesarean section.

Data element attributes

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Birth event—labour onset type, code N Health, Superseded 07/03/2014 See also Birth event—main indication for induction of labour,

code N[N] Health, Standardisation pending 22/09/2014

Implementation in Data Set Specifications:

Perinatal NMDS 2014- Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:

How labour commenced is closely associated with method of birth and maternal and neonatal morbidity. Induction rates vary for maternal risk factors and obstetric complications and are important indicators of obstetric intervention.

This item is collected for the mother only.

◊ Leave days from residential care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—number of leave days, total N[NN]
METeOR identifier:	534017
Registration status:	Health, Standard 07/03/2014
Definition:	The total number of days spent on leave from a residential care service during an episode of residential care.
Data Element Concept:	Episode of residential care—number of leave days

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

A day is measured from midnight to midnight.

Leave days can occur for a variety of reasons, including:

- treatment by a specialised mental health service
- treatment by a non-specialised health service
- time in the community.

The following rules apply in the calculation of leave days:

- the day the **resident** goes on leave is counted as a leave day
- days the resident is on leave are counted as leave days
- the day the resident returns from leave is not counted as a leave day
- if the resident starts a residential stay and goes on leave on the same day, this is not counted as a leave day
- if the resident returns from leave and then goes on leave again on the same day, this is counted as a leave day
- if the resident returns from leave and ends residential care on the same day, the day should not be counted as leave day
- leave days at the end of a residential stay after the commencement of leave are not counted.

If a resident fails to return from leave, then the residential stay is formally ended.

Relational attributes

Related metadata references:

Supersedes Episode of residential care—number of leave days, total N[NN] Health, Superseded 07/03/2014

Implementation in Data Set Specifications:

Residential mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
Episode of residential care end date minus episode of residential care start date minus leave days from residential care must be >= 0 days.

Residential mental health care NMDS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

DSS specific information:
Episode of residential care end date minus episode of residential care start date minus leave days from residential care must be >= 0 days.

▲ Level of functional independence (FIM™ score)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—level of functional independence, Functional Independence Measure score code N
METeOR identifier:	449150
Registration status:	Health, Standard 11/04/2014
Definition:	A person's level of functional independence, as represented by a FIM™ score-based code. Functional independence is the ability to carry out activities of daily living safely and autonomously.
Data Element Concept:	Person—level of functional independence

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Total assistance with helper
2	Maximal assistance with helper
3	Moderate assistance with helper
4	Minimal assistance with helper
5	Supervision or setup with helper
6	Modified independence with no helper
7	Complete independence with no helper

Collection and usage attributes

Guide for use:

The Functional Independence Measure (FIM™) is an instrument which indicates a patient's disability level.

FIM™ is comprised of 18 items, grouped into 2 subscales - motor and cognition.

The motor subscale includes:

- Eating
- Grooming
- Bathing
- Dressing, upper body
- Dressing, lower body
- Toileting
- Bladder management
- Bowel management

- Transfers - bed/chair/wheelchair
- Transfers - toilet
- Transfers - bath/shower
- Walk/wheelchair
- Stairs

The cognition subscale includes:

- Comprehension
- Expression
- Social interaction
- Problem solving
- Memory

Each item is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task associated with that item. The total FIM™ score ranges from 18 to 126.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Data element attributes

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Implementation in Data Set Specifications: Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

Only the Functional Independence Measure scores at admission are required to be reported.

Only required to be reported for episodes of admitted patient care with Hospital service—care type, code N[N] recorded as:

- Code 2, Rehabilitation care; or
- Code 4, Geriatric evaluation and management.

Only required to be reported when the Episode of admitted patient care—clinical assessment only indicator, yes/no code N value is recorded as Code 2, No.

Not required to be reported for patients aged 16 years and under at admission.

▲ Level of functional independence (RUG-ADL score)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—level of functional independence, Resource Utilisation Groups - Activities of Daily Living score code N
METeOR identifier:	446318
Registration status:	Health, Standard 11/04/2014
Definition:	A person's level of functional independence, as represented by a RUG-ADL score-based code. Functional independence is the ability to carry out activities of daily living safely and autonomously.
Data Element Concept:	Person—level of functional independence

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
1	Independent or supervision only
2	Limited assistance
3	Limited physical assistance or Extensive assistance/total dependence/tube fed
4	Other than two persons physical assist
5	Two or more person physical assist

Collection and usage attributes

Guide for use:

The Resource Utilisation Groups - Activities of Daily Living (RUG-ADL) is a four item scale measuring a person's motor function for activities of daily living including:

- Bed mobility
- Toileting
- Transfers
- Eating

For bed mobility, toileting and transfers, valid values are:

1 - Independent or supervision only

3 - Limited physical assistance

4 - Other than two persons physical assist

5 - Two or more person physical assist

Note: a score of 2 is not valid.

For eating, valid values are:

1 - Independent or supervision only

2 - Limited assistance

3 - Extensive assistance/total dependence/tube fed

Note: a score of 4 or 5 is not valid.

Scores are summed for the four ADL variables: bed mobility, toilet use, transfer and eating. A total RUG-ADL scores ranges from a minimum 4 and maximum 18.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Data element attributes

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Reference documents: Fries BE, Schneider DP et al 1994, 'Refining a case-mix measure for nursing homes: Resource Utilization Groups (RUG-III)' Medical Care, vol. 32, pp. 668-685.

Relational attributes

Implementation in Data Set Specifications: Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

Only the Resource Utilisation Groups - Activities of Daily Living (RUG-ADL) scores at admission are required to be reported for maintenance care episodes.

RUG-ADL scores at palliative care phase start should be reported for all palliative care phases.

Only required to be reported for episodes of admitted patient care with Hospital service—care type, code N[N] recorded as:

- Code 3, Palliative care; or
- Code 6, Maintenance care.

Only required to be reported when the Episode of admitted patient care—clinical assessment only indicator, yes/no code N value is recorded as Code 2, No.

Not required to be reported for patients aged 16 years and under at admission.

DSS specific information:

For episodes of admitted patient care with Hospital service—care type, code N[N] recorded as 3 Palliative care, the RUG-ADL scores must be reported for each **palliative care phase** if the episode of admitted patient care had more than one phase.

▲ Level of psychiatric symptom severity (HoNOS 65+ score)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—level of psychiatric symptom severity, Health of the Nation Outcome Scale 65+ score code N
METeOR identifier:	449363
Registration status:	Health, Standard 11/04/2014
Definition:	An assessment of the severity of a person's psychiatric symptoms, as represented by a HoNOS 65+ score-based code.
Data Element Concept:	Person—level of psychiatric symptom severity

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
0	No problems within the period stated
1	Minor problem requiring no action
2	Mild problem but definitely present
3	Moderately severe problem
4	Severe to very severe problem

Collection and usage attributes

Guide for use:

The Health of the Nation Outcome Scale for elderly people (HoNOS65+) is used to rate adult mental health service users. Together, the scales rate various aspects of mental and social health.

HoNOS65+ is answered on an item-specific anchored 4-point scale with higher scores indicating more problems. Each scale is assigned a value of between 0 and 4. The twelve scales are as follows:

- Behavioural disturbance
- Non-accidental self injury
- Problem drinking or drug use
- Cognitive problems
- Problems related to physical illness or disability
- Problems associated with hallucinations and delusions
- Problems associated with depressive symptoms
- Other mental and behavioural problems
- Problems with social or supportive relationships
- Problems with activities of daily living

- Overall problems with living conditions
- Problems with work and leisure activities and the quality of the daytime environment

The sum of the individual scores of each of the scales represents the total HoNOS65+ score. The total HoNOS65+ score ranges from 0 to 48, and represents the overall severity of an individual's psychiatric symptoms.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Data element attributes

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Reference documents: Health of the Nation Outcome Scales (HoNOS), Royal College of Psychiatrists 1996. Viewed 17 October 2013, http://www.rcpsych.ac.uk/training/honos/whatishonos.aspx

Relational attributes

Implementation in Data Set Specifications: Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

Only the HoNOS65+ scores at admission are required to be reported.

Only required to be reported for episodes of admitted patient care with Hospital service—care type, code N[N] recorded as Code 5, Psychogeriatric care.

Only required to be reported when the Episode of admitted patient care—clinical assessment only indicator, yes/no code N value is recorded as Code 2, No.

◊ Local Hospital Network identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—Local Hospital Network identifier, code NNN
Synonymous names:	LHN ID; Local Health District identifier (NSW); Hospital and Health Service identifier (Qld); Local Health Network identifier (SA); Tasmanian Health Organisation identifier
METeOR identifier:	556975
Registration status:	Health, Standard 07/03/2014
Definition:	A unique **Local Hospital Network** (LHN) identifier for an establishment within a jurisdiction, as represented by a code.
Data Element Concept:	Establishment—Local Hospital Network identifier

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
101	South Eastern Sydney
102	Sydney
103	South Western Sydney
104	Western Sydney
105	Nepean Blue Mountains
106	Northern Sydney
107	Central Coast
108	Illawarra Shoalhaven
109	Hunter New England
110	Mid North Coast
111	Northern NSW
112	Western NSW
113	Southern NSW
114	Murrumbidgee
115	Far West
117	Sydney Children's Hospitals Network
118	St Vincent's Health Network
119	Justice Health & Forensic Mental Health
201	Beaufort and Skipton Health Service
202	East Grampians Health Service

203	Ballarat Health Services
204	Stawell Regional Health
205	East Wimmera Health Service
206	Hepburn Health Service
207	Maryborough District Health Service
208	Djerriwarrh Health Service (Vic)
209	Western Health (Vic)
210	Bendigo Health Care Group
211	Heathcote Health
212	Swan Hill District Health
213	Cohuna District Hospital
214	Echuca Regional Health
215	Kerang District Health
216	Maldon Hospital
218	Boort District Health
219	Rochester and Elmore District Health Service
220	Inglewood and District Health Service
221	Castlemaine Health
222	Kyneton District Health Service
223	Royal Children's Hospital (Melbourne)
224	Royal Women's Hospital (Melbourne)
225	Melbourne Health
226	Northern Health (Vic)
227	Victorian Institute of Forensic Mental Health
228	Colac Area Health
229	Hesse Rural Health Service (Winchelsea)
230	Otway Health and Community Services (Apollo Bay)
231	Barwon Health
232	Lorne Community Hospital
233	Alexandra District Hospital
234	Eastern Health (Vic)
235	Goulburn Valley Health
236	Kyabram and District Health Service
237	Numurkah and District Health Service
238	Nathalia District Hospital
239	Cobram District Hospital
240	Seymour District Memorial Hospital
241	Kilmore and District Hospital
242	Yea and District Memorial Hospital
243	Northeast Health Wangaratta
244	Yarrawonga District Health Service

245	Alpine Health (Vic)
246	Mansfield District Hospital
247	Benalla and District Memorial Hospital
248	Tallangatta Health Service
249	Albury Wodonga Health
250	Upper Murray Health and Community Services (Corryong)
251	Beechworth Health Service
252	West Gippsland Healthcare Group
253	Bass Coast Regional Health
254	Gippsland Southern Health Service
255	South Gippsland Hospital (Foster)
256	Bairnsdale Regional Health Service
257	Yarram and District Health Service
258	Omeo District Health
259	Central Gippsland Health Service
260	Latrobe Regional Hospital
261	Orbost Regional Health
262	St Vincent's Hospital (Melbourne) Limited
263	Royal Victorian Eye and Ear Hospital
264	Peter MacCallum Cancer Institute (Vic)
266	Austin Health (Vic)
267	Mercy Public Hospital Inc. (Vic)
268	Alfred Health (Vic)
269	Monash Health
270	Peninsula Health (Vic)
271	Kooweerup Regional Health Service
274	Rural Northwest Health (Vic)
275	Wimmera Health Care Group
276	Dunmunkle Health Services
277	West Wimmera Health Service
278	Edenhope and District Memorial Hospital
279	Mildura Base Hospital
280	Mallee Track Health and Community Service
281	Robinvale District Health Services
282	Western District Health Service (Vic)
283	Casterton Memorial Hospital
284	South West Healthcare (Vic)
285	Heywood Rural Health
286	Timboon and District Healthcare Service
287	Moyne Health Services (Port Fairy)

	288	Portland District Health
	289	Terang and Mortlake Health Service (Terang)
	290	Calvary Health Care Bethlehem Limited
	312	Cairns and Hinterland
	313	Townsville
	314	Mackay
	315	North West (Qld)
	316	Central Queensland
	317	Central West (Qld)
	318	Wide Bay
	319	Sunshine Coast
	320	Metro North (Qld)
	321	Children's Health Queensland
	322	Metro South (Qld)
	323	Gold Coast
	324	West Moreton
	325	Darling Downs
	326	South West (Qld)
	327	Torres and Cape
	401	Northern Adelaide
	402	Central Adelaide
	403	Southern Adelaide
	404	Country Health SA
	405	Women's and Children's Health Network (SA)
	501	North Metropolitan Health Service (WA)
	502	South Metropolitan Health Service (WA)
	503	WA Country Health Service
	580	Child Adolescent Health Service (WA)
	590	Notional Local Hospital Network (Royal St.)
	601	Tasmanian Health Organisation - South
	602	Tasmanian Health Organisation - North
	603	Tasmanian Health Organisation - North West
	701	Top End (NT)
	702	Central Australia (NT)
	801	Australian Capital Territory
Supplementary values:	997	Not applicable
	998	Unknown
	999	Not stated/inadequately described

Collection and usage attributes

Guide for use: A total of 136 Local Hospital Networks have been established across the states and territories. Of these, 122 are geographically based

networks and 14 are state or territory-wide networks that may deliver specialised hospital services across some jurisdictions.

CODE 101 South Eastern Sydney

Includes Lord Howe Island.

Codes 217, 265, 272, 310 and 311 have been deleted from the previous version of the list of permissible values and are not to be reused.

Comments: Some jurisdictions have their own local terminology for the areas and administrative units known nationally as Local Hospital Networks. For example, in New South Wales they are known as 'Local Health Districts', in Queensland they are known as 'Hospital and Health Services', in South Australia they are known as 'Local Health Networks', and in Tasmania they are known as 'Tasmanian Health Organisations'.

More information about Local Hospital Networks is available through the Local Hospital Network portal on the Department of Health website:

Department of Health, Canberra. Viewed 15 November 2013, http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/lochospnetwork

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: A concatenation of:

Australian state/territory identifier (character position 1);

State/Territory-specific hospital network identifier (character positions 2-3).

Comments: The Local Hospital Network identifier should be able to distinguish between all public hospital administrative areas or units nationally.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Is formed using Establishment—Australian state/territory identifier, code N Health, Standard 01/03/2005

Has been superseded by Establishment—Local Hospital Network identifier, code NNN Health, Standardisation pending 23/09/2014, Supersedes Hospital—Local Hospital Network identifier, code NNN Health, Superseded 07/03/2014

Implementation in Data Set Specifications: Local Hospital Networks DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Non-admitted patient care hospital aggregate NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Non-admitted patient care Local Hospital Network aggregate DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Non-admitted patient DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Public hospital establishments NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

▲ Lung cancer immunohistochemistry

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—lung cancer immunohistochemistry type, code N[N]
METeOR identifier:	433027
Registration status:	Health, Standard 08/05/2014
Definition:	The type of **immunohistochemistry** stains used to assist in the identification of abnormal cells and hence the diagnosis of a person with cancer, as represented by a code.
Context:	This should be collected for people with cancer where pathology data is available.
Data Element Concept:	Person with cancer—immunohistochemistry type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Thyroid transcription factor-1 (TTF-1)
2	Cytokeratin 5 (CK5)
3	Cytokeratin 6 (CK6)
4	Cytokeratin 7 (CK7)
5	Cytokeratin 20 (CK20)
6	p53-related transcription factor p63 (p63)
7	Napsin
88	Other

Supplementary values:

97	Not applicable-immunohistochemical staining not performed
98	Unknown if imunohistochemistry performed
99	Immunohistochemistry performed but stains not stated/inadequately described

Collection and usage attributes

Guide for use:	Record the code for each immunohistochemical profile obtained to assist in the diagnosis of lung cancer.
Comments:	Thyroid transcription factor-1 and cytokeratin 7 and 20 can be useful, in conjunction with tumour morphology and clinical and radiological findings, to help to distinguish between primary and metastatic lung adenocarcinomas.

Cytokeratin 5/6 and p63 immunostaining is used by some pathologists to help to determine whether a tumour is a squamous or non-squamous type.

The majority (about 75%) of primary lung adenocarcinomas are CK7 positive, CK20 negative and TTF-1 positive and Napsin stains are positive in approximately 80% of primary lung adenocarcinomas.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Royal College of Pathologists of Australasia 2010. Lung cancer structured reporting protocol. 1st Edition (Version 1.0). Surry Hills, NSW: Royal College of Pathologists of Australasia

Data element attributes

Collection and usage attributes

Guide for use: Record each **immunohistochemical** profile obtained to assist in the diagnosis of cancer.

When "other" is recorded, record the immunohistochemistry stain in text in Person with cancer—immunohistochemistry type, text X[49].

Collection methods: This information should be sought from the patient's medical record and may be included as a supplementary report in the original pathology report, or a stand-alone pathology report if a different laboratory performs the test.

Comments: Immunohistochemistry may be helpful in some instances for precise histological subclassification of the tumour and the exclusion of metastasis.

Source and reference attributes

Submitting organisation: Cancer Australia

Relational attributes

Related metadata references: See also Person with cancer—immunohistochemistry type, text X[X(49)] Health, Standard 08/05/2014

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on immunohistochemistry testing being completed.

▲ Lymphovascular invasion indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—lymphovascular invasion indicator, yes/no code N
METeOR identifier:	519212
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether there is evidence of the invasion of cancer cells into blood vessels and/or the lymphatic system in the person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—lymphovascular invasion indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: An indicator of whether there is evidence of invasion of cancer cells into blood vessels and/or the lymphatic system. Lymphovascular involvement usually precedes spread to the lymph nodes and hence is a predictor of lymph node metastases, although its value as a prognostic indicator is related to cancer type.

Relational attributes

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014
Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Lymphovascular invasion type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—lymphovascular invasion type, code N
METeOR identifier:	430045
Registration status:	Health, Standard 08/05/2014
Definition:	The type of invasion of cancer cells into blood vessels and/or lymphatic system in the person with cancer, as represented by a code.
Context:	This should be collected for people with cancer where pathology data is available.
Data Element Concept:	Person with cancer—lymphovascular invasion type

Value domain attributes

Representational attributes

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

Permissible values: / *Supplementary values:*

Value	Meaning
1	Involvement of artery
2	Involvement of vein
3	Involvement of lymphatics
4	Present but unable to distinguish type of vessel involved
7	Not applicable-pathology specimen not obtained or no lymphovascular invasion present
8	Unknown whether pathology specimen obtained
9	Pathology specimen obtained but lymphovascular invasion not stated/inadequately described

Collection and usage attributes

Guide for use:

Record code 9 when a pathological assessment of the tissue has been performed but the result is not known.

Distinguishing between lymphatics and veins can be difficult; record code 4 if lymphovascular invasion is present but the type of vessel involved is unknown.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Royal College of Pathologists of Australasia 2010. Lung cancer structured reporting protocol. 1st Edition (Version 1.0). Surry Hills, NSW: Royal College of Pathologists of Australasia

National Breast and Ovarian Cancer Centre and Australian Cancer Network 2008. The pathology reporting of breast cancer. A guide for pathologists, surgeons, radiologists and oncologists. 3rdedition. Surry Hills, NSW: National Breast and Ovarian Cancer Centre

Data element attributes

Collection and usage attributes

Guide for use:

Lymphovascular invasion refers to the invasion of cancer cells into the blood vessels or lymphatic channels.

Only record lymphovascular invasion described in the primary tumour, not for metastatic or recurrent disease.

If lymphovascular invasion is present, record whether an artery, vein or lymphatic channel is involved.

If more than one type of vessel is involved, record each appropriate code separately.

Collection methods:

This information should be sought from the patient's pathology report under microscopic findings.

Comments:

Lymphovascular invasion may be an important prognostic factor indicating the tumour is likely to spread, and may influence treatment decisions.

Source and reference attributes

Submitting organisation:

Cancer Australia

Reference documents:

Royal College of Pathologists of Australasia 2010. Lung cancer structured reporting protocol. 1st Edition (Version 1.0). Surry Hills, NSW: Royal College of Pathologists of Australasia

National Breast and Ovarian Cancer Centre 2009. Breast cancer specific data items for clinical cancer registration. Surry Hills, NSW: National Breast and Ovarian Cancer Centre

Relational attributes

Implementation in Data Set Specifications:

Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on lymphovascular invasion having occurred.

◊ Main indication for caesarean section

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—main indication for caesarean section, code NN
Synonymous names:	Reasons for caesarean section
METeOR identifier:	516640
Registration status:	Health, Standard 07/03/2014
Definition:	The primary indication for why a caesarean section is performed during a birth event, as represented by a code.
Data Element Concept:	Birth event—main indication for caesarean section

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Fetal compromise
02	Suspected fetal macrosomia
03	Malpresentation
04	Lack of progress; less than or equal to 3 cm cervical dilatation
05	Lack of progress in the first stage; 4 cm to less than 10 cm cervical dilatation
06	Lack of progress in the second stage
07	Placenta praevia
08	Placental abruption
09	Vasa praevia
10	Antepartum/intrapartum haemorrhage
11	Multiple pregnancy
12	Unsuccessful attempt at assisted delivery
13	Unsuccessful induction
14	Cord prolapse
15	Previous caesarean section
16	Previous shoulder dystocia
17	Previous perineal trauma/4th degree tear
18	Previous adverse fetal/neonatal outcome
19	Other obstetric, medical, surgical, psychological indications

	20	Maternal choice in the absence of any obstetric, medical, surgical, psychological indications
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 01 Fetal compromise

This includes suspected or actual fetal compromise and intra uterine growth restriction (IUGR).

CODE 04 Lack of progress; less than or equal to 3 cm cervical dilatation

Lack of progress includes slow or no progress.

If there has been an attempted induction of labour and then a lack of progress leading to a caesarean section use Code 13 as the main indication and Code 04 as an additional indication.

CODE 05 Lack of progress in the first stage; 4 cm to less than 10 cm cervical dilatation

Lack of progress includes slow or no progress.

If there has been an attempted induction of labour and then a lack of progress leading to a caesarean section use Code 13 as the main indication and Code 05 as an additional indication.

CODE 06 Lack of progress in the second stage

Lack of progress includes slow or no progress.

CODE 07 Placenta praevia

Record placenta praevia as the indication for caesarean section if there is ultrasound or clinical evidence that the edge of the placenta covers the internal cervical os, or encroaches into the lower segment less than 2 cm away from the internal cervical os.

CODE 08 Placental abruption

Record placental abruption as the indication for caesarean section if there is ultrasound or clinical evidence antenatally of abruption of the placenta prior to onset or during labour.

CODE 09 Vasa praevia

Record vasa praevia as the indication for caesarean section if there is ultrasound or visual evidence of exposed fetal blood vessels running across the fetal membrane below or at the level of the fetal presenting part in the lower segment of the uterus. This code is to be used when the caesarean section is planned or in the case of an emergency when the vessels may have ruptured.

CODE 10 Antepartum/intrapartum haemorrhage

Record antepartum/intrapartum haemorrhage as the indication for caesarean section if there has been any antenatal or intrapartum vaginal bleeding that leads to the immediate delivery of the baby by caesarean section. This code should only be used as a main indication if a more specific cause of the antepartum/intrapartum haemorrhage is not known.

Where there is a vasa praevia and an antepartum/intrapartum haemorrhage, Code 09 is to be recorded as the main indication and Code 10 as an additional indication.

CODE 19 Other obstetric, medical, surgical, psychological indications

Where a woman has a psychopathological indication for caesarean section, e.g. extreme fear of natural childbirth, this code should be used. It is not to be used for psychosocial indications which should be coded under Code 19.

CODE 20 Maternal choice in the absence of any obstetric, medical, surgical, psychological indications

This includes psychosocial indications.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use: This data element records the main indication for performing a caesarean section.

Only one code may be selected.

Collection methods: The main indication should be the indication that the clinician attending the birth believes to be the primary reason for the caesarean section being performed. It should be determined at the time of delivery and not revised later or selected based on information that becomes available after delivery such as results of tests or procedures.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also Birth event—additional indications for caesarean section, code NN Health, Standard 07/03/2014

See also Birth event—birth method, code N Health, Standard 06/09/2006

Has been superseded by Birth event—main indication for caesarean section, code N[N] Health, Standardisation pending 22/09/2014

Implementation in Data Set Specifications: Perinatal DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
Conditional on birth method being coded as a caesarean section.

◊ MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) indicator, yes/no code N
METeOR identifier:	504933
Registration status:	Health, Standard 21/11/2013
Definition:	An indicator of whether a Medicare Benefits Schedule (MBS) Health Assessment for Aboriginal and Torres Strait Islander People (Item 715) has been claimed for a person, as represented by a code.
Data Element Concept:	Person—MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

An MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) has been claimed for a person.

CODE 2 No

An MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) has not been claimed for a person.

Comments:

The MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) is used to ensure that Aboriginal and Torres Strait Islander people receive primary health care matched to their needs, by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause morbidity and early mortality. The health assessment includes an assessment of the patient's health, including their physical, psychological and social wellbeing. It also assesses what preventive health care, education and other assistance should be offered to the patient to improve their health and wellbeing.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Department of Health and Ageing 2011. Medicare Benefits Schedule (MBS) Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715), Department of Health and Ageing, Canberra. Viewed 27 May 2011, http://www.health.gov.au/internet/main/publishing.nsf/Content/C0D3F93D216CBEC2CA25771C000079D0/$File/6462(1004)%20Health%20Assessment%20Item%20Fact%20Sheet%20SCREEN.pdf

Relational attributes

Related metadata references: Supersedes Person—MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) indicator, yes/no code N Health, Superseded 21/11/2013

Implementation in Data Set Specifications: Indigenous primary health care DSS 2014-15 Health, Standard 21/11/2013
Indigenous, Endorsed 21/11/2013

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
This item is only collected for persons aged 0-4 years, and persons aged 25 years and over.

DSS specific information:

In the Indigenous primary health care DSS, this data element is collected once for persons aged 0-4 years who have received the MBS Health Assessment for Aboriginal and Torres Strait Islander People within the previous 12 months, and once for persons aged 25 years and older who have received the MBS Health Assessment for Aboriginal and Torres Strait Islander People within the previous 24 months.

Implementation in Indicators: **Used as numerator**
Indigenous primary health care: PI03a-Number of regular clients for whom an MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) was claimed, 2014 Health, Standard 21/11/2013
Indigenous, Endorsed 21/11/2013
Indigenous primary health care: PI03b-Proportion of regular clients for whom an MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) was claimed, 2014 Health, Standard 21/11/2013
Indigenous, Endorsed 21/11/2013

◊ Medical indemnity claim amount

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim—total amount expended, total Australian currency N[N(8)]
METeOR identifier:	482237
Registration status:	Health, Standard 21/11/2013
Definition:	The amount of money expended on a current or closed medical indemnity claim for claimant payments, and for legal defence, investigative and associated expenses, but excluding administrative costs and net of recoveries from third parties, in Australian dollars.
Data Element Concept:	Medical indemnity claim—total amount expended

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	The amount recorded at this data item should equal the sum of the amounts recorded for the data elements: *Medical indemnity claim – medical indemnity claimant payment amount, total Australian currency N[N(8)]* and *Medical indemnity claim – legal and investigative expenses amount, total Australian currency N[N(8)]*. This amount should be $0 when a claim has not incurred any expenses (apart from administration costs).
Comments:	The National Claims and Policies Database (APRA 2006) data item 20 'Gross Payments to Date' is identical to this data item.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare
Reference documents:	APRA (Australian Prudential Regulation Authority) 2006. Data specifications National Claims and Policies Database document number 3.1. Canberra: APRA

Relational attributes

Related metadata references:	See also Medical indemnity claim—claimant payment amount, total Australian currency N[N(8)] Health, Standard 21/11/2013 See also Medical indemnity claim—legal and investigative expenses amount, total Australian currency N[N(8)] Health, Standard 21/11/2013 Supersedes Medical indemnity claim—medical indemnity claim size, code N[N] Health, Superseded 21/11/2013
Implementation in Data Set Specifications:	Medical indemnity DSS 2014- Health, Standard 21/11/2013 *Implementation start date:* 01/07/2014

◊ Medical indemnity claim finalisation date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim management episode—medical indemnity claim finalisation date, DDMMYYYY
METeOR identifier:	535262
Registration status:	Health, Standard 21/11/2013
Definition:	The date on which a medical indemnity claim file was closed, expressed as DDMMYYYY.
Data Element Concept:	Medical indemnity claim management episode—medical indemnity claim finalisation date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	The medical indemnity claim finalisation date is the date on which a medical indemnity claim file was closed. This data element must remain blank if the medical indemnity claim has not yet been closed or a structured settlement is not yet agreed. However, it must be recorded if a medical indemnity claim is closed. This data element should be used in conjunction with the data element: *Date—accuracy indicator, code AAA* to flag whether each component in the date is accurate, estimated or unknown.
Comments:	This data item is collected by the Australian Prudential Regulation Authority (2006) as part of their National Claims and Policies Database.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare
Reference documents:	APRA (Australian Prudential Regulation Authority) 2006. Data specifications National Claims and Policies Database document number 3.1. Canberra: APRA

Relational attributes

Related metadata references:	See also Date—accuracy indicator, code AAA Community

Services, Standard 30/09/2005, Housing assistance, Standard 23/08/2010, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010

Supersedes Medical indemnity claim management episode—medical indemnity claim finalisation date, DDMMYYYY Health, Superseded 21/11/2013

Implementation in Data Set Specifications:

Medical indemnity DSS 2014- Health, Standard 21/11/2013

Implementation start date: 01/07/2014

Conditional obligation:
Conditional upon a medical indemnity claim file being closed.

▲ Medical indemnity claim legal and investigative expenses amount

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim—legal and investigative expenses amount, total Australian currency N[N(8)]
METeOR identifier:	482265
Registration status:	Health, Standard 21/11/2013
Definition:	The amount of money expended for legal defence, investigation and associated expenses on a medical indemnity claim, excluding administrative costs and net of recoveries from third parties, in Australian dollars.
Data Element Concept:	Medical indemnity claim—legal and investigative expenses amount

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	The amount records these expenses cumulatively up to and including the year in which the claim is closed. Except when there have been recoveries from third parties, the amount recorded for this item should be at least as much as that recorded for the same claim in a previous year, including when a claim changes its status from closed to reopened. Claimant legal costs, whether or not paid by the insurer, are excluded. The recorded amount should be $0 when there have been no legal defence or investigative costs.
Comments:	APRA (2006) data item 25 'Gross Claim Payments by Head of Damage before Third Party Recoveries' for finalised claims has 3 fields, 'Defendant legal costs' (25.9), 'Investigation costs' (25.10), and 'Other' (25.11), whose summed AU$ equals the AU$ amount for this Medical indemnity Data Set Specification data item for closed claims.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare
Reference documents:	APRA (Australian Prudential Regulation Authority) 2006. Data specifications National Claims and Policies Database document number 3.1. Canberra: APRA

Relational attributes

Related metadata references:	See also Medical indemnity claim—total amount expended, total Australian currency N[N(8)] Health, Standard 21/11/2013
Implementation in Data Set Specifications:	Medical indemnity DSS 2014- Health, Standard 21/11/2013 *Implementation start date:* 01/07/2014

◊ Medical indemnity claim reserve amount

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim management episode—reserve amount, total Australian currency N[N(8)]
METeOR identifier:	482224
Registration status:	Health, Standard 21/11/2013
Definition:	The estimated financial liability to the health authority of the costs to be incurred in finalising the current medical indemnity claim management episode, in Australian dollars.
Data Element Concept:	Medical indemnity claim management episode—reserve amount

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	The reserve amount includes anticipated payments to claimants as well as anticipated legal, investigative and associated costs, but excludes administrative costs. The reserve amount covers recognised but as yet unpaid liabilities related to a claim as well as its estimated future liabilities. The reserve amount should be recorded as $0 for claims that are closed.
Comments:	The National Claims and Policies Database (APRA 2006) data item 22 'Gross case estimate at end of reporting period' is identical to this data item.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare
Reference documents:	APRA (Australian Prudential Regulation Authority) 2006. Data specifications National Claims and Policies Database document number 3.1. Canberra: APRA

Relational attributes

Related metadata references:	Supersedes Medical indemnity claim management episode—reserve size, range code N[N] Health, Superseded 21/11/2013

Implementation in Data Set Specifications:	Medical indemnity DSS 2014- Health, Standard 21/11/2013 *Implementation start date:* 01/07/2014

▲ Medical indemnity claimant payment amount

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical indemnity claim—claimant payment amount, total Australian currency N[N(8)]
METeOR identifier:	482271
Registration status:	Health, Standard 21/11/2013
Definition:	The amount of money expended as compensation to a medical indemnity claimant, net of recoveries from third parties, in Australian dollars.
Data Element Concept:	Medical indemnity claim—claimant payment amount

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	The amount should include interim payments to claimants for claims while they are still open as well as final payments to claimants when a claim is closed. Except when recoveries from third parties are involved, the amount recorded for this item should be at least as much as that recorded for the same claim in a previous year, including when a claim changes its status from closed to reopened. Claimant legal costs, where reimbursed, are included. The amount should be recorded as $0 when there has been no expenditure on claimant payments.
Comments:	APRA (2006) data item 25 'Gross Claim Payments by Head of Damage before Third Party Recoveries' for finalised claims has 7 fields whose summed AU$ equals the AU$ amount for this Medical indemnity Data Set Specification data item for closed claims. The APRA fields are 'Past economic loss' (25.1), 'Future economic loss' (25.2), 'Past medical, hospital, caring and related services' (25.3), 'Future medical, hospital and related services' (25.4), 'Future caring services' (25.5), 'General damages' (25.6), and 'Plaintiff legal costs' (25.8).

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	Australian Institute of Health and Welfare
Reference documents:	APRA (Australian Prudential Regulation Authority) 2006. Data specifications National Claims and Policies Database document number 3.1. Canberra: APRA

Relational attributes

Related metadata references:	See also Medical indemnity claim—total amount expended, total Australian currency N[N(8)] Health, Standard 21/11/2013
Implementation in Data Set Specifications:	Medical indemnity DSS 2014- Health, Standard 21/11/2013 *Implementation start date:* 01/07/2014

▲ Medical speciality of medical graduate trainees

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical graduate trainee—medical specialty type, code N[N].N[N]
METeOR identifier:	542872
Registration status:	Health, Standard 07/03/2014
Definition:	The medical speciality qualification for which a medical graduate trainee is studying, as represented by a code.
Data Element Concept:	Medical graduate trainee—medical specialty type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N].N[N]
Maximum character length:	4

Permissible values:

Value	Meaning
1.0	Addiction medicine
2.0	Anaesthesia
3.0	Dermatology
4.0	Emergency medicine
5.0	General practice
6.0	Intensive care medicine
7.0	Medical administration
8.0	Obstetrics and gynaecology
9.0	Occupational and environmental medicine
10.0	Ophthalmology
11.0	Paediatrics and child health
12.0	Pain medicine
13.0	Palliative medicine
14.0	Pathology
15.0	Physician
15.1	Physician - cardiology
15.2	Physician - endocrinology
15.3	Physician - gastroenterology and hepatology
15.4	Physician - general medicine
15.5	Physician - geriatric medicine
15.6	Physician - medical oncology
15.7	Physician - nephrology

	15.8	Physician - neurology
	15.88	Physician - other physician type
	16.0	Psychiatry
	17.0	Public health medicine
	18.0	Radiation oncology
	19.0	Radiology
	20.0	Rehabilitation medicine
	21.0	Sexual health medicine
	22.0	Sport and exercise medicine
	23.0	Surgery
	23.1	Surgery - general
	23.2	Surgery - orthopaedic
	23.3	Surgery - otolaryngology
	23.4	Surgery - plastic
	23.88	Surgery - other surgery type
	80.0	Medical profession certificate or diploma
Supplementary values:	99.9	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Data element attributes

Collection and usage attributes

Guide for use: CODE 80.0 Medical profession certificate or diploma

Includes medical certificate and diploma courses from specialist colleges with public hospital workplace based training requirements.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Implementation in Data Set Specifications: Health professional graduate trainee cluster Health, Standard 07/03/2014

◊ Mental health care referral destination

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—mental health care referral destination, code N
Synonymous names:	Referral destination to further care (from specialised mental health residential care)
METeOR identifier:	534056
Registration status:	Health, Standard 07/03/2014
Definition:	The type of health care the **resident** is referred to by the residential mental health care service for further care at the end of residential stay, as represented by a code.
Data Element Concept:	Episode of residential care—mental health care referral destination

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Specialised mental health admitted patient care
2	Specialised mental health residential care
3	Specialised mental health ambulatory care
4	Private psychiatrist care
5	General practitioner care
6	Other care
7	Not referred
8	Not applicable (i.e. end of reference period)

Supplementary values:

Value	Meaning
9	Unknown/not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Where the resident is referred to two or more types of health care, the type of health care provided by the service primarily responsible for the care of the resident is to be reported.

Relational attributes

Related metadata references:	Has been superseded by Episode of residential care—mental health care referral destination, code N Health, Standardisation

pending 22/09/2014

Supersedes Episode of residential care—referral destination (mental health care), code N Health, Superseded 07/03/2014

Implementation in Data Set Specifications:

Residential mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

◊ Mental health legal status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—mental health legal status, code N
METeOR identifier:	534063
Registration status:	Health, Standard 07/03/2014
Definition:	Whether a person is treated on an involuntary basis under the relevant state or territory mental health legislation, at any time during an episode of admitted patient care, an episode of residential care or treatment of a patient/client by a community based service during a reporting period, as represented by a code.
Context:	Mental health care: This metadata item is required to monitor trends in the use of compulsory treatment provisions under state and territory mental health legislation by Australian hospitals and community health care facilities, including 24-hour community based residential services. For those hospitals and community mental health services which provide psychiatric treatment to involuntary patients, mental health legal status information is an essential metadata item within local record systems.
Data Element Concept:	Episode of care—mental health legal status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Involuntary patient
2	Voluntary patient

Supplementary values:

Value	Meaning
9	Not reported/unknown

Collection and usage attributes

Guide for use: CODE 1 Involuntary patient

Involuntary patient should only be used by facilities which are approved for this purpose. While each state and territory mental health legislation differs in the number of categories of involuntary patient that are recognised, and the specific titles and legal conditions applying to each type, the legal status categories which provide for compulsory detention or compulsory treatment of the patient can be readily differentiated within each jurisdiction. These include special categories for forensic patients

who are charged with or convicted of some form of criminal activity. Each state/territory health authority should identify which sections of their mental health legislation provide for detention or compulsory treatment of the patient and code these as involuntary status.

CODE 2 Voluntary patient

Voluntary patient to be used for reporting to the NMDS-Community mental health care, where applicable.

CODE 9 Not reported/unknown

This code is to be used if the mental health legal status for the patient is either not reported or unknown.

Data element attributes

Collection and usage attributes

Guide for use:

The mental health legal status of admitted patients treated within approved hospitals may change many times throughout the episode of care.

Patients may be admitted to hospital on an involuntary basis and subsequently be changed to voluntary status; some patients are admitted as voluntary but are transferred to involuntary status during the hospital stay. Multiple changes between voluntary and involuntary status during an episode of care in hospital or treatment in the community may occur depending on the patient's clinical condition and his/her capacity to consent to treatment.

Similarly, the mental health legal status of residents treated within residential care services may change on multiple occasions throughout the episode of residential care or residential stay.

Approval is required under the state or territory mental health legislation in order to detain patients in hospital for the provision of compulsory mental health care or for patients to be treated compulsorily in the community.

Collection methods:

Admitted patients are to be reported as involuntary if the patient is involuntary at any time during the episode of care.

Residents in **residential mental health services** are to be reported as involuntary if the resident is involuntary at any time during the episode of residential care.

Patients of ambulatory mental health care services are to be reported as involuntary if the patient is involuntary at the time of a service contact.

Relational attributes

Related metadata references:

Supersedes Episode of care—mental health legal status, code N Health, Superseded 07/03/2014

Implementation in Data Set Specifications:

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Admitted patient mental health care NMDS 2014-15 Health,

Standardisation pending 18/07/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Community mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Community mental health care NMDS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

Residential mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Residential mental health care NMDS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

▲ Molecular pathology indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—molecular pathology indicator, yes/no/unknown code N
Synonymous names:	Molecular pathology
METeOR identifier:	435150
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether **molecular pathology** testing was performed to characterise a person's cancer, as represented by a code.
Data Element Concept:	Person with cancer—molecular pathology 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:	8	Unknown

Data element attributes

Collection and usage attributes

Guide for use:	Record whether or not molecular testing was performed on the biospecimen sample of a person with cancer. This should be collected for people with cancer where pathology data is available.
Collection methods:	This information should be sought from the patient's pathology report or a pathology database.
Comments:	Collected to identify the number of patients who undergo molecular testing. The presence of genetic or molecular abnormalities may be of clinical significance and influence treatment decisions.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Royal College of Pathologists of Australasia 2010. Lung cancer structured reporting protocol. 1st Edition (Version 1.0). Surry Hills, NSW: Royal College of Pathologists of Australasia

Relational attributes

Related metadata references:	See also Person with cancer—lung cancer molecular pathology test results, code N[N] Health, Standard 08/05/2014 See also Person with cancer—molecular pathology test date, DDMMYYYY Health, Standard 08/05/2014 See also Person with cancer—molecular pathology test results, (other) code X[X(19)] Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Molecular pathology test date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—molecular pathology test date, DDMMYYYY
Synonymous names:	Molecular pathology date
METeOR identifier:	506791
Registration status:	Health, Standard 08/05/2014
Definition:	The date on which a **molecular pathology** test was performed to characterise a person's cancer, expressed as DDMMYYYY.
Data Element Concept:	Person with cancer—molecular pathology test date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Record the date that **molecular pathology** testing occurred. This is the date that testing took place, not the date that the sample was collected. This item should be collected for people with cancer where pathology data is available.
Collection methods:	This information should be sought from the patient's pathology report or a pathology database.
Comments:	Collected to identify the amount and timing of molecular testing. The presence of genetic or molecular abnormalities may be of clinical significance and influence treatment decisions.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Royal College of Pathologists of Australasia 2010. Lung cancer structured reporting protocol. 1st Edition (Version 1.0). Surry Hills, NSW: Royal College of Pathologists of Australasia

Relational attributes

Related metadata references:	See also Person with cancer—lung cancer molecular pathology test results, code N[N] Health, Standard 08/05/2014 See also Person with cancer—molecular pathology indicator, yes/no/unknown code N Health, Standard 08/05/2014

See also Person with cancer—molecular pathology test results, (other) code X[X(19)] Health, Standard 08/05/2014

Implementation in Data Set Specifications:

Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on molecular profiling being performed for cancer.

▲ Molecular test results (lung cancer)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—lung cancer molecular pathology test results, code N[N]
Synonymous names:	Molecular pathology results
METeOR identifier:	434682
Registration status:	Health, Standard 08/05/2014
Definition:	The results of a **molecular pathology** test for genetic and molecular abnormalities in a person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—molecular pathology test results

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	APC - adenomatous polyposis coli
2	ATM - ataxia telangiectasia mutated
3	EGFR - epidermal growth factor receptor
4	ERBB4 - v-erb-a erythroblastic leukaemia viral oncogene homolog 4
5	ERCC1 - excision repair cross-complementing rodent repair deficiency, complementation group 1
6	KDR - kinase insert domain receptor
7	KRAS - v-Ki-ras2 Kirsten rat sarcoma viral oncogene homolog
8	NF1 - neurofibromin 1
9	PTEN - phosphatase and tensin homolog
10	RB1 - retinoblastoma 1
11	RRM1 - ribonucleotide reductase M1
12	STK11 - serine/threonine kinase 11
13	TYMS - thymidylate synthetase
14	P53 - tumour protein p53
15	ERBB2 - v-erb-a erythroblastic leukaemia viral oncogene homolog 2
16	EML4-ALK - echinoderm microtubule-associated

		protein-like 4 – anaplastic lymphoma kinase
	17	B-RAF - v-Raf murine sarcoma viral oncogene homolog B1
	18	ROS - C-Ros Oncogene 1, Receptor Tyrosine Kinase
	19	MET - Met Proto-Oncogene (Hepatocyte Growth Factor Receptor)
	88	Other
Supplementary values:	97	Not applicable-no abnormalities detected
	98	Unknown whether abnormalities detected
	99	Abnormalities detected but type not stated/inadequately described

Collection and usage attributes

Guide for use:

Each code represents a HUGO Gene Nomenclature Committee (HGNC) assigned unique gene symbol. The full name, location and additional information about each gene can be obtained from their online database at www.genenames.org.

Record the code for each genetic or molecular abnormality detected.

Molecular pathology testing is usually performed for non-small cell lung cancer (NSCLC) and when the result may influence treatment.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents:

Harris TJR & McCormick F 2010. The molecular pathology of cancer. Nat. Rev. Clin. Oncol. 7:251-265

Royal College of Pathologists of Australasia 2010. Lung cancer structured reporting protocol. 1st Edition (Version 1.0). Surry Hills, NSW: Royal College of Pathologists of Australasia

HGNC Database, HUGO Gene Nomenclature Committee (HGNC), EMBL Outstation - Hinxton, European Bioinformatics Institute, Wellcome Trust Genome Campus, Hinxton, Cambridgeshire, CB10 1SD, UK. Viewed 21 June 2011, http://www.genenames.org

Data element attributes

Collection and usage attributes

Guide for use:

Record the results of a **molecular pathology** test for genetic and molecular abnormalities in a person with cancer.

This item should be completed when the data element Molecular pathology indicator is coded as 1, denoting that molecular testing has been performed.

Molecular testing is usually performed when the result may influence treatment. For example, somatic mutations in the EGFR gene are associated with favourable outcomes from treatment

with gefitinib.

Collection methods: This information should be sought from the patient's pathology report.

Comments: The presence of genetic or molecular abnormalities may be of clinical significance and influence treatment decisions.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Harris TJR & McCormick F 2010. The molecular pathology of cancer. Nat. Rev. Clin. Oncol. 7:251-265

Relational attributes

Related metadata references:

See also Person with cancer—molecular pathology indicator, yes/no/unknown code N Health, Standard 08/05/2014

See also Person with cancer—molecular pathology test date, DDMMYYYY Health, Standard 08/05/2014

See also Person with cancer—molecular pathology test results, (other) code X[X(19)] Health, Standard 08/05/2014

Implementation in Data Set Specifications:

Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on molecular profiling being performed for cancer.

▲ Molecular test results description

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—molecular pathology test results, (other) code X[X(19)]
Synonymous names:	Molecular pathology; Molecular profiling
METeOR identifier:	450360
Registration status:	Health, Standard 08/05/2014
Definition:	The results of a **molecular pathology** test for genetic and molecular abnormalities in a person with cancer, as represented by text.
Data Element Concept:	Person with cancer—molecular pathology test results

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	X[X(19)]
Maximum character length:	20

Collection and usage attributes

Guide for use:	Record the HUGO Gene Nomenclature Committee (HGNC) assigned, unique gene symbol (or gene abbreviation, short gene name) corresponding to each genetic or molecular abnormality detected. The symbol is available from their curated online repository at http://www.genenames.org. Gene symbols are designated by upper-case Latin letters or by a combination of upper-case letters and Arabic numerals, with the exception of the # symbol. They do not contain punctuation except for the HLA, immunoglobulin and T cell receptor gene symbols, which may be hyphenated. Generally, gene symbols will be no longer than six characters.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Wain HM, Bruford EA, Lovering RC, Lush MJ, Wright MW, Povey S 2002. Guidelines for Human Gene Nomenclature. Genomics 79(4):464-470 HGNC Database, HUGO Gene Nomenclature Committee (HGNC), EMBL Outstation - Hinxton, European Bioinformatics Institute, Wellcome Trust Genome Campus, Hinxton, Cambridgeshire, CB10 1SD, UK. Viewed 21 June 2011, http://www.genenames.org

Data element attributes

Collection and usage attributes

Guide for use:

Record results of a **molecular pathology** test for genetic and molecular abnormalities in a person with cancer in text.

Molecular testing is usually performed for cancer when the result may influence treatment.

This should be collected for people with cancer where pathology data is available.

Collection methods:

This information should be sought from the patient's pathology report.

Comments:

The presence of genetic or molecular abnormalities may be of clinical significance and influence treatment decisions.

Source and reference attributes

Submitting organisation:

Cancer Australia

Reference documents:

Royal College of Pathologists of Australasia 2010. Lung cancer structured reporting protocol. 1st Edition (Version 1.0). Surry Hills, NSW: Royal College of Pathologists of Australasia

Harris TJR & McCormick F 2010. The molecular pathology of cancer. Nat. Rev. Clin. Oncol. 7:251-265

Relational attributes

Related metadata references:

See also Person with cancer—lung cancer molecular pathology test results, code N[N] Health, Standard 08/05/2014

See also Person with cancer—molecular pathology indicator, yes/no/unknown code N Health, Standard 08/05/2014

See also Person with cancer—molecular pathology test date, DDMMYYYY Health, Standard 08/05/2014

Implementation in Data Set Specifications:

Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on molecular pathology test results being coded as CODE 88 Other.

▲ Multidisciplinary team review indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—multidisciplinary team review indicator, yes/no/unknown code N
Synonymous names:	MDT review indicator; Multidisciplinary care indicator
METeOR identifier:	428137
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether a patient's cancer treatment is discussed and a treatment plan developed by a multidisciplinary team, as represented by a code.
Data Element Concept:	Cancer treatment—multidisciplinary team review 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:

8	Unknown

Data element attributes

Collection and usage attributes

Guide for use:

Record a multidisciplinary team (MDT) review that occurs prior to the implementation of, or during the course of treatment for cancer. The initial treatment for cancer includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

Access to a unit offering multidisciplinary care is recommended for patients with cancer.

Multidisciplinary care (MDC) is defined as an integrated team approach to health care in which medical and allied health care professionals consider all relevant treatment options and develop collaboratively an individual treatment plan for each patient. (National Breast Cancer Centre 2005, page 5.)

There are a number of models of MDC in Australia. These include:

- A 'tumour board' model in which the patient's case is discussed by the team, a recommendation for treatment is made, and the treating clinician informs the patient of the recommendation and

makes the appropriate referrals.

- A variation of this model in which the patient attends a clinic after the discussion and meets the members of the team who will be involved in their ongoing care.

The MDT review may be conducted according to any of these models; the essential component is that the multidisciplinary team assesses the patient's treatment options and develops a treatment plan.

Multidisciplinary team membership will vary depending on the cancer type but should consist of the core disciplines required for the provision of good care, and reflect both the clinical and psychosocial aspects of care.

For example, for lung cancer the core team would ideally be represented by respiratory medicine, cardiothoracic surgery, medical oncology, radiation oncology, pathology, radiology, nurse specialist and palliative care, while non-core team membership would consist of nuclear medicine, social work, physiotherapy, psychiatry/psychology, dietetics and occupational therapy.

Collection methods: This information should be sought from the patient's medical record, referral letters or attending medical clinician.

Comments: There is increasing evidence that a multidisciplinary team approach to health care improves patient satisfaction with treatment and outcomes. Furthermore, decisions made using this approach are more likely to accord with evidence-based guidelines than those made by individual clinicians.

Multidisciplinary care also benefits clinicians by, for example, providing opportunities to interact with colleagues, enhanced educational opportunities and streamlining of referral pathways.

There is currently little provision in patient's medical records for the formal recording of multidisciplinary team review. The development of specific forms to capture this information is strongly recommended.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Australian Cancer Network 2004. Clinical practice guidelines for the prevention, diagnosis and management of lung cancer. Approved by the National Health & Medical Research Council 2004. Sydney: The Cancer Council Australia

National Breast Cancer Centre 2005. Multidisciplinary meeting for cancer care: a guide for health service providers. Camperdown, NSW: National Breast Cancer Centre

Relational attributes

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

DSS specific information:
This item is to be collected in relation to the initial course of treatment for cancer.

▲ Multiple primary tumours descriptor

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—multiple primary tumours descriptor, code N
METeOR identifier:	429482
Registration status:	Health, Standard 08/05/2014
Definition:	Whether the multiple primary tumours in the person with cancer are synchronous or metachronous, as represented by a code.
Data Element Concept:	Person with cancer—multiple primary tumours descriptor

Value domain attributes

Representational attributes

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

Permissible values: / *Supplementary values:*

Value	Meaning
1	Synchronous
2	Metachronous
7	Not applicable, i.e. single primary tumour only
8	Number of primary tumours unknown
9	Multiple primary tumours present, but synchronicity not stated/inadequately described

Collection and usage attributes

Guide for use:	Record the appropriate code at diagnosis, then update at the first appearance of a subsequent second primary where multiple tumours are discovered.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Breathnach OS & Skarin AT 2009. Multiple primary lung cancers. Wolters Kluwer Health, UpToDate Inc., Waltham, MA. Viewed 8 March 2011, http://www.uptodate.com/contents/multiple-primary-lung-cancers

Data element attributes

Collection and usage attributes

Guide for use:	Synchronous primary tumours are detected simultaneously, either preoperatively or in the resected specimen. Metachronous primary tumours are detected after a time interval

between detection of the first lesion and detection of a subsequent primary lesion.

Collection methods: This information should be sought from the patient's pathology report and medical record.

Comments: Patients with multiple primary tumours may have a worse prognosis or more extensive treatment than patients with a single tumour. In addition, the management and prognosis when multiple primary tumours are present may vary depending on whether the tumours are synchronous or metachronous.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Breathnach OS & Skarin AT 2009. Multiple primary lung cancers. Wolters Kluwer Health, UpToDate Inc., Waltham, MA. Viewed 8 March 2011, http://www.uptodate.com/contents/multiple-primary-lung-cancers

Relational attributes

Related metadata references: See also Person with cancer—multiple primary tumours indicator, yes/no code N Health, Standard 08/05/2014

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is to be recorded if Person with cancer—multiple primary tumours indicator, yes/no code N indicates the presence of multiple primary tumours.

Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is to be recorded if Person with cancer—multiple primary tumours indicator, yes/no code N indicates the presence of multiple primary tumours.

▲ Multiple primary tumours indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—multiple primary tumours indicator, yes/no code N
METeOR identifier:	519548
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether a person with cancer has multiple primary tumours, as represented by a code.
Data Element Concept:	Person with cancer—multiple primary tumours indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Record whether a person with cancer has multiple primary tumours, regardless of whether they are synchronous or metachronous.

Patients with multiple primary tumours may have a worse prognosis or more extensive treatment than patients with a single tumour. In addition, the management and prognosis when multiple primary tumours are present may vary depending on whether the tumours are synchronous or metachronous.

Source and reference attributes

Submitting organisation: Cancer Australia

Relational attributes

Related metadata references:	See also Person with cancer—multiple primary tumours descriptor, code N Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014 Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Myometrial thickness

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—myometrial thickness, total millimetres N[N]
METeOR identifier:	424269
Registration status:	Health, Standard 08/05/2014
Definition:	The total myometrial thickness for a person with endometrial cancer, expressed in millimetres.
Data Element Concept:	Person with cancer—myometrial thickness

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
97	Not applicable
98	Unknown
99	Not stated/inadequately described

Unit of measure: Millimetre (mm)

Collection and usage attributes

Guide for use: Size in millimetres with valid values from 1 to 96.

Source and reference attributes

Submitting organisation: Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use: Record the total myometrial thickness in millimetres (mm).

Depth of myometrial invasion is a prognostic factor for endometrial cancer. Myometrial thickness ranges from 2 to 40 mm. A myometrial thickness of 5 mm or less is considered to be normal.

The fractional myometrial invasion by tumour cells, i.e. the ratio of myometrial invasive depth to total normal myometrial thickness, is predictive of lymph node metastases in high risk endometrial cancers.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents:

Hauth EA, Jaeger HJ, Libera H, Lange S, Forsting M 2007. MR imaging of the uterus and cervix in healthy women: determination of normal values. European Radiology 17:734

O'Connell LO, Fries MH, Zeringue E, Brehm W 1998. Triage of Abnormal Postmenopausal Bleeding: A comparison of endometrial biopsy and transvaginal sonohysterography versus fractional curettage with hysteroscopy. American Journal of Obstetrics & Gynecology 178:956-61

RCPA 2011. Endometrial Cancer Structured Reporting Protocol (1st Edition 2011). Sydney: Royal College of Pathologists of Australasia

Weber AM, Belinson JL, Bradley LD, Piedmonte MR 1997. Vaginal ultrasonography versus endometrial biopsy in women with postmenopausal bleeding. American Journal of Obstetrics & Gynecology 177:924-9

Relational attributes

Related metadata references: See also Person with cancer—depth of myometrial invasion, total millimetres N[N] Health, Standard 08/05/2014

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is only to be recorded for patients with endometrial cancer, as indicated by Person with cancer—primary site of cancer, topography code (ICD-O-3) ANN.N.

▲ Non-admitted service type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—non-admitted service type, code (Tier 2 v3.0) NN.NN
METeOR identifier:	548189
Registration status:	Health, Standard 07/03/2014 Tasmanian Health, Final 02/07/2014
Definition:	The type of service through which an establishment provides health care to a non-admitted patient in a non-admitted setting, as represented by a code.
Data Element Concept:	Non-admitted patient service event—non-admitted service type

Value domain attributes

Representational attributes

Classification scheme:	Tier 2 Non-Admitted Services classification (version 3.0)
Representation class:	Code
Data type:	Number
Format:	NN.NN
Maximum character length:	4

Collection and usage attributes

Guide for use:	The code set is based on the list and definitions outlined in the document: Tier 2 Non-Admitted Services Definitions Manual (version 3.0).

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority
Origin:	Independent Hospital Pricing Authority, 2014. Tier 2 Outpatient Clinic Definitions (version 3.0). Independent Hospital Pricing Authority, Sydney. Viewed 30 April 2014, http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/non-admitted-care

Data element attributes

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority

Relational attributes

Related metadata references:	Supersedes Non-admitted patient service event—non-admitted service type, code (Tier 2 v2.0) NN.NN Health, Superseded 07/03/2014, Independent Hospital Pricing Authority, Standard 31/10/2012

Has been superseded by Non-admitted patient service event—non-admitted service type, code (Tier 2 v4.0) NN.NN Health, Standardisation pending 23/09/2014

Implementation in Data Set Specifications:

Non-admitted patient care hospital aggregate NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Non-admitted patient care Local Hospital Network aggregate DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Non-admitted patient DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

◊ Number of episodes of residential care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—number of episodes of residential care, total NNNN
METeOR identifier:	534013
Registration status:	Health, Standard 07/03/2014
Definition:	The total number of episodes of completed residential care occurring during the reference period (between 1 July and 30 June each year). This includes both formal and statistical episodes of residential care.
Data Element Concept:	Episode of residential care—number of episodes of residential care

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	The sum of the number of episodes of residential care where the Episode of residential care end date has a value: • Equal to or greater than the beginning of the reference period (01 July each year); and • Less than or equal to the end of the reference period (30 June each year at midnight).
Collection methods:	To be reported for all specialised residential mental health care services, including non-government residential mental health care services and less than 24-hour residential mental health care services.

Relational attributes

Related metadata references:	Supersedes Episode of residential care—number of episodes of residential care, total NNNN Health, Superseded 07/03/2014
Implementation in Data Set Specifications:	Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014 *Implementation start date:* 01/07/2014 *Implementation end date:* 30/06/2015 Mental health establishments NMDS 2015-16 Health,

Standardisation pending 23/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

Staffed residential services mental health service type cluster Health, Standardisation pending 19/09/2014

▲ Number of health professional graduate trainees (FTE)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent health professional graduate trainees, total N[NNN{.N}]
METeOR identifier:	534795
Registration status:	Health, Standard 07/03/2014
Definition:	The total full-time equivalent number of health professional graduate trainees in an establishment, as represented by a number.
Data Element Concept:	Establishment—full-time equivalent health professional graduate trainees

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	Where graduate trainees work in more than one establishment, full-time equivalent graduate trainees should be apportioned between establishments on the basis of hours worked in each.

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority

Relational attributes

Implementation in Data Set Specifications:	Health professional graduate trainee cluster Health, Standard 07/03/2014

DSS specific information:
If a legitimate data value cannot be provided by a jurisdiction for a particular category, such an occurrence should be handled via the use of a supplementary value of 9999.7.

▲ Number of new health professional graduates (FTE)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent new health professional graduates, total N[NNN{.N}]
METeOR identifier:	534747
Registration status:	Health, Standard 07/03/2014
Definition:	The total full-time equivalent number of new health professional graduates in an establishment.
Data Element Concept:	Establishment—full-time equivalent new health professional graduates

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	Where new graduates work in more than one establishment, full-time equivalent new graduates should be apportioned between establishments on the basis of hours worked in each.

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority

Relational attributes

Implementation in Data Set Specifications:	New health professional graduate cluster Health, Standard 07/03/2014 *DSS specific information:* If a legitimate data value cannot be provided by a jurisdiction for a particular category, such an occurrence should be handled via the use of a supplementary value of 9999.7. New health professional graduate cluster Health, Standardisation pending 18/09/2014 *DSS specific information:* If a legitimate data value cannot be provided by a jurisdiction for a particular category, such an occurrence should be handled via

the use of a supplementary value of 9999.7.

◊ Organisation name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—organisation name, text [X(200)]
Synonymous names:	Business name; Entity name
METeOR identifier:	453823
Registration status:	Community Services, Standard 06/02/2012 Health, Standard 08/05/2014 Early Childhood, Standard 09/03/2012
Definition:	The full title of an organisation's name by which it trades or is recognised, as represented by text.
Data Element Concept:	Organisation—organisation name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(200)]
Maximum character length:	200

Data element attributes

Collection and usage attributes

Guide for use:	An organisation may have multiple names. Naming standards for incorporated companies are defined in the Australian Securities and Investments Commission (ASIC), Schedule 6 of the Corporation Regulations.
Collection methods:	If special characters or symbols form part of the name they should be included. This includes all characters from the standard printable ASCII character set such as the letters A-Z, hyphens, commas, apostrophes, @, # etc, as well as the non-standard or extended ASCII characters such as ü, á, é, ®, ™etc. Mixed case should be used rather than upper case only.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Relational attributes

Related metadata references:	Supersedes Service provider organisation (name)—organisation name, text [X(200)] Community Services, Superseded 06/02/2012, Health, Superseded 08/05/2014, Early Childhood,

Superseded 09/03/2012

Implementation in Data Set Specifications:

Early Childhood Education and Care: Aggregate NMDS 2012 Early Childhood, Superseded 08/04/2013

Implementation start date: 01/07/2012

DSS specific information:

This item should be used to report the operating or trading name of the early childhood education and care service which delivers a preschool program to children.

The registered business name should not be used if it is different from the name of early childhood education and care service that it manages or owns.

A campus name or satellite school name (e.g. where the service provider organisation operates preschool programs at multiple geographical locations using the same service provider name) may also be used.

Each service provider must have a discrete service provider organisation name to allow identification of each individual location for provision of a preschool program.

The organisation name type data item is not required.

Early Childhood Education and Care: Aggregate NMDS 2013 Early Childhood, Superseded 28/05/2014

Implementation start date: 01/07/2013

DSS specific information:

This item should be used to report the operating or trading name of the early childhood education and care service which delivers a preschool program to children.

The registered business name should not be used if it is different from the name of early childhood education and care service that it manages or owns.

A campus name or satellite school name (e.g. where the service provider organisation operates preschool programs at multiple geographical locations using the same service provider name) may also be used.

Each service provider must have a discrete service provider organisation name to allow identification of each individual location for provision of a preschool program.

The organisation name type data item is not required.

Early Childhood Education and Care: Aggregate NMDS 2014 Early Childhood, Standard 28/05/2014

Implementation start date: 01/07/2014

DSS specific information:

This item should be used to report the operating or trading name of the early childhood education and care service which delivers an early childhood education program to children.

The registered business name should not be used if it is

different from the name of the early childhood education and care service that it manages or owns.

A campus name or satellite school name (e.g. where the service provider organisation operates early childhood education programs at multiple geographical locations using the same service provider name) may also be used.

Each service provider must have a discrete service provider organisation name to allow identification of each individual location for provision of an early childhood education program.

The organisation name type data item is not required.

Early Childhood Education and Care: Unit Record Level NMDS 2012 Early Childhood, Superseded 08/04/2013

Implementation start date: 01/07/2012

DSS specific information:

This item should be used to report the operating or trading name of the early childhood education and care service which delivers a preschool program to children.

The registered business name should not be used if it is different from the name of early childhood education and care service that it manages or owns.

A campus name or satellite school name (e.g. where the service provider organisation operates preschool programs at multiple geographical locations using the same service provider name) may also be used.

Each service provider must have a discrete service provider organisation name to allow identification of each individual location for provision of a preschool program.

The organisation name type data item is not required.

Early Childhood Education and Care: Unit Record Level NMDS 2013 Early Childhood, Superseded 28/05/2014

Implementation start date: 01/07/2013

DSS specific information:

This item should be used to report the operating or trading name of the early childhood education and care service which delivers a preschool program to children.

The registered business name should not be used if it is different from the name of early childhood education and care service that it manages or owns.

A campus name or satellite school name (e.g. where the service provider organisation operates preschool programs at multiple geographical locations using the same service provider name) may also be used.

Each service provider must have a discrete service provider organisation name to allow identification of each individual location for provision of a preschool program.

The organisation name type data item is not required.

Early Childhood Education and Care: Unit Record Level NMDS

2014 Early Childhood, Standard 28/05/2014

Implementation start date: 01/07/2014

DSS specific information:

This item should be used to report the operating or trading name of the early childhood education and care service which delivers an early childhood education program to children.

The registered business name should not be used if it is different from the name of the early childhood education and care service that it manages or owns.

A campus name or satellite school name (e.g. where the service provider organisation operates early childhood education programs at multiple geographical locations using the same service provider name) may also be used.

Each service provider must have a discrete service provider organisation name to allow identification of each individual location for provision of an early childhood education program.

The organisation name type data item is not required.

Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is to be recorded when the data element Person—tissue sample collected indicator, yes/no code N indicates that a tissue sample has been collected.

DSS specific information:
Use this data element to record the name of the laboratory or biobank in which a tissue sample is stored. Collect this data element in conjunction with Person—tissue sample collected indicator, yes/no code N.

Juvenile Justice Detention file cluster Community Services, Standardisation pending 16/12/2013

Implementation start date: 01/07/2011

DSS specific information:

This Data Element is used in the Detention file cluster to identify the name of the youth justice remand or detention centre where the young person is detained.

If the detention end date of the current detention period is after the detention start date of the next detention period, the organisation name (youth justice remand or detention centre) of the current period and the next detention period must be the same.

Mental health organisation details cluster Health, Standardisation pending 19/09/2014

Organisation details data dictionary Community Services, Standard 06/02/2012

◊ Other cancer treatment description

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—other cancer treatment, text X[X(149)]
METeOR identifier:	561623
Registration status:	Health, Standard 08/05/2014
Definition:	The cancer-directed treatment administered during the course of treatment for cancer, other than surgery, radiotherapy or systemic therapy, as represented by text.
Data Element Concept:	Cancer treatment—other cancer treatment

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(149)]
Maximum character length:	150

Source and reference attributes

Submitting organisation:	Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use:

This data item is to record cancer-directed treatments that cannot be appropriately assigned to the specific treatment codes in the cancer treatment data items for surgery, radiotherapy, systemic therapy agents and systemic therapy procedures.

Cancer-directed treatments refer to those treatments that destroy or modify cancer tissue anywhere in the body. The exception to this is treatments for hematopoietic diseases (refer to additional notes below).

Cancer-directed treatments may be palliative (to control symptoms, alleviate pain, or make the patient more comfortable) or curative.

Record all other treatments administered during the course of treatment.

Each treatment event delivered to the patient should be recorded; multiple entries are permitted.

Record antibody treatments, vaccine treatments, and those targeted therapies that use drugs or substances other than chemotherapy agents in this data item. Targeted therapies using chemotherapy agents are recorded in the data items for chemotherapy. Targeted therapies are treatments that use drugs

or other substances to identify and attack specific cancer cells.

Do not record ancillary drugs. For example, allopurinol, which is commonly used as prophylaxis with chemotherapy agents to prevent severe hyperuricemia. A list of drugs regarded as ancillary is available in the SEER*Rx-Interactive Antineoplastic Drugs Database Version 1.4.1.

Treatment events may include (for example):

- Treatment unique to hematopoietic diseases, for example, phlebotomy, transfusions or aspirin. ONLY record aspirin therapy used to thin the blood for symptomatic control of thrombocythemia. Do not record aspirin used for pain or cardiovascular protection.
- Embolisation that is performed using alcohol as an embolising agent or for embolisation to a site other than the liver where the embolising agent is unknown. Embolisation using chemotherapeutic agents is coded separately with chemotherapy, and embolisation using a radioactive agent or seeds is coded with brachytherapy-radiation treatment.
- Any experimental or newly developed treatment that cannot be appropriately assigned to other specific treatment data items.
- A double-blind clinical trial. Record the treatment actually administered to the patient in the appropriate treatment data item when the double-blind trial code is broken.
- Cancer treatments administered by non-medical personnel. This includes unconventional methods whether administered as single therapy or in combination with conventional therapies. Record alternative therapies only if the patient doesn't receive any other type of treatment.

Collection methods: The information should be obtained from the patient's medical record.

Comments: Information on other cancer treatments is used to describe and evaluate the quality of care and treatment practices.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

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

Johnson CH & Adamo M (Editors) 2007. SEER Program Coding and Staging Manual 2007, MD 2008 revision. Bethesda:National Cancer Institute, NIH Publication number 07-5581

Relational attributes

Related metadata references: See also Cancer treatment—cancer treatment type, code N[N] Health, Standard 08/05/2014

Supersedes Cancer treatment—other cancer treatment, text [X(150)] Health, Superseded 08/05/2014

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on the patient having treatment that cannot be defined as surgery, radiotherapy or systemic therapy according to the definitions of those data items in this data set specification.

Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is to be recorded for a patient having treatment that cannot be defined as surgery, radiotherapy or systemic therapy according to the definitions of those data items in this data set specification.

DSS specific information:
This data element is to be used to describe treatment, other than surgery, radiotherapy or systemic therapy, used to treat a first recurrence of gynaecological cancer.

◊ Outcome of treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—outcome of treatment, code N.N
METeOR identifier:	561665
Registration status:	Health, Standard 08/05/2014
Definition:	The response of the tumour at the completion of the course of treatment for cancer, as represented by a code.
Data Element Concept:	Cancer treatment—outcome of treatment

Value domain attributes

Representational attributes

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

Permissible values: / *Supplementary values:*

Value	Meaning
1.0	Complete response/no evidence of disease
2.1	Partial response
2.2	Stable or static disease
2.3	Progressive disease
7.0	Not assessed or unable to be assessed
8.0	Unknown
9.0	Not stated/inadequately described

Collection and usage attributes

Guide for use:

The outcome of treatment is recorded at the completion of the course of treatment for the cancer.

CODE 1.0 Complete response/no evidence of disease

Complete disappearance of all measurable disease, including tumour markers, for at least four weeks. No new lesions or new evidence of disease. For breast cancer, this reflects "No evidence of disease".

CODE 2.1 Partial response

A decrease by at least 50% of the sum of the products of the maximum diameter and perpendicular diameter of all measurable lesions, for at least four weeks. No new lesions or worsening of disease.

CODE 2.2 Stable or static disease

No change in measurable lesions qualifying as partial response or progression and no evidence of new lesions.

CODE 2.3 Progressive disease

An increase by at least 25% of the sum of the products of the

maximum diameter and a perpendicular diameter of any measurable lesion, or the appearance of new lesions.

CODE 9.0 Not stated/inadequately described

The tumour was assessed but the percentage of increase or decrease in the tumour size is not stated or is inadequately described.

Source and reference attributes

Submitting organisation: Cancer Australia

Data element attributes

Collection and usage attributes

Collection methods: This information should be obtained from the patient's medical record.

Comments: Information regarding the outcome of treatment is required for patient follow-up and outcomes studies.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: New South Wales Health Department

Reference documents: Public Health Division 2001. NSW Clinical Cancer Data Collection for Outcomes and Quality: Data Dictionary, Version 1. Sydney:NSW Health Department

Relational attributes

Related metadata references: Supersedes Cancer treatment—outcome of treatment, code N.N Health, Superseded 08/05/2014

See also Cancer treatment—treatment outcome date, DDMMYYYY Health, Recorded 12/05/2014

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 08/05/2014

Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is conditional on a patient completing treatment for their first recurrence of cancer.

DSS specific information:
This data element is to be recorded for patients who have completed their primary course of treatment or treatment for the first recurrence of cancer. For patients who have completed treatment for their first recurrence of cancer this should be recorded multiple times, once in relation to their primary course of treatment and once in relation to treatment for the first recurrence of cancer.

▲ Palliative care phase

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—palliative care phase, code N
METeOR identifier:	445942
Registration status:	Health, Standard 11/04/2014 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	The patient's stage of illness or situation within the episode of care in terms of the recognised **phases of palliative care**, as represented by a code.
Data Element Concept:	Episode of admitted patient care—palliative care phase

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Stable
2	Unstable
3	Deteriorating
4	Terminal

Supplementary values:

Value	Meaning
9	Not reported

Collection and usage attributes

Guide for use: The palliative care phase is the stage of the palliative care patient's illness.

CODE 1 Stable

The patient symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned. The situation of the family/carers is relatively stable and no new issues are apparent. Any needs are met by the established plan of care.

CODE 2 Unstable

The patient experiences the development of a new unexpected problem or a rapid increase in the severity of existing problems, either of which require an urgent change in management or emergency treatment. The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multidisciplinary team.

CODE 3 Deteriorating

The patient experiences a gradual worsening of existing symptoms or the development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment. The family/carers experience gradually worsening

distress and other difficulties, including social and practical difficulties, as a result of the illness of the person. This requires a planned support program and counselling as necessary.

CODE 4 Terminal

Death is likely in a matter of days and no acute intervention is planned or required. The typical features of a person in this phase may include the following:

- Profoundly weak.
- Essentially bed bound.
- Drowsy for extended periods.
- Disoriented for time and has a severely limited attention span.
- Increasingly disinterested in food and drink.
- Finding it difficult to swallow medication.

This requires the use of frequent, usually daily, interventions aimed at physical, emotional and spiritual issues. The family/carers recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement.

CODE 9 Not reported

The phase of the illness has not been reported.

Palliative care phases are not sequential and a patient may move back and forth between phases. Palliative care phases provide a clinical indication of the type of care required and have been shown to correlate strongly with survival within longitudinal prospective studies.

Source and reference attributes

Origin: Palliative Care Outcomes Collaboration (PCOC) 2009. PCOC V2 Data Definitions and Guidelines. Australian Health Services Research Institute, University of Wollongong, Wollongong. Viewed 24 August 2012, http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow090306.pdf

Data element attributes

Collection and usage attributes

Guide for use: The bereavement phase of palliative care must not be recorded when reporting this data element.

Collection methods: The type of phase is to be recorded at the start of the episode of admitted patient palliative care and for every subsequent change in phase thereafter during the same admitted patient episode.

The palliative care provider reviews the patient daily (or at each visit) and records phase changes if and when they occur during the episode.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Implementation in Data Set Specifications: Activity based funding: Admitted sub-acute and non-acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Standard 11/10/2012

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:

Only required to be reported for episodes of admitted patient care with hospital service-care type, code N[N].N recorded as 3.0 palliative care.

Only required to be reported when Episode of admitted patient care-assessment only indicator, yes/no, code N value recorded as 2 no.

DSS specific information:

For episodes of admitted patient care with hospital service-care type, code N[N].N recorded as 3.0 palliative care, the palliative care phase must be reported for each **palliative care phase** if the episode of admitted patient care had more than one phase.

Admitted sub-acute and non-acute care activity based funding DSS 2012-2013 Independent Hospital Pricing Authority, Superseded 11/10/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:
Only required to be reported for episodes of care for patients with a care type of palliative care.

Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

Only required to be reported for episodes of admitted patient care with Hospital service—care type, code N[N] recorded as Code 3, Palliative care.

Only required to be reported when the Episode of admitted patient care—clinical assessment only indicator, yes/no code N value is recorded as Code 2, No.

Not required to be reported for patients aged 16 years and under at admission.

DSS specific information:

For episodes of admitted patient care with Hospital service—care type, code N[N] recorded as Code 3, Palliative care, the palliative care phase must be reported for each **palliative care phase** if the episode of admitted patient care had more than one phase.

▲ Palliative care phase end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—palliative phase of care end date, DDMMYYYY
METeOR identifier:	445598
Registration status:	Health, Standard 11/04/2014 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	The date on which an admitted patient completes a **phase of palliative care**, expressed as DDMMYYYY.
Data Element Concept:	Episode of admitted patient care—palliative phase of care end date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	The end date is the date on which an admitted palliative care patient completes a palliative care phase type.
Collection methods:	The palliative phase of care end date is to be recorded at the completion of the palliative care phase and at the completion of every subsequent phase thereafter in the same admitted patient palliative care episode.

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority
Reference documents:	Palliative Care Outcomes Collaboration Assessment Toolkit. Palliative Care Outcomes Collaboration, University of Wollongong, Wollongong. Viewed 19 September 2012, http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow129133.pdf

Relational attributes

Implementation in Data Set Specifications:	Activity based funding: Admitted sub-acute and non-acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Standard 11/10/2012 *Implementation start date:* 01/07/2013 *Implementation end date:* 30/06/2014 *Conditional obligation:*

Only required to be reported for episodes of admitted patient care with hospital service-care type, code N[N].N recorded as 3.0 palliative care.

Only required to be reported when Episode of admitted patient care-assessment only indicator, yes/no, code N value recorded as 2 no.

DSS specific information:

For episodes of admitted patient care with hospital service-care type, code N[N].N recorded as 3.0 palliative care, the palliative care phase must be reported for each **palliative care phase** if the episode of admitted patient care had more than one phase.

Admitted sub-acute and non-acute care activity based funding DSS 2012-2013 Independent Hospital Pricing Authority, Superseded 11/10/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:
Only required to be reported for episodes of care for patients with a care type of palliative care.

Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

Only required to be reported for episodes of admitted patient care with Hospital service—care type, code N[N] recorded as Code 3, Palliative care.

Only required to be reported when the Episode of admitted patient care—clinical assessment only indicator, yes/no code N value is recorded as Code 2, No.

Not required to be reported for patients aged 16 years and under at admission.

DSS specific information:

For episodes of admitted patient care with Hospital service—care type, code N[N] recorded as Code 3, Palliative care, the palliative care phase end date must be reported for each **palliative care phase** if the episode of admitted patient care had more than one phase.

▲ Palliative care phase start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—palliative phase of care start date, DDMMYYYY
METeOR identifier:	445848
Registration status:	Health, Standard 11/04/2014 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	The date on which an admitted patient commences a **phase of palliative care**, expressed as DDMMYYYY.
Data Element Concept:	Episode of admitted patient care—palliative phase of care start date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	The commencement date is the date on which an admitted palliative care patient commences a new palliative care phase type. Subsequent phase begin dates are equal to the previous phase end date.
Collection methods:	The palliative phase of care start date is to be recorded at the commencement of the episode of admitted patient palliative care and at the commencement of every subsequent palliative care phase thereafter in the same admitted patient episode.

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority
Reference documents:	Palliative Care Outcomes Collaboration Assessment Toolkit. Palliative Care Outcomes Collaboration, University of Wollongong, Wollongong. Viewed 19 September 2012, http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow129133.pdf

Relational attributes

Implementation in Data Set Specifications:	Activity based funding: Admitted sub-acute and non-acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Standard 11/10/2012 *Implementation start date:* 01/07/2013 *Implementation end date:* 30/06/2014

Conditional obligation:

Only required to be reported for episodes of admitted patient care with hospital service-care type, code N[N].N recorded as 3.0 palliative care.

Only required to be reported when Episode of admitted patient care-assessment only indicator, yes/no, code N value recorded as 2 no.

DSS specific information:

For episodes of admitted patient care with hospital service-care type, code N[N].N recorded as 3.0 palliative care, the palliative care phase must be reported for each **palliative care phase** if the episode of admitted patient care had more than one phase.

Admitted sub-acute and non-acute care activity based funding DSS 2012-2013 Independent Hospital Pricing Authority, Superseded 11/10/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:
Only required to be reported for episodes of care for patients with a care type of palliative care.

Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

Only required to be reported for episodes of admitted patient care with Hospital service—care type, code N[N] recorded as Code 3, Palliative care.

Only required to be reported when the Episode of admitted patient care—clinical assessment only indicator, yes/no code N value is recorded as Code 2, No.

Not required to be reported for patients aged 16 years and under at admission.

DSS specific information:

For episodes of admitted patient care with Hospital service—care type, code N[N] recorded as Code 3, Palliative care, the palliative care phase start date must be reported for each **palliative care phase** if the episode of admitted patient care had more than one phase.

◊ Parity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—parity, total pregnancies N[N]
METeOR identifier:	501710
Registration status:	Health, Standard 07/03/2014
Definition:	The total number of previous pregnancies experienced by the woman that have resulted in a **live birth** or a **stillbirth**.
Context:	Perinatal statistics.
Data Element Concept:	Female—parity

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

To calculate parity, count all previous pregnancies that resulted in a live birth or a stillbirth of at least 20 weeks gestation or at least 400 grams birthweight. Excluded from the count are:

- the current pregnancy;
- pregnancies resulting in spontaneous or induced abortions before 20 weeks gestation; and
- ectopic pregnancies.

A primipara (a woman giving birth for the first time) has a parity of 0.

Collection methods:

A pregnancy with multiple fetuses is counted as one pregnancy.

Comments:

The number of previous pregnancies that resulted in a birth is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Female—parity, total N[N] Health, Superseded 07/03/2014

Implementation in Data Set Specifications: Perinatal NMDS 2014- Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
This item is collected for the mother only.

Implementation in Indicators: **Used as denominator**
National Core Maternity Indicators: PI 05-Induction of labour for selected women giving birth for the first time (2013) Health, Candidate 03/07/2014

▲ Perineural invasion indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—perineural invasion indicator, yes/no/not applicable/not stated/inadequately described code N
Synonymous names:	Perineural involvement; PNI
METeOR identifier:	429134
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether perineural invasion is evident in a pathology specimen of the person with cancer, as represented by a code.
Context:	This should be collected for people with cancer where pathology data is available.
Data Element Concept:	Person with cancer—perineural invasion 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:	7	Not applicable
	9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Perineural invasion refers to cancer cells tracking along or around a nerve within the space surrounding a nerve. Its presence may be indicative of perineural spread, which can make the resection of malignant lesions more difficult. Only record perineural invasion in the primary tumour, not for metastatic or recurrent disease.
Collection methods:	This information should be sought from the patient's pathology report under microscopic findings.
Comments:	The presence of perineural invasion may be an important prognostic factor for some cancers.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Royal College of Pathologists of Australasia 2010. Lung cancer structured reporting protocol. 1st Edition (Version 1.0). Surry Hills, NSW: Royal College of Pathologists of Australasia

Potter ST & Partin AW 2000. The significance of perineural invasion found on needle biopsy of the prostate: implications for definitive therapy. Reviews in Urology Spring edition:87-88

Relational attributes

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ PPH blood loss

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—estimated blood loss indicating primary postpartum haemorrhage, estimated blood loss volume category, code N
METeOR identifier:	522192
Registration status:	Health, Standard 07/03/2014
Definition:	The estimated amount of blood lost by a female postpartum indicating the occurrence of **primary postpartum haemorrhage**, as represented by a code set.
Data Element Concept:	Female—estimated blood loss indicating primary postpartum haemorrhage

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	500–999 mls
2	1000–1499 mls
3	1500 mls or more

Supplementary values:

9	Not stated/inadequately described

Proposed unit of measure: millilitre (ml)

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Data element attributes

Relational attributes

Related metadata references:

See also Female—blood transfusion due to primary postpartum haemorrhage indicator, yes/no/not stated/inadequately described code N Health, Standard 07/03/2014

See also Female—primary postpartum haemorrhage indicator, yes/no/not stated/inadequately described code N Health, Standard 07/03/2014

Implementation in Data Set Specifications:

Perinatal DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

Conditional on primary postpartum haemorrhage indicator being coded yes.

Perinatal DSS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

Conditional obligation:
This data element is conditional on Female—primary postpartum haemorrhage indicator, yes/no/not stated/inadequately described code N being coded to Yes.

▲ Primary course of chemotherapy delay reason

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—primary course of chemotherapy delay reason, code N
METeOR identifier:	424458
Registration status:	Health, Standard 08/05/2014
Definition:	The reason for a delay in the primary course of **chemotherapy** for cancer treatment, as represented by a code.
Data Element Concept:	Cancer treatment—primary course of chemotherapy delay reason

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Delay due to toxicity
	2	Delay due to other complication
	3	Delay due to patient decision
	8	Other
Supplementary values:	9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use:	Record the reason that there was a delay in the primary course of chemotherapy.
Collection methods:	Collect from patient medical records.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Cancer Australia Working Group, 2010.

Relational attributes

Implementation in Data Set Specifications:	Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014 *Conditional obligation:* This data element is to be recorded when Cancer treatment—

chemotherapy delay indicator, yes/no/unknown code N indicates a delay in planned chemotherapy treatment.

◊ Primary impairment type (AROC 2012 code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—primary impairment type, code (AROC 2012) NN.NNNN
METeOR identifier:	498519
Registration status:	Health, Standard 11/04/2014 Independent Hospital Pricing Authority, Standard 11/10/2012
Definition:	The impairment which is the primary reason for the admission to the sub-acute episode, as represented by a code.
Data Element Concept:	Episode of admitted patient care—primary impairment type

Value domain attributes

Representational attributes

Classification scheme:	Impairment type code (AROC 2012)
Representation class:	Code
Data type:	String
Format:	NN.NNNN
Maximum character length:	7

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority

Data element attributes

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority

Relational attributes

Related metadata references:	Supersedes Episode of admitted patient care—primary impairment type, code NN.NNNN Independent Hospital Pricing Authority, Superseded 11/10/2012
Implementation in Data Set Specifications:	Activity based funding: Admitted sub-acute and non-acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Standard 11/10/2012 *Implementation start date:* 01/07/2013 *Implementation end date:* 30/06/2014 *Conditional obligation:* Only required to be reported for episodes of admitted patient care with hospital service-care type, code N[N].N recorded as 2.0 rehabilitation care. Only required to be reported when Episode of admitted

patient care-assessment only indicator, yes/no, code N value recorded as 2 no.

Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

Only required to be reported for episodes of admitted patient care with Hospital service—care type, code N[N] recorded as Code 2, Rehabilitation care.

Only required to be reported when the Episode of admitted patient care—clinical assessment only indicator, yes/no code N value is recorded as Code 2, No.

Not required to be reported for patients aged 16 years and under at admission.

▲ Primary postpartum haemorrhage indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—primary postpartum haemorrhage indicator, yes/no/not stated/inadequately described code N
METeOR identifier:	504959
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a female who has given birth experienced a **primary postpartum haemorrhage**, as represented by a code.
Data Element Concept:	Female—primary postpartum haemorrhage 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 To be reported if the woman experienced a **primary postpartum haemorrhage**. CODE 2 No To be reported if a woman did not experience a **primary postpartum haemorrhage**. CODE 9 Not stated/inadequately described To be recorded by data entry personnel (state/territory health authority) if the data field is left blank or is inadequately completed in the perinatal data collection form or extract. Clinicians should not record code 9.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references:

See also Female—blood transfusion due to primary postpartum haemorrhage indicator, yes/no/not stated/inadequately described code N Health, Standard 07/03/2014

See also Female—estimated blood loss indicating primary postpartum haemorrhage, estimated blood loss volume category, code N Health, Standard 07/03/2014

Implementation in Data Set Specifications:

Perinatal DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Perinatal DSS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Principal clinician specialty involved in health-care incident

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health-care incident—principal clinician specialty involved in health-care incident, clinical specialties code N[N]
METeOR identifier:	532137
Registration status:	Health, Standard 21/11/2013
Definition:	The clinical specialty of the health-care provider who played the most prominent role in the health-care incident, as represented by a code.
Data Element Concept:	Health-care incident—principal clinician specialty involved in health-care incident

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
3	Cardiology
4	Cardio-thoracic surgery
5	Chiropractics
6	Clinical genetics
7	Haematology (clinical)
8	Immunology and allergy (clinical)
9	Clinical pharmacology (excluding pharmacy)
11	Cosmetic surgery
13	Dentistry
14	Dermatology
15	Diagnostic radiology
16	Otolaryngology
17	Emergency medicine
18	Endocrinology
21	Gastroenterology and hepatology
22	General medicine
23	General practice–non-procedural
24	General practice–procedural
25	General surgery

26	Geriatric medicine
27	Gynaecology only
28	Infectious diseases
29	Intensive care medicine
30	Medical oncology
31	Midwifery
32	Neurology
33	Neurosurgery
34	Neonatal or perinatal medicine
35	Nuclear medicine
36	Nursing–general
37	Nursing–nurse practitioner
38	Nutrition or dietician
39	Obstetrics and gynaecology
40	Obstetrics only
41	Occupational and environmental medicine
42	Ophthalmology
44	Orthopaedic surgery
45	Osteopathy
46	Paediatrics (general)
47	Paediatric surgery
48	Paramedical and ambulance staff
49	Pathology
50	Pharmacy (excluding clinical pharmacology)
51	Physiotherapy
52	Plastic and reconstructive surgery
53	Podiatry
54	Psychiatry
55	Psychology
56	Public health medicine
57	Rehabilitation medicine
58	Nephrology
59	Respiratory and sleep medicine
60	Rheumatology
62	Sports and exercise medicine
63	Radiation oncology (therapeutic radiology)
65	Urology
66	Vascular surgery
67	Other allied health (including complementary medicine)
68	Other hospital-based medical practitioner

	71	Anaesthesia
	72	Maternal-fetal medicine
	73	Medical administration
	75	Oral and maxillofacial surgery
	76	Palliative medicine
	77	Urogynaecology
	78	Reproductive endocrinology and infertility
	79	Addiction medicine
	80	Paediatric emergency medicine
	81	Sexual health medicine
	82	Pain medicine
	83	Community child health
	84	Gynaecological oncology
	85	Obstetrical and gynaecological ultrasound
Supplementary values:	97	Not applicable
	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 13 Dentistry

'Dentistry' excludes oral and maxillofacial surgery.

CODE 15 Diagnostic radiology

'Diagnostic radiology' includes diagnostic ultrasound.

CODE 16 Otolaryngology

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

CODE 22 General medicine

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

CODE 25 General surgery

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

CODE 27 Gynaecology only

'Gynaecology only' includes gynaecologists who only diagnose, treat and aid in the prevention of disorders of the female reproductive system (RANZCOG 2013).

CODE 31 Midwifery

'Midwifery' includes registered midwives only.

CODE 35 Nuclear medicine

'Nuclear medicine' includes radiotherapy and radiation oncology.

CODE 36 Nursing–general

'Nursing-general' includes enrolled and registered nurses.

CODE 37 Nursing–nurse practitioner

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

CODE 39 Obstetrics and gynaecology

'Obstetrics and gynaecology' includes specialists who carry out gynaecological examinations, diagnosis and operations on women; discuss suitable contraceptive methods with referred patients; provide medical care before, during and after childbirth; deliver babies through normal procedures or by caesarean section; examine mothers and babies after childbirth to check for complications; and treat infertility by chemical or operative measures (RANZCOG 2013).

CODE 40 Obstetrics only

'Obstetrics only' includes obstetricians who only provide medical care before, during and after childbirth (RANZCOG 2013).

CODE 41 Occupational and environmental medicine

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

CODE 46 Paediatrics

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

CODE 49 Pathology

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

CODE 59 Respiratory and sleep medicine

'Respiratory and sleep medicine' includes thoracic medicine.

CODE 67 Other allied health (including complementary medicine)

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

CODE 68 Other hospital-based medical practitioners

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

CODE 71 Anaesthesia

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

CODE 82 Pain medicine

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

CODE 97 Not applicable

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

CODE 99 Not stated/inadequately described

'Not stated/inadequately described' should be used when the

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

Comments:

The general aim of this list is to include all categories that might be of relevance to medical indemnity claims. The medical specialties included in this value domain are taken from the List of Australian Recognised Medical Specialties, a list approved by the Minister for Health and Ageing (AMC 2013) and from the lists of clinical specialties developed by various health authorities for use in their medical indemnity data collections.

The categories of medical specialists align well between the Australian Prudential Regulation Authority (2006) National Claims and Policies Database (NCPD) and the Medical Indemnity National Collection (MINC). The NCPD specifications have separate codes for several allied health and complementary fields which are subsumed within the MINC category 'Other allied health (including complementary medicine)'. In the NCPD, 'student practitioner or intern' is a separate category. The MINC codes students based on the speciality they are training in, and classifies interns with 'Other hospital-based medical practitioners' (AIHW 2013).

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Reference documents:

AIHW (Australian Institute of Health and Welfare) 2013. Australia's medical indemnity claims 2011–12. Safety and quality of health care series no.14. Cat. no. HSE 137. Canberra: AIHW

AMC (Australian Medical Council) 2013. The List of Australian Recognised Medical Specialties. Canberra. Viewed 17 July 2013, http://www.amc.org.au/images/Recognition/AMC-list-of-specialties.pdf

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

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

RANZCOG (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists) 2013. About the specialty. Viewed 17 July 2013, http://www.ranzcog.edu.au/the-ranzcog/about-specialty.html

Data element attributes

Collection and usage attributes

Guide for use:

This data element should record the specialty of the clinician who played the most prominent role in the incident that gave rise to the medical indemnity claim; that is, the individual whose actions or omissions are directly implicated in 'what went wrong'. The individual may or may not be a defendant in the medical indemnity claim.

Only one code may be selected for this data element.

The principal clinician specialty should usually relate to the primary incident or allegation type.

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

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

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

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

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Health-care incident—additional clinician specialty involved in health-care incident, clinical specialties code N[N] Health, Standard 21/11/2013

Supersedes Health-care incident—principal clinician specialty involved in health-care incident, clinical specialties code N[N] Health, Superseded 21/11/2013

Implementation in Data Set Medical indemnity DSS 2014- Health, Standard 21/11/2013

Specifications: *Implementation start date:* 01/07/2014

▲ Psychosocial services referral type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—psychosocial services type, code N[N]
METeOR identifier:	431257
Registration status:	Health, Standard 08/05/2014
Definition:	The type of psychosocial service a person with cancer is referred to as part of their cancer treatment or follow-up, as represented by a code.
Data Element Concept:	Person with cancer—psychosocial services type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Psychiatrist
2	Psychologist
3	Social worker
4	Specialist nurse or nurse counsellor
5	Cancer or volunteer support group
6	Individual peer support
7	Counsellor or bereavement counsellor
8	Pastoral care
9	Community services

Supplementary values:

Value	Meaning
97	Not applicable-patient not referred to psychosocial services
98	Unknown whether patient referred to psychosocial services
99	Patient referred to psychosocial services but type not stated/inadequately described

Collection and usage attributes

Guide for use:

Record the psychosocial service a person with cancer was referred to. Where multiple psychosocial services were referred to, this item should be recorded multiple times.

Pastoral care refers to counselling provided by pastors, chaplains, clergy and other religious leaders or spiritual advisors.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Cancer Institute NSW & NSW Health Department 2006. NSW clinical cancer registration: minimum data set data dictionary, version 1.9. Sydney: Cancer Institute NSW

Data element attributes

Collection and usage attributes

Guide for use:	Record the psychosocial service a person with cancer was referred to. Where multiple psychosocial services were referred to, this item should be recorded multiple times. Referral to psychosocial services will generally come from a person with cancer's primary treatment clinician or GP. The person diagnosed with cancer experiences a range of practical, psychological, physical and emotional difficulties. For example, these may include coping with the shock of their diagnosis and fears over their health and future. They may experience physical symptoms and treatment-related adverse effects such as nausea, fatigue and a general decline in functioning. There may be changes in their role and family functioning, occupational or employment status, and financial status. Some will have to come to terms with progressive illness and approaching death. The opportunity to access psychosocial services may be limited for some patients by local circumstances and the availability of resources such as access to psychiatrists, clinical psychologists or specialist oncology nurses.
Collection methods:	This information should be sought from the patient's medical record.
Comments:	This information is used to evaluate the quality of psychosocial care for patients with cancer, and may have implications for access to, and the provision of, cancer services.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	National Breast and Ovarian Cancer Centre and National Cancer Control Initiative 2003. Clinical practice guidelines for the psychosocial care of adults with cancer. Camperdown, NSW: National Breast and Ovarian Cancer Centre Cancer Institute NSW & NSW Health Department 2006. NSW clinical cancer registration: minimum data set data dictionary, version 1.9. Sydney: Cancer Institute NSW

Relational attributes

Related metadata references:	See also Person with cancer—date of referral to psychosocial services, DDMMYYYY Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Public hospital related revenue categories

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—public hospital related revenue, revenue streams code N[N]
METeOR identifier:	545906
Registration status:	Health, Standard 11/04/2014
Definition:	Categories of revenue related to public hospitals received by an establishment, as represented by a code.
Data Element Concept:	Establishment—public hospital related revenue

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Department of Veterans' Affairs
2	Compensable schemes
3	Other patient revenue
4	Commonwealth funding/subsidies
5	State or territory health authority funding
6	Other state or territory funding
7	National Health Funding Pool - state or territory government component
8	National Health Funding Pool - Commonwealth government component
9	Infrastructure/facility fees
10	Other recoveries
11	Revenue not elsewhere reported

Collection and usage attributes

Guide for use:

CODE 1 Department of Veterans' Affairs

All Department of Veterans' Affairs (DVA) patient revenue received by an establishment in respect of individual patient liability for accommodation and other establishment charges.

Includes revenues received for health services provided to veterans, war widows and widowers with gold or white DVA cards. Types of services include public and private hospitals, local medical officers and specialists, residential aged care subsidy, allied health, rehabilitation appliances, dental services,

community nursing, Veterans' Home Care and travel for treatment.

Excludes revenues received for pharmaceuticals provided to veterans, war widows and widowers with gold, white or orange DVA cards. Also excludes revenue received from the Department of Defence.

CODE 2 Compensable schemes

All revenue from compensation schemes received by an establishment in respect of individual patient liability for accommodation and other establishment charges.

Compensation schemes for this data element include workers compensation insurance, motor vehicle third party insurance and other compensation (e.g. public liability, common law, medical negligence).

Workers compensation insurance includes benefits paid under workers compensation insurance to the establishment provided to workers, including trainees and apprentices, who have experienced a work-related injury. Type of benefits includes fees for medical or related treatment.

Motor vehicle third party insurance includes personal injury claims arising from motor accidents and compensation for accident victims and their families for injuries or death.

Other compensation includes revenues received from benefits paid under public liability, common law and medical negligence. Also includes revenue from:

- accident and sickness insurance
- life insurance
- general insurance
- other insurance business excluded by the Private Health Insurance (Health Insurance Business) Rules
- overseas visitors for whom travel insurance is the major funding source.

CODE 3 Other patient revenue

All revenue received by an establishment in respect of individual patient liability for accommodation and other establishment charges, but excluding Department of Veterans' Affairs and compensation scheme patient revenue.

Other patient revenue includes revenue from private health insurance. Private health insurance includes revenue from businesses mainly engaged in providing insurance cover for hospital, medical, dental or pharmaceutical expenses or costs. Includes revenue received from the Department of Defence.

Excludes:

- Accident and sickness insurance
- Liability insurance
- Life insurance
- General insurance
- Other insurance business excluded by the Private Health Insurance (Health Insurance Business) Rules
- Overseas visitors for whom travel insurance is the major

funding source.

CODE 4 Commonwealth funding/subsidies

All revenue paid directly by the Commonwealth Government to an establishment for services within the scope of the collection.

Includes funding for transition care, residential aged care subsidies (including MPS payments), aged care assessment, Home and Community Care and Section 100 drugs. Excludes payments related to the National Health Funding Pool.

CODE 5 State or territory health authority funding

All revenue provided by the state or territory health authority, used by an establishment to support the delivery and/or administration of services within the scope of the collection. Excludes payments related to the National Health Funding Pool.

CODE 6 Other state or territory funding

All revenue provided by state or territory funding sources from government departments external to the state/territory health authority used to support the delivery and/or administration of services within the scope of the collection.

CODE 7 National Health Funding Pool - state or territory component

Revenue provided by the National Health Funding Pool, including Activity Based Funding payments, used by an establishment to support the delivery and/or administration of services within the scope of the collection. Includes only those funds in the pool that were provided by the state or territory government.

CODE 8 National Health Funding Pool - Commonwealth government component

Revenue provided by the National Health Funding Pool, including Activity Based Funding payments, used by establishment to support the delivery and/or administration of services within the scope of the collection. Includes only those funds in the pool that were provided by the Commonwealth government.

CODE 9 Infrastructure/facility fees

All infrastructure or facility fees revenue received by an establishment.

Infrastructure or facility fees are income received from the use of hospital facilities by salaried medical officers exercising their rights of private practice and by private practitioners treating private patients in hospital.

CODE 10 Other recoveries

Revenue that is in the nature of a recovery or expenditure incurred, including income from provision of meals and accommodation, but excluding infrastructure and facility fees.

CODE 11 Revenue not reported elsewhere

Revenue that was received by the establishment that has not been reported elsewhere.

Includes revenue received by the establishment for the provision of services under contracted care arrangements.

Collection methods:

Record as currency up to hundreds of millions of dollars.

Rounded to nearest whole dollar.

Data element attributes

Source and reference attributes

Submitting organisation: PHE NMDS Working Group

Relational attributes

Related metadata references: See also Establishment—public hospital related revenue, total Australian currency N[N(8)] Health, Standard 11/04/2014

Implementation in Data Set Specifications: Revenue data element cluster Health, Standard 11/04/2014

▲ Public hospital related revenue in Australian dollars

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—public hospital related revenue, total Australian currency N[N(8)]
METeOR identifier:	542019
Registration status:	Health, Standard 11/04/2014
Definition:	The revenue relating to public hospitals received by an establishment, measured in Australian dollars.
Data Element Concept:	Establishment—public hospital related revenue

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Submitting organisation:	PHE NMDS Working Group

Relational attributes

Related metadata references:	See also Establishment—public hospital related revenue, revenue streams code N[N] Health, Standard 11/04/2014
Implementation in Data Set Specifications:	Revenue data element cluster Health, Standard 11/04/2014

▲ Qualified profession (health professional graduate trainee)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health professional graduate trainee—qualified profession type, code N[N].N
METeOR identifier:	542865
Registration status:	Health, Standard 07/03/2014
Definition:	The type of profession for which a health professional graduate trainee is qualified, as represented by a code.
Data Element Concept:	Health professional graduate trainee—qualified profession type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1.0	Aboriginal and Torres Strait Islander health worker
2.0	Audiology
3.0	Chiropractic
4.0	Dentistry
5.0	Dietetics
6.0	Exercise physiology
7.0	Medical laboratory science
8.0	Medicine
8.1	Medicine - prevocational postgraduate year 1
8.2	Medicine - prevocational postgraduate year 2
8.3	Medicine - prevocational postgraduate year 3+
9.0	Midwifery
10.0	Nursing
10.1	Nursing - enrolled nurse
10.2	Nursing - registered nurse
10.3	Nursing - nurse practitioner
10.8	Nursing - other nursing profession
11.0	Occupational therapy
12.0	Optometry
13.0	Oral health

	14.0	Orthoptics
	15.0	Orthotics and prosthetics
	16.0	Osteopathy
	17.0	Paramedicine
	18.0	Pharmacy
	19.0	Physiotherapy
	20.0	Podiatry
	21.0	Psychology
	22.0	Radiation science
	23.0	Social work
	24.0	Sonography
	25.0	Speech pathology
Supplementary values:	99.9	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Data element attributes

Collection and usage attributes

Guide for use:

CODE 4.0 Dentistry

Includes dentist and dental specialist.

CODES 8.1, 8.2 and 8.3 Medicine - prevocational postgraduates years 1, 2 and 3+

These codes are not applicable when reporting health professional graduate trainee full-time equivalents.

CODE 10.8 Nursing - other nursing profession

Includes nursing graduates who have attained their initial qualification and are undertaking further study. For example, for a clinical nurse specialist or nurse educator qualification.

CODE 13.0 Oral health

Includes dental hygienist, dental therapist, dental prosthetist and oral health therapist.

CODE 22.0 Radiation science

Includes medical diagnostic radiographer, medical radiation therapist, nuclear medicine technologist.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Implementation in Data Set Specifications: Health professional graduate trainee cluster Health, Standard 07/03/2014

▲ Qualified profession (new health professional graduate)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	New health professional graduate—qualified profession type, code N[N].N
METeOR identifier:	542861
Registration status:	Health, Standard 07/03/2014
Definition:	The type of profession for which a new health professional graduate is qualified, as represented by a code.
Data Element Concept:	New health professional graduate—qualified profession type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1.0	Aboriginal and Torres Strait Islander health worker
2.0	Audiology
3.0	Chiropractic
4.0	Dentistry
5.0	Dietetics
6.0	Exercise physiology
7.0	Medical laboratory science
8.0	Medicine
8.1	Medicine - prevocational postgraduate year 1
8.2	Medicine - prevocational postgraduate year 2
8.3	Medicine - prevocational postgraduate year 3+
9.0	Midwifery
10.0	Nursing
10.1	Nursing - enrolled nurse
10.2	Nursing - registered nurse
10.3	Nursing - nurse practitioner
10.8	Nursing - other nursing profession
11.0	Occupational therapy
12.0	Optometry
13.0	Oral health
14.0	Orthoptics

	15.0	Orthotics and prosthetics
	16.0	Osteopathy
	17.0	Paramedicine
	18.0	Pharmacy
	19.0	Physiotherapy
	20.0	Podiatry
	21.0	Psychology
	22.0	Radiation science
	23.0	Social work
	24.0	Sonography
	25.0	Speech pathology
Supplementary values:	99.9	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Data element attributes

Collection and usage attributes

Guide for use:

CODE 8.0 Medicine

Includes medical graduates who are undertaking their compulsory internship. This is also known as the intern year or postgraduate year one. Satisfactory completion of an intern year is required before junior doctors are granted general medical registration. Most junior doctors work for at least one or two more years after their intern year to gain more experience.

CODE 8.1 Medicine - prevocational postgraduate year 1

Includes medical graduates in their first postgraduate year of training.

CODE 8.2 Medicine - prevocational postgraduate year 2

Includes medical graduates in their second postgraduate year of training.

CODE 8.3 Medicine - prevocational postgraduate year 3+

Includes medical graduates in their third postgraduate year of training, or medical graduates undergoing prevocational postgraduate training for greater than three years.

CODE 13.0 Oral health

Includes dental hygienist, dental therapist, dental prosthetist and oral health therapist.

CODE 22.0 Radiation science

Includes medical diagnostic radiographer, medical radiation therapist and nuclear medicine technologist.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references:	Has been superseded by New health professional graduate—qualified profession type, code N[N].N Health, Standardisation pending 18/09/2014
Implementation in Data Set Specifications:	New health professional graduate cluster Health, Standard 07/03/2014

◊ Radiation dose administered

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiation dose administered, total Gray N[NN.NN]
METeOR identifier:	561384
Registration status:	Health, Standard 08/05/2014
Definition:	The largest prescribed dose of radiation administered during the course of treatment for cancer, measured in Gray (Gy).
Data Element Concept:	Cancer treatment—radiation dose administered

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
999.97	Not applicable-radiotherapy was not administered
999.98	Unknown whether radiotherapy was administered
999.99	Radiotherapy was administered but the dose is not stated/inadequately described

Unit of measure:	Gray (Gy)
Unit of measure precision:	2

Collection and usage attributes

Guide for use: One gray is equivalent to 100 centigray (cGy). For example, a radiation dose of 5040 cGy equates to 50.40 Gy. This would be recorded as 50.40.

Data element attributes

Collection and usage attributes

Guide for use: The gray (Gy) is the SI (International System of Units) unit of absorbed radiation dose of ionizing radiation (for example, X-rays), and is defined as the absorption of one joule of ionizing radiation by one kilogram of matter (usually human tissue).

The radiation dose administered records the largest prescribed dose to the target. This means that for patients that have a boost treatment, the largest prescribed dose is the addition of the boost to the other phases of treatment.

Record the largest prescribed dose to the target site for all courses of **radiotherapy** delivered to the patient during the course of treatment.

The patient may receive more than one course of radiotherapy during the course of treatment. For example, radiotherapy may be administered to the primary site and the site of a distant metastasis. Record the radiation dose received for each course of treatment.

The radiation dose administered is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of treatment.

The International Commission on Radiation Units and Measurements (ICRU) develops internationally acceptable recommendations regarding quantities and units of radiation and radioactivity, procedures suitable for the measurement and application of these quantities in clinical radiology and radiobiology, and physical data needed in the application of these procedures to support uniformity in reporting.

The ICRU recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pairs and so on). The ICRU50 reference dose should be recorded for photon therapy if available, otherwise a description of the received dose at the centre of the planning target volume. The ICRU58 should be recorded for brachytherapy. For maximum consistency in this field, the ICRU recommendations should be followed whenever possible.

Do not include treatment with unsealed radioisotopes.

Collection methods:

The radiation dose will typically be found in the radiation oncologist's summary letter for the course of treatment or in the radiotherapy treatment summary in the patient's medical record.

Determining the total dose may require assistance from the radiation oncologist for consistent coding.

Comments:

The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome. Patient outcomes are strongly related to the radiotherapy dose delivered.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references:

Supersedes Cancer treatment—radiation dose administered, total Gray N[NN.NN] Health, Superseded 08/05/2014

See also Cancer treatment—radiotherapy completion date, DDMMYYYY Health, Standard 08/05/2014

See also Cancer treatment—radiotherapy fractions administered,

	total fractions N[N] Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy start date, DDMMYYYY Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy target site for lung cancer, code N Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy target site, code N[N] Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy treatment type, code N[N] Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Radiotherapy for cancer cluster Health, Standard 08/05/2014

◊ Radiotherapy completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiotherapy completion date, DDMMYYYY
METeOR identifier:	561389
Registration status:	Health, Standard 08/05/2014
Definition:	The completion date of the **radiotherapy** administered during the course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—radiotherapy completion date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	The completion date for radiotherapy is the date the last dose was administered. Record the completion date of radiotherapy for all courses administered during the course of treatment for cancer. The patient may receive more than one course of radiotherapy during the course of treatment. For example, radiotherapy may be administered to the primary site and the site of a distant metastasis. Record the completion date for each course of treatment. The completion date of radiotherapy is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of treatment. Record the completion date for radiotherapy administered as external beam radiotherapy or brachytherapy. Do not include radiotherapy with unsealed radioisotopes. Dates of surgery, systemic agent therapies and systemic therapy procedures are collected as separate items.
Collection methods:	The radiotherapy completion date will typically be found in the radiation oncologist's summary letter for the course of treatment or in the radiotherapy treatment summary in the patient's medical record.
Comments:	Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation:	Cancer Australia
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references:	See also Cancer treatment—radiation dose administered, total Gray N[NN.NN] Health, Standard 08/05/2014 Supersedes Cancer treatment—radiotherapy completion date, DDMMYYYY Health, Superseded 08/05/2014 See also Cancer treatment—radiotherapy fractions administered, total fractions N[N] Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy start date, DDMMYYYY Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy target site for lung cancer, code N Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy target site, code N[N] Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy treatment type, code N[N] Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Radiotherapy for cancer cluster Health, Standard 08/05/2014

◊ Radiotherapy fractions administered

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiotherapy fractions administered, total fractions N[N]
METeOR identifier:	561464
Registration status:	Health, Standard 08/05/2014
Definition:	The total number of **radiotherapy** sessions (fractions) administered during the course of treatment for cancer.
Data Element Concept:	Cancer treatment—radiotherapy fractions administered

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
97	Not applicable-no radiotherapy was administered
98	Unknown whether radiotherapy was administered
99	Radiotherapy administered but the number of fractions not stated/inadequately described

Collection and usage attributes

Guide for use: Valid values are 1 to 96.

Data element attributes

Collection and usage attributes

Guide for use:

A total dose of radiation is delivered to the patient in a number of even parts or treatment sessions (fractions). Although a treatment session may include several treatment portals delivered within a confined period of time, usually a few minutes, it is still considered one fraction.

Record the number of fractions of radiotherapy treatment for all courses delivered to the patient during the course of treatment for cancer.

The patient may receive more than one course of radiotherapy during the course of treatment. For example, radiotherapy may be administered to the primary site and the site of a distant metastasis. Record the total radiation dose for each course of treatment.

	The number of fractions administered is recorded regardless of whether the course of treatment is completed as intended and regardless of the intent or timing of treatment. The number of radiotherapy fractions recorded should include any boost. Brachytherapy (or implants) may be delivered more than once, each treatment is recorded as a fraction. Do not include treatment with unsealed radioisotopes.
Collection methods:	The number of radiotherapy fractions delivered will typically be found in the radiation oncologist's summary letter for the initial course of treatment or in the radiotherapy treatment summary in the patient's medical record. Determining the number of fractions may require assistance from the radiation oncologist for consistent coding.
Comments:	The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Submitting organisation:	Cancer Australia
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references:	See also Cancer treatment—radiation dose administered, total Gray N[NN.NN] Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy completion date, DDMMYYYY Health, Standard 08/05/2014 Supersedes Cancer treatment—radiotherapy fractions administered, total fractions N[N] Health, Superseded 08/05/2014 See also Cancer treatment—radiotherapy start date, DDMMYYYY Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy target site for lung cancer, code N Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy target site, code N[N] Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy treatment type, code N[N] Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Radiotherapy for cancer cluster Health, Standard 08/05/2014

◊ Radiotherapy start date—cancer treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiotherapy start date, DDMMYYYY
METeOR identifier:	561469
Registration status:	Health, Standard 08/05/2014
Definition:	The start date of the **radiotherapy** administered during the course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—radiotherapy start date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Record the first or earliest date radiotherapy commenced for all courses of radiotherapy administered during the course of treatment. The patient may receive more than one course of radiotherapy during the course of treatment. For example, in the treatment of cancer, radiotherapy may be administered to the primary site and the site of a distant metastasis. Record the start date for each course of treatment. The start date of radiotherapy is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of treatment. Record the start date for radiotherapy administered as external beam radiotherapy or brachytherapy. Do not include radiotherapy with unsealed radioisotopes. This item should be used when collecting information about cancer patient care for safety and quality monitoring and other public health purposes. If collecting radiotherapy start date to examine service volumes for the purpose of calculating radiotherapy waiting times use *Patient – radiotherapy start date, DDMMYYYY*.
Collection methods:	The radiotherapy commencement date(s) will typically be found in the radiation oncologist's summary letter for the course of treatment or in the radiotherapy treatment summary in the patient's medical record.

Comments: Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation: Cancer Australia

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

Relational attributes

Related metadata references:

See also Cancer treatment—radiation dose administered, total Gray N[NN.NN] Health, Standard 08/05/2014

See also Cancer treatment—radiotherapy completion date, DDMMYYYY Health, Standard 08/05/2014

See also Cancer treatment—radiotherapy fractions administered, total fractions N[N] Health, Standard 08/05/2014

Supersedes Cancer treatment—radiotherapy start date, DDMMYYYY Health, Superseded 08/05/2014

See also Cancer treatment—radiotherapy target site, code N[N] Health, Standard 08/05/2014

See also Cancer treatment—radiotherapy treatment type, code N[N] Health, Standard 08/05/2014

See also Patient—radiotherapy start date, DDMMYYYY Health, Standard 07/12/2011

Implementation in Data Set Specifications: Radiotherapy for cancer cluster Health, Standard 08/05/2014

◊ Radiotherapy target site

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiotherapy target site, code N[N]
METeOR identifier:	561476
Registration status:	Health, Standard 08/05/2014
Definition:	The target site of **radiotherapy** administered during the course of treatment for cancer, as represented by a code.
Data Element Concept:	Cancer treatment—radiotherapy target site

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Primary site only
2	Regional nodes only
3	Distant metastases only
4	Primary site and regional nodes
5	Primary site and distant metastases
6	Primary site, regional nodes and distant metastases
7	Regional nodes and distant metastases

Supplementary values:

Value	Meaning
97	Not applicable-radiotherapy was not administered
98	Unknown whether radiotherapy was administered
99	Radiotherapy was administered but the site not stated/inadequately described

Collection and usage attributes

Guide for use:	More than one site may be targeted for radiotherapy during the course of treatment; select the appropriate code value.

Source and reference attributes

Submitting organisation:	Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use:

The target site is collected for all courses of radiotherapy administered to the patient during the course of treatment.

The target site for radiotherapy is recorded regardless of whether the course of treatment is completed as intended, the intent or timing of the radiotherapy, and the radiation therapy treatment modality.

Record the value representing all the sites targeted for radiotherapy during the course of treatment. There may be more than one site targeted for treatment. For example, the primary tumour site and the site of a distant metastasis may receive radiotherapy as part of the course of treatment. In this case code "5" would be recorded.

The target site for surgery is collected as a separate data item.

Collection methods:

This information should be obtained from the patient's radiotherapy records.

Determining the target site of radiotherapy may require assistance from the radiation oncologist for consistent coding.

Comments:

This is collected to identify which sites are targeted by radiotherapy and is useful in evaluating patterns of care and patient outcomes.

Source and reference attributes

Submitting organisation:

Cancer Australia

Relational attributes

Related metadata references:

See also Cancer treatment—radiation dose administered, total Gray N[NN.NN] Health, Standard 08/05/2014

See also Cancer treatment—radiotherapy completion date, DDMMYYYY Health, Standard 08/05/2014

See also Cancer treatment—radiotherapy fractions administered, total fractions N[N] Health, Standard 08/05/2014

See also Cancer treatment—radiotherapy start date, DDMMYYYY Health, Standard 08/05/2014

Supersedes Cancer treatment—radiotherapy target site, code N[N] Health, Superseded 08/05/2014

See also Cancer treatment—radiotherapy treatment type, code N[N] Health, Standard 08/05/2014

Implementation in Data Set Specifications:

Radiotherapy for cancer cluster Health, Standard 08/05/2014

▲ Radiotherapy target site (lung cancer)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiotherapy target site for lung cancer, code N
Synonymous names:	Radiation therapy site
METeOR identifier:	433274
Registration status:	Health, Standard 08/05/2014
Definition:	The target site of **radiotherapy** administered during the course of treatment for lung cancer, as represented by a code.
Data Element Concept:	Cancer treatment—radiotherapy target site

Value domain attributes

Representational attributes

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

Permissible values: / *Supplementary values:*

Value	Meaning
1	Thoracic site
2	Non-thoracic site
3	Thoracic and non-thoracic sites
7	Not applicable-radiotherapy was not administered
8	Unknown whether radiotherapy was administered
9	Radiotherapy was administered but the site not stated/inadequately described

Collection and usage attributes

Guide for use: More than one site may be targeted for radiotherapy.

Record the appropriate code describing the site(s) that was the target of radiotherapy treatment administered for lung cancer.

Source and reference attributes

Submitting organisation: Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use: Record the appropriate code describing the target site of radiotherapy administered for lung cancer.

The target site for radiotherapy is recorded regardless of whether the course of treatment is completed as intended, the intent or timing of the radiotherapy, and the radiation treatment modality.

Radiotherapy may be administered to both a thoracic and non-thoracic site. For example, a patient with lung cancer may receive radical radiotherapy to the primary site +/- regional nodes followed by prophylactic cranial irradiation or whole brain irradiation.

Collection methods: This information should be obtained from the patient's radiotherapy records or from the radiation oncologist's summary letter.

Determining the target site of radiotherapy may require assistance from the radiation oncologist for consistent coding.

Comments: This is collected to identify which sites are targeted by radiotherapy and is useful in evaluating patterns of care and patient outcomes on a regional or national basis.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2011 revision. Commission on Cancer

Relational attributes

Related metadata references: See also Cancer treatment—radiation dose administered, total Gray N[NN.NN] Health, Standard 08/05/2014

See also Cancer treatment—radiotherapy completion date, DDMMYYYY Health, Standard 08/05/2014

See also Cancer treatment—radiotherapy fractions administered, total fractions N[N] Health, Standard 08/05/2014

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Collect when a person with cancer has undergone radiotherapy as part of their initial course of cancer treatment.

▲ Radiotherapy treatment complication indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—gynaecological cancer post-radiotherapy complication indicator, yes/no/unknown code N
METeOR identifier:	546597
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of the presence of **treatment complications** within 30 days of a course of radiotherapy for gynaecological cancer, as represented by a code.
Data Element Concept:	Cancer treatment—gynaecological cancer post-radiotherapy complication 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:

8	Unknown

Data element attributes

Collection and usage attributes

Guide for use: Record whether there are any treatment complications within 30 days of a course of radiotherapy for gynaecological cancer.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	NBOCC Working Group, 2008

Relational attributes

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element should be recorded in relation to the primary course of treatment for gynaecological cancer.

DSS specific information:
This relates to the primary course of treatment for gynaecological cancer.

▲ Radiotherapy treatment complication type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—treatment complication type, gynaecological cancer-related radiotherapy code N
METeOR identifier:	424314
Registration status:	Health, Standard 08/05/2014
Definition:	The type (or types) of **treatment complication** occurring within 30 days of radiotherapy for women with gynaecological cancer, as represented by a code.
Context:	For monitoring side effects of radiotherapy in 30 days post-treatment.
Data Element Concept:	Cancer treatment—treatment complication type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Bowel obstruction requiring surgery
2	Fistula requiring stoma formation
3	Pelvic insufficiency
8	Other

Supplementary values:

9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	NBOCC Working Group, 2008

Data element attributes

Collection and usage attributes

Guide for use:	Record the code for the type/s of **treatment complication**/s that occur within 30 days of the primary course of radiotherapy for gynaecological cancer. This item can be recorded multiple times to account for multiple treatment complications.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	NBOCC Working Group, 2008

Relational attributes

Implementation in Data Set Specifications:

Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element should be recorded when Cancer treatment—gynaecological cancer post-radiotherapy complication indicator, yes/no/unknown code N indicates the presence of a radiotherapy related treatment complication.

◊ Radiotherapy treatment type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiotherapy treatment type, code N[N]
Synonymous names:	Radiotherapy treatment modality
METeOR identifier:	561521
Registration status:	Health, Standard 08/05/2014
Definition:	The type of **radiotherapy** administered during the course of treatment for cancer, as represented by a code.
Data Element Concept:	Cancer treatment—radiotherapy treatment type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	External beam radiotherapy only
2	Brachytherapy only
3	Unsealed radioisotopes only
4	External beam radiotherapy and brachytherapy
5	External beam radiotherapy and unsealed radioisotopes
6	Brachytherapy and unsealed radioisotopes
7	External beam radiotherapy, brachytherapy and unsealed radioisotopes

Supplementary values:

Value	Meaning
97	Not applicable-radiotherapy was not administered
98	Unknown whether radiotherapy was administered
99	Radiotherapy was administered but the treatment type not stated/inadequately described

Collection and usage attributes

Guide for use:

More than one radiotherapy treatment type may be delivered during the course of treatment; select the appropriate code value.

The difference between the types of radiotherapy relates to the position of the radiation source:

- External beam radiotherapy (EBRT) is delivered by directing the radiation at the tumour from outside the body

- Brachytherapy or sealed source radiotherapy is delivered by placing the radiation source in close proximity to the tumour site
- Unsealed radioisotopes or systemic radioisotope therapy is delivered by infusion into the bloodstream or by ingestion and is a form of targeted therapy.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: DeVita VT, Hellman S, Rosenberg SA 2005. Cancer: Principles and practice of oncology, 7th edition. Philadelphia: Lippincott Williams & Wilkins

Data element attributes

Collection and usage attributes

Guide for use:

External beam radiotherapy (EBRT) is delivered by directing the radiation at the tumour from outside the body. Types of external beam radiotherapy include conventional EBRT, intensity modulated radiation therapy (IMRT) and 3-dimensional conformal radiotherapy (3D-CRT).

Brachytherapy is delivered by placing the radiation source in close proximity to the tumour site. The radioactive isotopes are sealed in tiny pellets or "seeds" which are placed in the body using delivery devices such as needles or catheters. Types include interstitial brachytherapy, which uses a source placed within tumour tissue, for example, within a prostate tumour; and intracavitary brachytherapy, whereby the source is placed within a surgical cavity or a body cavity. Brachytherapy can involve the temporary or permanent placement of radioactive sources.

Unsealed radioisotopes or systemic radioisotope therapy is delivered by infusion into the bloodstream or by ingestion and is a form of targeted therapy. Targeting can be due to the chemical properties of the isotope, for example, radioiodine is specifically absorbed by the thyroid gland. It can also be achieved by attaching the radioisotope to another molecule or antibody to guide it to the target tissue. Examples of treatment with unsealed radioisotopes include the infusion of metaiodobenzylguanidine (MIBG) to treat neuroblastoma and of oral iodine-131 to treat thyroid cancer.

Radiotherapy treatment type is collected for all courses of radiotherapy delivered to the patient during the course of treatment.

The radiotherapy treatment type is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of treatment.

More than one radiotherapy treatment type may be administered during the course of treatment; select the appropriate code value.

If external beam radiotherapy and/or brachytherapy were administered, the radiation dose received and number of fractions should also be collected as well as the start and finish

	dates of the radiotherapy. Most external beam radiotherapy is delivered on an outpatient basis. Brachytherapy is likely to be delivered to admitted patients.
Collection methods:	The radiotherapy treatment modality will typically be found in the radiation oncologist's summary letter for the course of treatment or in the radiotherapy treatment summary in the patient's medical record. Determining the treatment modality may require assistance from the radiation oncologist for consistent coding.
Comments:	To evaluate patterns of radiotherapy care and analyse patient outcomes, it is necessary to know which treatment modalities were employed in the delivery of treatment.

Source and reference attributes

Submitting organisation:	Cancer Australia
Origin:	Commission on Cancer, American College of Surgeons New South Wales Health Department
Reference documents:	American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer Cancer Institute NSW 2006. NSW Clinical Cancer Registration: Minimum Data Set Data Dictionary, version 1.9 draft

Relational attributes

Related metadata references:	See also Cancer treatment—radiation dose administered, total Gray N[NN.NN] Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy completion date, DDMMYYYY Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy fractions administered, total fractions N[N] Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy start date, DDMMYYYY Health, Standard 08/05/2014 See also Cancer treatment—radiotherapy target site, code N[N] Health, Standard 08/05/2014 Supersedes Cancer treatment—radiotherapy treatment type, code N[N] Health, Superseded 08/05/2014
Implementation in Data Set Specifications:	Radiotherapy for cancer cluster Health, Standard 08/05/2014

▲ Reason(s) second-line treatment administered

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—reason(s) second-line treatment administered, code N
METeOR identifier:	457437
Registration status:	Health, Standard 08/05/2014
Definition:	The reason(s) that **second-line treatment**, treatment that was not part of the planned initial course of treatment, was administered to a person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—reason(s) second-line treatment administered

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Incomplete response to first-line treatment
2	Toxic effects of first-line treatment
3	Recurrence or progressive disease
6	Other

Supplementary values:

Value	Meaning
7	Not applicable-no second-line treatment administered
8	Unknown whether second-line treatment administered
9	Second-line treatment administered but reason for not stated/inadequately described

Collection and usage attributes

Guide for use:	Record each relevant code at the commencement of second-line treatment for cancer.

Source and reference attributes

Submitting organisation:	Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use:	Record the reason(s) **second-line treatment** was administered for cancer. This item can be recorded multiple times for each person with cancer (for example both incomplete response and toxic effects) and

may be updated if any of the supplementary values were previously recorded.

It may be given when the cancer doesn't respond to first-line treatment, when first-line treatment has side effects that are not tolerated, or for disease progression or recurrence following a disease-free interval. The first recurrence may be many years after initial diagnosis and treatment for some patients.

Collection methods: This information should be sought from the patient's medical record.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Royal College of Physicians of London 1999. Lung cancer: a core data set. London: Royal College of Physicians of London

National Cancer Institute, 2008. Dictionary of Cancer Terms. Definition of second-line therapy. Viewed June 14, 2011, http://www.expertglossary.com/cancer/definition/second-line-therapy

Relational attributes

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on the administration of second-line treatment for cancer.

▲ Reason(s) treatment not administered (cancer)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—reason(s) treatment not administered, code N
METeOR identifier:	428257
Registration status:	Health, Standard 08/05/2014
Definition:	The reason(s) a person with cancer was not administered treatment for cancer, as represented by a code.
Data Element Concept:	Person with cancer—reason(s) treatment not administered

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Advanced age
2	Comorbid conditions
3	Poor performance status
4	Patient died prior to planned or recommended treatment
5	Patient or family declined treatment

Supplementary values:

Value	Meaning
88	Other
97	Not applicable-treatment administered to patient
98	Unknown whether treatment administered to patient
99	Treatment not administered to patient but reasons not stated/inadequately described

Collection and usage attributes

Guide for use: Record all the reasons why treatment was not administered.

Codes 1-3 should be recorded when it is a clinician's decision to not administer treatment.

Code 5 should be recorded when it is a patient or family's decision to decline treatment.

Source and reference attributes

Submitting organisation:	Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use:	Record the reason that a person with an initial diagnosis of cancer was not administered treatment. Treatment refers to any surgery, radiotherapy or systemic therapy agent that removes or modifies either primary or secondary malignant tissue. It may be curative or palliative in intent. For this item the use of supportive therapy such as the administration of analgesia or anti-emetics is not classed as treatment.
Collection methods:	This information should be sought from the patient's medical record.
Comments:	This information is used to evaluate the quality of care by distinguishing between contraindications to treatment due to patient risk factors, patient or family refusing treatment, and treatment not being offered for reasons unknown.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Relational attributes

Implementation in Data Set Specifications:	Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Record identifier (80 character maximum)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Record—identifier, X[X(79)]
Synonymous names:	State record identifier
METeOR identifier:	555463
Registration status:	Health, Standard 07/03/2014
Definition:	A record identifier that is unique to the reporting body, as represented by a code.
Data Element Concept:	Record—identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	X[X(79)]
Maximum character length:	80

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:

In the context of the Admitted patient care NMDS, the Record identifier data element exists to aid with data processing. This data element is generated for inclusion in data submissions to facilitate referencing of specific records in discussions between the receiving agency and the reporting body. It is to be used solely for this purpose.

When stipulated in a data specification, each record in a data submission will be assigned a unique numeric or alphanumeric record identifier to permit easy referencing of individual records in discussions between the receiving agency and the reporting body. The unique record identifier assigned by the reporting body should be generated in a fashion that allows the associated data record to be traced to its original form in the reporting body's source database.

Reporting jurisdictions may use their own alphabetic, numeric or

alphanumeric coding system.

This field cannot be left blank.

Non-admitted patient DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:

In the context of the Non-admitted patient DSS, the Record identifier data element exists to aid with data processing. This data element is generated for inclusion in data submissions to facilitate referencing of specific records in discussions between the receiving agency and the reporting body. It is to be used solely for this purpose.

When stipulated in a data specification, each record in a data submission will be assigned a unique numeric or alphanumeric record identifier to permit easy referencing of individual records in discussions between the receiving agency and the reporting body. The unique record identifier assigned by the reporting body should be generated in a fashion that allows the associated data record to be traced to its original form in the reporting body's source database.

Reporting jurisdictions may use their own alphabetic, numeric or alphanumeric coding system.

This field cannot be left blank.

Non-admitted patient DSS 2015-16 Health, Candidate 24/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

DSS specific information:

In the context of the Non-admitted patient DSS, the Record identifier data element exists to aid with data processing. This data element is generated for inclusion in data submissions to facilitate referencing of specific records in discussions between the receiving agency and the reporting body. It is to be used solely for this purpose.

When stipulated in a data specification, each record in a data submission will be assigned a unique numeric or alphanumeric record identifier to permit easy referencing of individual records in discussions between the receiving agency and the reporting body. The unique record identifier assigned by the reporting body should be generated in a fashion that allows the associated data record to be traced to its original form in the reporting body's source database.

Reporting jurisdictions may use their own alphabetic, numeric or alphanumeric coding system.

This field cannot be left blank.

Non-admitted patient emergency department care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Non-admitted patient emergency department care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

▲ Recurrent contracted care expenditure in Australian dollars

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent contracted care expenditure, total Australian currency N[N(8)]
METeOR identifier:	552596
Registration status:	Health, Standard 11/04/2014
Definition:	All recurrent expenditure on the provision of contracted care by private hospitals incurred by an establishment, measured in Australian dollars.
Data Element Concept:	Establishment—recurrent contracted care expenditure

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	PHE NMDS Working Group

Relational attributes

Implementation in Data Set Specifications:	Recurrent contracted care expenditure data element cluster Health, Standard 11/04/2014

▲ Recurrent contracted care expenditure product streams

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—recurrent contracted care expenditure, National Health Reform Agreement 2011 product streams code N[N]

METeOR identifier: 552598

Registration status: Health, Standard 11/04/2014

Definition: The product streams relating to the National Health Reform Agreement for total recurrent contracted care expenditure incurred by an establishment, as represented by a code.

Data Element Concept: Establishment—recurrent contracted care expenditure

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N[N]

Maximum character length: 2

Permissible values:

Value	Meaning
1	Admitted acute care
2	Admitted subacute care
3	Other admitted care
4	Emergency care services
5	Non-admitted care (in-scope for NHRA)
6	Direct teaching, training and research
7	Commonwealth funded aged care
8	Other aged care
9	Non-admitted care (out of scope for NHRA)
88	Other (out of scope for NHRA)

Collection and usage attributes

Guide for use: The scope of the National Health Reform Agreement (NHRA) should be defined using the most recent National Efficient Price Determination produced by the Independent Hospital Pricing Authority (IHPA).

CODE 1 Admitted acute care

The expenditure incurred by an establishment for admitted patients receiving acute care, including expenditure associated with the care of unqualified newborns (which would be reported under the mother's episode of care).

CODE 2 Admitted subacute care

The expenditure incurred by an establishment for admitted patients receiving subacute care.

CODE 3 Other admitted care

The expenditure incurred by an establishment for other admitted patients, including expenditure associated with maintenance care.

CODE 4 Emergency care services

The expenditure incurred by an establishment on non-admitted patients receiving care through emergency care services. Excludes admitted patients receiving care through the emergency department. The definition of emergency care services for ABF purposes is available at the Independent Hospital Pricing Authority website - http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/emergency-care

CODE 5 Non-admitted care (in-scope for NHRA)

The expenditure incurred by an establishment on non-admitted patients receiving services deemed to be in-scope of the National Health Reform Agreement.

CODE 6 Direct teaching, training and research

The expenditure incurred by an establishment for direct teaching, training and research.

CODE 7 Commonwealth funded aged care

The expenditure incurred by an establishment for Australian Government funded aged care patients (including residential aged care and Multi-Purpose Services).

CODE 8 Other aged care

The expenditure incurred by establishments for other aged care patients, excluding Australian Government funded aged care patients (such as residential aged care and Multi-Purpose Services).

CODE 9 Non-admitted care (out of scope for NHRA)

The expenditure incurred by an establishment on non-admitted patients receiving services deemed not to be in-scope of the National Health Reform Agreement.

CODE 88 Other (out of scope for NHRA)

The expenditure incurred by an establishment on services not reported elsewhere for a financial year.

Source and reference attributes

Submitting organisation:	Public Hospital Establishments NMDS Working Group
Reference documents:	http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/national-efficient-price-determination-lp

Data element attributes

Relational attributes

Implementation in Data Set Specifications:	Recurrent contracted care expenditure data element cluster Health, Standard 11/04/2014

▲ Recurrent expenditure by NHRA product streams

Identifying and definitional attributes

Metadata item type: Data Element

Technical name: Establishment—total recurrent expenditure, National Health Reform Agreement 2011 product streams code N[N]

METeOR identifier: 540184

Registration status: Health, Standard 11/04/2014

Definition: The product streams related to the National Health Reform Agreement for all recurrent expenditure incurred by an establishment, including salaries and wages, depreciation, and other non-salary recurrent expenditure (such as lease costs, administration expenses, contracted care and domestic services), as represented by a code.

Data Element Concept: Establishment—total recurrent expenditure

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N[N]

Maximum character length: 2

Permissible values:

Value	Meaning
1	Admitted acute care
2	Admitted subacute care
3	Other admitted care
4	Emergency care services
5	Non-admitted care (in-scope for NHRA)
6	Direct teaching, training and research
7	Commonwealth funded aged care
8	Other aged care
9	Non-admitted care (out of scope for NHRA)
88	Other (out of scope for NHRA)

Collection and usage attributes

Guide for use: The scope of the National Health Reform Agreement (NHRA) should be defined using the most recent National Efficient Price Determination produced by the Independent Hospital Pricing Authority (IHPA).

CODE 1 Admitted acute care

The expenditure incurred by an establishment for admitted patients receiving acute care, including expenditure associated with the care of unqualified newborns (which would be reported under the mother's episode of care).

CODE 2 Admitted subacute care

The expenditure incurred by an establishment for admitted patients receiving subacute care.

CODE 3 Other admitted care

The expenditure incurred by an establishment for other admitted patients, including expenditure associated with maintenance care.

CODE 4 Emergency care services

The expenditure incurred by an establishment on non-admitted patients receiving care through emergency care services. Excludes admitted patients receiving care through the emergency department. The definition of emergency care services for ABF purposes is available at the Independent Hospital Pricing Authority website - http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/emergency-care

CODE 5 Non-admitted care (in-scope for NHRA)

The expenditure incurred by an establishment on non-admitted patients receiving services deemed to be in-scope of the National Health Reform Agreement.

CODE 6 Direct teaching, training and research

The expenditure incurred by an establishment for direct teaching, training and research.

CODE 7 Commonwealth funded aged care

The expenditure incurred by an establishment for Australian Government funded aged care patients (including residential aged care and Multi-Purpose Services).

CODE 8 Other aged care

The expenditure incurred by establishments for other aged care patients, excluding Australian Government funded aged care patients (such as residential aged care and Multi-Purpose Services).

CODE 9 Non-admitted care (out of scope for NHRA)

The expenditure incurred by an establishment on non-admitted patients receiving services deemed not to be in-scope of the National Health Reform Agreement.

CODE 88 Other (out of scope for NHRA)

The expenditure incurred by an establishment on services not reported elsewhere for a financial year.

Source and reference attributes

Submitting organisation: Public Hospital Establishments NMDS Working Group

Reference documents: http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/national-efficient-price-determination-lp

Data element attributes

Collection and usage attributes

Guide for use: The total of recurrent expenditure for all product streams plus depreciation should equal the sum of all recurrent non-salary expenditure and recurrent salaries and wages expenditure.

Relational attributes

Related metadata references:	See also Establishment—total recurrent expenditure, total Australian currency N[N(8)] Health, Standard 11/04/2014
Implementation in Data Set Specifications:	Total recurrent expenditure on National Health Reform Agreement product streams data element cluster Health, Standard 11/04/2014

▲ Recurrent non-salary expenditure total dollars

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent non-salary expenditure, total Australian currency N[N(8)]
METeOR identifier:	542155
Registration status:	Health, Standard 11/04/2014
Definition:	The recurrent expenditure incurred by establishments, excluding salaries and wages, measured in Australian dollars.
Data Element Concept:	Establishment—recurrent non-salary expenditure

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Round to nearest whole dollar.

Relational attributes

Related metadata references:	See also Establishment—recurrent non-salary expenditure categories, code N[N] Health, Standard 11/04/2014
Implementation in Data Set Specifications:	Recurrent non-salary expenditure data element cluster Health, Standard 11/04/2014

▲ Recurrent non-salary public hospital expenditure categories

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent non-salary expenditure categories, code N[N]
METeOR identifier:	542106
Registration status:	Health, Standard 11/04/2014
Definition:	The categories of recurrent expenditure incurred by establishments, excluding salaries and wages, as represented by a code.
Data Element Concept:	Establishment—recurrent non-salary expenditure

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Administrative expenses - insurance
2	Administrative expenses - other
3	Depreciation - building
4	Depreciation - other
5	Domestic services
6	Interest payments
7	Lease costs
8	Patient transport costs
9	Repairs and maintenance
10	Superannuation employer contributions
11	Other on-costs
12	Supplies - drug
13	Supplies - food
14	Supplies - medical and surgical
15	Visiting medical officer payments
88	Not elsewhere recorded

Collection and usage attributes

Guide for use: CODE 1 Administrative expenses - insurance

The expenditure incurred by establishments for the purposes of

insurance (excluding workers' compensation premiums and medical indemnity).

CODE 2 Administrative expenses - other

The expenditure incurred by establishments of a management expenses/administrative support nature such as any rates and taxes, printing, telephone, stationery but excluding insurance, workers' compensation premiums and medical indemnity.

CODE 3 Depreciation - building

A building is a rigid, fixed and permanent structure which has a roof (ABS 2011). Building depreciation includes depreciation charges for buildings and fixed fit-out such as items fitted to the building (e.g. lights, partitions etc.).

This item includes charges from public private partnerships (PPP) involving the supply and use of buildings. For this purpose, 'supply' is considered to be the interest payments on the building and 'use' is considered to be the expenditure through the special purpose vehicle. Maintenance and repairs are excluded and should be reported against Code 9.

A PPP contract may also include expense for other expenditure such as cleaning or security services. Expenditure relating to these services will be reported under the appropriate code such as Code 5 Domestic Services. Only PPP Interest and Special Purposes Vehicle (SPV) expense should be reported in Code 3 Depreciation - building.

Building depreciation should be identified separately from other depreciation and other recurrent expenditure categories.

CODE 4 Depreciation - other

Other depreciation should be identified separately from building depreciation and other recurrent expenditure categories.

CODE 5 Domestic services

The expenditure incurred by establishments on domestic services include electricity, other fuel and power, domestic services for staff, accommodation and kitchen expenses but not including salaries and wages, food costs or equipment replacement and repair costs.

CODE 6 Interest payments

Payments made by or on behalf of the establishment in respect of borrowings (e.g. interest on bank overdraft) provided the establishment is permitted to borrow. This does not include the cost of equity capital (i.e. dividends on shares) in respect of profit-making private establishments.

CODE 7 Lease costs

A lease is an agreement whereby the lessor conveys to the lessee in return for a payment or series of payments the right to use an asset for an agreed period of time.

CODE 8 Patient transport costs

The expenditure incurred by establishments on transporting patients excluding salaries and wages of transport staff where payment is made by an establishment.

CODE 9 Repairs and maintenance

The expenditure incurred by establishments on maintaining,

repairing, replacing and providing additional equipment, maintaining and renovating building and minor additional works.

CODE 10 Superannuation employer contribution

Contributions paid in Australian dollars or (for an emerging cost scheme) that should be paid (as determined by an actuary) on behalf of establishment employees by the establishment to a superannuation fund providing retirement and related benefits to establishment employees, for a financial year.

The definition specifically excludes employee superannuation contributions (not a cost to the establishment) and superannuation final benefit payments.

The following different funding bases are identified:

- paid by hospital to fully funded scheme;
- paid by Commonwealth Government or State government to fully funded scheme;
- unfunded or emerging costs schemes where employer component is not presently funded.

Fully funded schemes are those in which employer and employee contributions are paid into an invested fund. Benefits are paid from the fund. Most private sector schemes are fully funded.

Emerging cost schemes are those in which the cost of benefits is met at the time a benefit becomes payable; that is, there is no ongoing invested fund from which benefits are paid. The Commonwealth superannuation fund is an example of this type of scheme as employee benefits are paid out of general revenue.

CODE 11 Other on-costs

The expenditure incurred by establishments on employee-related expenses, excluding salaries, wages and superannuation employer contributions, paid on behalf of establishment either by the establishment, or another organisation such as a state health authority.

The definition specifically excludes:

- salaries, wages and supplements for all employees of the organisation (including contract staff employed by an agency, provided staffing data are also available)
- superannuation employer contributions paid or for an emerging cost scheme, that should be paid (as determined by an actuary) on behalf of establishment employees either by the establishment or another organisation such as a state health authority, to a superannuation fund providing retirement and related benefits to establishment employees.
- workers' compensation premiums
- all paid leave (recreation, sick and long-service).

The definition includes:

- salary and wage payments relating to workers' compensation leave
- payroll tax, fringe benefits tax and redundancy payments.

CODE 12 Supplies - drug

The expenditure incurred by establishments on all drugs

including the cost of containers.

CODE 13 Supplies - food

The expenditure incurred by establishments on all food and beverages but not including kitchen expenses such as utensils, cleaning materials, cutlery and crockery.

CODE 14 Supplies - medical and surgical

The expenditure incurred by establishments on all consumables of a medical or surgical nature (excluding drug supplies) but not including expenditure on equipment repairs.

CODE 15 Visiting medical officer payments

The expenditure incurred by establishments to visiting medical officers for medical services provided to hospital (public) patients on an honorary, sessionally paid, or fee for service basis.

All payments made by an institutional health care establishment to visiting medical officers for medical services provided to hospital (public) patients on an honorary, sessionally paid, or fee for service basis.

A visiting medical officer is a medical practitioner appointed by the hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee for service basis. This category includes the same Australian and New Zealand Standard Classification of Occupations codes as the salaried medical officers category.

CODE 88 Not elsewhere recorded

The expenditure incurred by establishments on all other recurrent expenditure not elsewhere recorded. Gross expenditure should be reported with no revenue offsets (except for inter-hospital transfers).

Includes expenditure by the establishment on contracted care arrangements.

Data element attributes

Collection and usage attributes

Guide for use: Excludes salary and wage payments and premiums relating to workers' compensation leave.

Relational attributes

Related metadata references: See also Establishment—recurrent non-salary expenditure, total Australian currency N[N(8)] Health, Standard 11/04/2014

Implementation in Data Set Specifications: Recurrent non-salary expenditure data element cluster Health, Standard 11/04/2014

▲ Referral to palliative care services indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—referral to palliative care services indicator, yes/no/unknown code N
Synonymous names:	Supportive care, symptomatic care
METeOR identifier:	431284
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether the person with cancer was referred to **palliative care** services as part of their cancer treatment or follow-up, as represented by a code.
Data Element Concept:	Person with cancer—referral to palliative care services 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:	8	Unknown

Data element attributes

Collection and usage attributes

Guide for use:	Record whether the patient was referred to **palliative care** services. Referral to palliative care services is referral to palliative care administered by palliative care specialists such as a palliative care team or palliative physician. The point of transition to palliative care is when treatment goals become focussed on improving quality of life. However, the transition does not imply a discontinuation of active care or abandonment from treating cancer team.
Collection methods:	This information should be sought from the patient's medical record.
Comments:	This information is used to evaluate the quality of care for patients with cancer, and may have implications for access to, and the provision of, cancer services.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	National Breast and Ovarian Cancer Centre (NBOCC) and National Cancer Control Initiative (NCCI) 2003. Clinical practice guidelines for the psychosocial care of adults with cancer. Camperdown, NSW: National Breast and Ovarian Cancer Centre & National Cancer Control Initiative

Relational attributes

Related metadata references:	See also Person with cancer—date of referral to palliative care services, DDMMYYYY Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Referral to psychosocial services indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—referral to psychosocial services indicator, yes/no/unknown code N
METeOR identifier:	519990
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether a person with cancer has been directed to **psychosocial services** as part of their cancer treatment or follow-up, as represented by a code.
Data Element Concept:	Person with cancer—referral to psychosocial services 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:	8	Unknown

Data element attributes

Collection and usage attributes

Guide for use:	Record whether the patient was referred to **psychosocial services** such as psychological interventions, counselling, spiritual support or domiciliary care.
Comments:	This information is used to evaluate the quality of psychosocial care for patients, and may have implications for access to, and the provision of, services.

Relational attributes

Implementation in Data Set Specifications:	Lung cancer (clinical) DSS Health, Standard 08/05/2014

◊ Residential stay start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Residential stay—episode start date, DDMMYYYY
METeOR identifier:	534061
Registration status:	Health, Standard 07/03/2014
Definition:	The date on which a **resident** formally starts a residential stay, expressed as DDMMYYYY.
Data Element Concept:	Residential stay—episode start date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

Related metadata references:

Supersedes Residential stay—episode start date, DDMMYYYY Health, Superseded 07/03/2014

Implementation in Data Set Specifications:

Residential mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:

Right justified and zero filled.

Residential stay start date ≤ episode of residential care end date.

Residential stay start date ≥ date of birth

Residential mental health care NMDS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

DSS specific information:

Right justified and zero filled.

Residential stay start date ≤ episode of residential care end date.

Residential stay start date ≥ date of birth

▲ Residual tumour indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—residual (R) tumour indicator, yes/no code N
METeOR identifier:	430267
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether residual tumour is present after the course of treatment for cancer, as represented by a code.
Data Element Concept:	Cancer treatment—residual (R) tumour indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:	Record the presence of residual tumour on completion of the course of treatment for cancer. In some cases treated with surgery and/or neoadjuvant therapy, residual tumour will be present at the primary site after treatment because of incomplete resection or local and regional disease extending beyond the scope of resection.
Collection methods:	This information should be sought from the patient's medical record, referral letters or attending medical clinician.
Comments:	The presence of residual tumour may indicate the effect of treatment, influence further treatment decisions, and be a strong predictor of prognosis.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	American Joint Committee on Cancer 2010. AJCC Cancer Staging Manual, 7th edition. Springer: New York

Relational attributes

Implementation in Data Set Specifications:	Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is to be recorded for patients with ovarian cancer and stage IV endometrial cancer when surgical treatment for gynaecological cancer has been completed.

Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Collect when a person with cancer has completed their initial course of cancer treatment.

▲ Residual tumour type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—residual (R) tumour type, code AX
METeOR identifier:	521153
Registration status:	Health, Standard 08/05/2014
Definition:	The type of tumour that remains after the course of cancer treatment, as represented by a code.
Data Element Concept:	Cancer treatment—residual (R) tumour type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
R0	No residual tumour
R1	Microscopic residual tumour
R2	Macroscopic residual tumour
RX	Presence of residual tumour cannot be assessed

Supplementary values:

R7	Not applicable-surgery was not performed

Collection and usage attributes

Guide for use: Record the presence or absence of residual tumour after treatment.

Residual disease is based on the UICC TNM cancer staging system descriptor represented by the symbol R.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Sobin LH, Gospodarowicz MK, Wittekind C (Editors) 2009. International Union Against Cancer (UICC): TNM Classification of Malignant Tumours. 7th ed. Hoboken, New Jersey: John Wiley & Sons

Data element attributes

Relational attributes

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Collect when a person with cancer has completed their initial course of cancer treatment.

▲ Salaries and wages

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent salaries and wages expenditure, total Australian currency N[N(8)]
METeOR identifier:	541973
Registration status:	Health, Standard 11/04/2014
Definition:	Recurrent expenditure on salaries and wages to employees of an establishment, measured in Australian dollars.
Data Element Concept:	Establishment—recurrent salaries and wages expenditure

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Submitting organisation:	PHE NMDS Working Group

Relational attributes

Implementation in Data Set Specifications:	Recurrent salaries and wages expenditure data element cluster Health, Standard 11/04/2014

▲ Second-line treatment intention

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—second-line treatment intention, code N
METeOR identifier:	430242
Registration status:	Health, Standard 08/05/2014
Definition:	The intended outcome of **second-line treatment** administered to a person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—second-line treatment intention

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Prophylactic
2	Curative
3	Palliative

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Prophylactic

This code is used for treatment to prevent the occurrence or spread of disease.

CODE 2 Curative

This code is used when treatment is given for control of the disease.

CODE 3 Palliative

This code is used when treatment is given primarily for the purpose of pain control. Other benefits of the treatment are considered secondary contributions to quality of life.

CODE 9 Not stated/inadequately described

This code is used when treatment was administered and the intention was not stated or was inadequately described. This code is not intended for use in primary data collection but can be assigned for reporting purposes where there is missing data.

Data element attributes

Collection and usage attributes

Guide for use:

Record the intention of treatment at the commencement of **second-line treatment** for cancer.

Do not update the record if the intention of treatment changes during the course of second-line treatment.

Prophylactic treatment is treatment to prevent the occurrence or spread of disease which is not for the purpose of curing the disease or managing patient symptoms.

Curative treatment is any treatment which aims for long-term survival (over 2 years) for a significant proportion of those patients treated curatively.

Palliative treatment is any treatment where the intention is to relieve symptoms and possibly prolong life, but where long-term survival is highly unlikely.

Collection methods:

This information should be sought from the patient's medical record.

Comments:

The purpose of collecting the intention of treatment for cancer is to establish the frequency with which potentially curative chemotherapy treatments are utilised.

Source and reference attributes

Submitting organisation:

Cancer Australia

Reference documents:

Royal College of Physicians of London 1999. Lung cancer: a core data set. London: Royal College of Physicians of London

National Cancer Institute, 2008. Dictionary of Cancer Terms. Definition of second-line therapy. Viewed August 30, 2013, http://www.cancer.gov/dictionary?CdrID=346513

Relational attributes

Related metadata references:

See also Person with cancer—second-line treatment type, code N[N] Health, Standard 08/05/2014

Implementation in Data Set Specifications:

Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on the administration of second-line treatment for cancer.

▲ Second-line treatment type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—second-line treatment type, code N[N]
Synonymous names:	Second-line therapy
METeOR identifier:	432433
Registration status:	Health, Standard 08/05/2014
Definition:	The type of cancer-directed **second-line treatment** administered to a person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—second-line treatment type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Surgery only
2	Radiotherapy only
3	Systemic agent therapy only
4	Surgery and radiotherapy
5	Surgery and systemic agent therapy
6	Radiotherapy and systemic agent therapy
7	Surgery, radiotherapy and systemic agent therapy

Supplementary values:

Value	Meaning
97	Not applicable—treatment was not administered
98	Unknown whether treatment was administered
99	Treatment was administered but the type was not stated/inadequately described

Collection and usage attributes

Guide for use:

More than one treatment type may be administered during a course of cancer treatment; select the appropriate code value.

Systemic agent therapy refers to:

- **chemotherapy**
- hormone therapy
- immunotherapy

Surgery includes:

- surgical procedure for cancer
- systemic therapy procedure involving surgery

A systemic therapy procedure is a medical, surgical or radiation procedure that has an effect on the hormonal or immunologic balance of the patient.

Treatments other than surgery, radiotherapy or systemic agent therapy administered as part of the treatment are recorded separately.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer, 28E

Data element attributes

Collection and usage attributes

Guide for use: Record cancer-directed **second-line treatment** for a person with cancer. Cancer-directed treatment is that which destroys or modifies cancer tissue anywhere in the body.

Treatment may involve one or more modalities; record the code for each type of treatment administered.

Systemic therapy procedures are medical, surgical or radiation procedures that have an effect on the hormonal or immunological balance of the patient, and refer to haematologic transplant and endocrine procedures.

Note the distinction between the administration of systemic agents or drugs, and systemic therapy procedures that affect the hormonal or immunologic balance of the patient.

Collection methods: This information should be sought from the patient's medical record.

Comments: The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Chicago: Commission on Cancer

National Cancer Institute, 2008. Dictionary of Cancer Terms. Definition of second-line therapy. Viewed June 14, 2011, http://www.expertglossary.com/cancer/definition/second-line-therapy

Relational attributes

Related metadata references: See also Person with cancer—second-line treatment intention, code N Health, Standard 08/05/2014

Implementation in Data Set Specifications: Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:

Conditional on the administration of second-line treatment for cancer.

◊ Surgery target site

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—surgery target site, topography code (ICD-O-3) ANN.N
METeOR identifier:	561567
Registration status:	Health, Standard 08/05/2014
Definition:	The target site of cancer-directed surgery performed during the course of treatment for cancer, as represented by an ICD-O-3 code.
Data Element Concept:	Cancer treatment—surgery target site

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	String
Format:	ANN.N
Maximum character length:	5

Collection and usage attributes

Guide for use:	Record all four alphanumeric characters of the topography code. The number after the decimal point represents the subsite or subcategory.

Data element attributes

Collection and usage attributes

Guide for use:	The target site is collected for all cancer-directed surgery performed during the course of treatment. Cancer-directed surgery refers to all surgery that destroys or modifies cancer tissue anywhere in the body. Cancer-directed surgery may be palliative, (to control symptoms, alleviate pain, or make the patient more comfortable), or curative. Target sites for biopsies that remove the entire tumour and/or leave only microscopic margins are to be recorded here. All sites or regions targeted for cancer-directed surgery during the course of treatment should be recorded. There may be more than one site targeted for treatment. For example, the primary tumour site and the site of a distant metastasis may receive cancer-directed surgery as part of the course of treatment. The target site for radiotherapy is collected as a separate item.
Collection methods:	This information should be obtained from the patient's medical record.

Comments:	This is collected to identify which anatomical structures are targeted by surgery and is useful in evaluating patterns of care and patient outcomes.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references:	Supersedes Cancer treatment—surgery target site, topography code (ICD-O-3) ANN.N Health, Superseded 08/05/2014 See also Cancer treatment—surgical procedure date, DDMMYYYY Health, Standard 08/05/2014 See also Cancer treatment—surgical procedure for cancer, procedure code (ACHI 8th edn) NNNNN-NN Health, Superseded 08/05/2014 See also Cancer treatment—surgical procedure for cancer, procedure code (ACHI 8th edn) NNNNN-NN Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Surgery for cancer cluster Health, Standard 08/05/2014

▲ Surgical margin qualifier (lung cancer)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—lung cancer surgical margin qualifier, code N[N]
METeOR identifier:	433052
Registration status:	Health, Standard 08/05/2014
Definition:	The orientation of the surgical margin that is closest to the invasive or in situ carcinoma after surgical treatment for lung cancer, as represented by a code.
Data Element Concept:	Cancer treatment—surgical margin qualifier

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Bronchial
2	Mediastinal
3	Vascular
4	Parenchymal
5	Parietal pleural
6	Chest wall
88	Other

Supplementary values:

Value	Meaning
97	Not applicable-surgery was not performed
98	Unknown whether margin involvement was present
99	Margin involvement present but not qualified

Collection and usage attributes

Guide for use:	Record the code number for the surgical margin closest to the invasive or in situ carcinoma.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	College of American Pathologists (CAP) 2009. Protocol for the examination of specimens from patients with primary non-small cell carcinoma, small cell carcinoma, or carcinoid tumour of the lung. Viewed 7 June 2011, http://www.cap.org/apps/docs/committees/cancer/

cancer_protocols/2011/Lung_11protocol.pdf

Data element attributes

Collection and usage attributes

Guide for use:

Surgical margins represent sites that have either been cut or bluntly dissected by the surgeon to resect the specimen.

The presence of tumour at a surgical margin is an important finding because there is the potential for residual tumour remaining in the patient in the area surrounding a positive margin.

Record the code for the margin described as the closest surgical margin from the invasive or in situ carcinoma. Where two or more margins are reported, only the closest should be recorded.

Record only for the most definitive surgical procedure performed. For instance, if a surgical procedure to remove a portion of tumour at the primary site is followed by additional surgery to remove the remainder of the tumour at that site, code the closest surgical margin for the final surgical procedure.

Record for the primary tumour site only, not for metastatic sites.

Collection methods:

This information should be sought from the patient's pathology report under microscopic findings.

Collect this item when a person undergoes surgery for the treatment of lung cancer.

Comments:

Identifying the margins involved by in situ or invasive carcinoma is useful for surgical audit. Margin involvement may influence treatment decisions and is a prognostic indicator.

Source and reference attributes

Submitting organisation:

Cancer Australia

Relational attributes

Related metadata references:

See also Cancer treatment—distance of closest surgical margin, total millimetres N[N] Health, Standard 08/05/2014

Implementation in Data Set Specifications:

Lung cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Collect when a person with cancer has undergone surgery during their initial course of cancer treatment for the purpose of removing lung cancer (either invasive or in situ).

◊ Surgical procedure date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—surgical procedure date, DDMMYYYY
METeOR identifier:	561574
Registration status:	Health, Standard 08/05/2014
Definition:	The date on which a cancer-directed surgical procedure was performed during the course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—surgical procedure date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	The surgical procedure date is collected for all cancer-directed surgery delivered to the patient during treatment for cancer. Cancer-directed surgery refers to all surgery that destroys or modifies cancer tissue anywhere in the body. Cancer-directed surgery may be palliative (to control symptoms, alleviate pain, or make the patient more comfortable), or curative. The date of each surgical treatment episode should be entered separately. Procedure dates for biopsies that remove all of the tumour and/or leave only microscopic margins are to be recorded here. Dates for radiotherapy and systemic treatments are collected as separate items.
Collection methods:	This information should be obtained from the patient's medical record.
Comments:	Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Source and reference attributes

Submitting organisation:	Cancer Australia
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards

(ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references:	See also Cancer treatment—surgery target site, topography code (ICD-O-3) ANN.N Health, Standard 08/05/2014 Supersedes Cancer treatment—surgical procedure date, DDMMYYYY Health, Superseded 08/05/2014 See also Cancer treatment—surgical procedure for cancer, procedure code (ACHI 8th edn) NNNNN-NN Health, Superseded 08/05/2014 See also Cancer treatment—surgical procedure for cancer, procedure code (ACHI 8th edn) NNNNN-NN Health, Standard 08/05/2014
Implementation in Data Set Specifications:	Surgery for cancer cluster Health, Standard 08/05/2014

◊ Surgical procedure for cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—surgical procedure for cancer, procedure code (ACHI 8th edn) NNNNN-NN
METeOR identifier:	562816
Registration status:	Health, Standard 08/05/2014
Definition:	The cancer-directed surgical procedure performed during the course of treatment for cancer, as represented by a code.
Data Element Concept:	Cancer treatment—surgical procedure for cancer

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 8th edition
Representation class:	Code
Data type:	Number
Format:	NNNNN-NN
Maximum character length:	7

Data element attributes

Collection and usage attributes

Guide for use:	The procedure code is collected for all cancer-directed surgery performed during treatment for cancer. Cancer-directed surgery refers to all surgery that destroys or modifies cancer tissue anywhere in the body. Cancer-directed surgery may be palliative (to control symptoms, alleviate pain, or make the patient more comfortable), or curative. Biopsies that remove the entire tumour and/or leave only microscopic margins are to be recorded here. The procedure code for each surgical treatment episode should be entered separately. Endocrine surgery for the purpose of modifying hormone levels is recorded with data element *Cancer treatment – systemic therapy procedure, code N[N].*
Collection methods:	This information should be obtained from the patient's medical record.
Comments:	The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Submitting organisation:	Cancer Australia
Origin:	National Centre for Classification in Health New South Wales Department of Health, Public Health Division
Reference documents:	Public Health Division 2001. NSW Clinical Cancer Data Collection for Outcomes and Quality: Data Dictionary, Version 1. Sydney:NSW Health Department American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer American College of Surgeons 1998. Standards of the Commission on Cancer: Registry Operations and Data Standards (ROADS), Volume II. Commission on Cancer

Relational attributes

Related metadata references:	See also Cancer treatment—surgery target site, topography code (ICD-O-3) ANN.N Health, Standard 08/05/2014 See also Cancer treatment—surgical procedure date, DDMMYYYY Health, Standard 08/05/2014 Supersedes Cancer treatment—surgical procedure for cancer, procedure code (ACHI 8th edn) NNNNN-NN Health, Superseded 08/05/2014
Implementation in Data Set Specifications:	Surgery for cancer cluster Health, Standard 08/05/2014

▲ Surgical specialty gynaecological cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical specialist—surgical specialty, initial gynaecological surgical speciality code N[N]
METeOR identifier:	424298
Registration status:	Health, Standardisation pending 12/02/2014
Definition:	The medical specialty of the surgeon who performed surgery for gynaecological cancer treatment, as represented by a code.
Data Element Concept:	Medical specialist—surgical specialty

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Gynaecological oncologist
2	Gynaecologist
3	General surgeon
8	Other

Supplementary values:

98	Unknown

Collection and usage attributes

Guide for use:

CODE 1 Gynaecological oncologist

A specialist in obstetrics and gynaecology, awarded the Fellowship of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), having completed a formal three-year training program in gynaecological cancer care and passed the examination for the Certificate of Gynaecological Oncology CGO).

CODE 2 Gynaecologist

A specialist in obstetrics and gynaecology awarded the Fellowship of RANZCOG, having completed advanced training prescribed or approved by the Council and who furnish to the Council satisfactory evidence of completion of such advanced training.

CODE 3 General surgeon

A specialist in surgery, having satisfactorily undertaken the Royal Australasian College of Surgeons (RACS) Fellowship Examination to ensure that attainment of Fellowship standards.

CODE 8 Other

Other medical practitioners with no specialist surgical/gynaecological cancer training.

Comments: Justification: Provides data about patterns of care/management.

Source and reference attributes

Reference documents: Australian Cancer Network and National Breast Cancer Centre. Clinical practice guidelines for the management of women with epithelial ovarian cancer. NBCC. 2004.
Royal Australasian College of Surgeon (RACS) and Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

Data element attributes

Collection and usage attributes

Guide for use: Record the medical specialty of the surgeon who performed surgery for gynaecological cancer during the initial course of treatment.

Collection methods: Collect from patient medical records.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Australian Cancer Network and National Breast Cancer Centre. Clinical practice guidelines for the management of women with epithelial ovarian cancer. NBCC. 2004

Royal Australasian College of Surgeon (RACS) and Royal Australian College of Obstetricians and Gynaecologists

Relational attributes

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is only to be recorded for patients who have undergone surgery relating to their initial course of treatment for gynaecological cancer.

▲ Surgical treatment complication indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—primary surgical treatment complication indicator, yes/no/unknown code N
Synonymous names:	Critical event indicator
METeOR identifier:	546455
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of the occurrence of **treatment complications** within 30 days of primary surgery for cancer treatment, as represented by a code.
Data Element Concept:	Cancer treatment—primary surgical treatment complication 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:

8	Unknown

Data element attributes

Collection and usage attributes

Guide for use: Record the whether there were any critical events/**treatment complications** within 30 days of primary surgery for cancer treatment. These include:

- Unplanned return to theatre
- Death within 30 days of surgery
- Post-operative fistula
- Intra-operative haemorrhage (more than 6 units of transfusion)
- Pulmonary embolism
- Unplanned transfer to intensive care unit (ICU)
- Post-operative hospital stay of greater than 21 days

Collection methods: Collect from medical records.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Gynaecology Oncology Subspecialty Practice Improvement Critical

Project (GO SPICE)

Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

Relational attributes

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

▲ Surgical treatment complication type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—treatment complication type, cancer-related primary surgery complication type code N[N]
Synonymous names:	Critical event type
METeOR identifier:	424310
Registration status:	Health, Standard 08/05/2014
Definition:	The type of **treatment complication/s** arising within 30 days of undergoing surgical treatment for cancer, as represented by a code.
Data Element Concept:	Cancer treatment—treatment complication type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Unplanned return to theatre
2	Death within 30 days of surgery
3	Post-operative fistula
4	Intra-operative haemorrhage (greater than 6 units of transfusion)
5	Pulmonary embolism
6	Unplanned transfer to intensive care unit (ICU)
7	Post-operative stay greater than 21 days
88	Other complication or critical event

Supplementary values:

Value	Meaning
98	Unknown
99	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Gynaecology Oncology Subspecialty Practice Improvement Critical Project (GO SPICE) Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

Data element attributes

Collection and usage attributes

Guide for use: Record the type of any treatment complications that occur within 30 days of primary surgery. If multiple events occur, all events should be recorded.

Collection methods: Collect from medical records.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Gynaecology Oncology Subspecialty Practice Improvement Critical Project (GO SPICE)

Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

Relational attributes

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is to be recorded when Cancer treatment—primary surgical treatment complication indicator, yes/no/unknown code N indicates the presence of a treatment complication.

◊ Systemic therapy agent or protocol

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—systemic therapy agent or protocol, text X[X(149)]
METeOR identifier:	561301
Registration status:	Health, Standard 08/05/2014
Definition:	The systemic therapy agent or protocol administered during the course of treatment for cancer, as represented by text.
Data Element Concept:	Cancer treatment—systemic therapy agent or protocol

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(149)]
Maximum character length:	150

Data element attributes

Collection and usage attributes

Guide for use:

Systemic therapy agents are drugs that travel through the bloodstream and reach and effect cells all over the body. They are administered orally or intravenously.

Each systemic therapy agent or protocol used during the treatment of the cancer should be recorded.

The name of each systemic therapy agent or protocol given as treatment is recorded regardless of whether the course of treatment is completed as intended, and regardless of the intent or timing of the treatment.

Oral systemic therapy agents normally given on an outpatient basis should also be included.

Systemic therapy agents may be administered as single-agent treatments or as a combination of drugs administered according to a prespecified regimen or protocol. A protocol is a precise and detailed plan for therapy that includes the type, quantity, method and length of time of taking the drugs required for any treatment cycle.

A combination of drugs may be known by acronyms but since details of drugs and acronyms may vary it is recommended that the name of each agent be recorded.

When recording systemic therapy protocol names, eviQ should be used wherever possible. eviQ Cancer Treatments Online is a point of care clinical information resource that provides health professionals with current evidence based, peer maintained, best

practice cancer treatment protocols and information. It was developed and is maintained by the Cancer Institute NSW.

If a single agent is being used or a protocol is not included in eviQ, then the full, generic name of any agent should be recorded preferably using the Australian Medicines Terminology (AMT), or if necessary, the Australian Medicines Handbook (AMH) or MIMS. If a generic name is not available because the drug is experimental or under patent protection, record the brand name.

The eviQ protocol identifier number should be recorded separately in the data element *Cancer treatment – systemic therapy agent(s) or protocol, eviQ protocol identifier, NNNNNN*.

Systemic therapy agents are encompassed in the treatment modalities **chemotherapy**, **immunotherapy** and **hormone therapy** administered for the treatment of cancer.

A patient may receive treatment with a protocol that includes different types of systemic therapy agents, for example, a chemotherapy agent and an immunotherapy agent.

Targeted therapies (treatments that use drugs or other substances to identify and attack specific cancer cells) using a chemotherapy agent are included. Other targeted therapies, such as monoclonal antibody therapy, are recorded in the data element *Cancer treatment – other cancer treatment, text [X(150)]*.

Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment. Only record prednisone as hormone therapy when administered in combination with chemotherapy such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

Tumour involvement or cancer treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Hormone replacement therapy should only be recorded as part of a subsequent course of treatment and not the initial course of treatment.

Collection methods: This information should be collected from the patient's medical record.

Comments: Note the distinction between the administration of systemic agents or drugs and systemic therapy procedures that affect the hormonal or immunologic balance of the patient.

The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Stedman TL 2006. Stedman's medical dictionary. 28th edition. Maryland: Lippincott Williams & Wilkins

Standard Cancer Treatment and Management Pathways

Program, Cancer Services and Education Division. eviQ Cancer Treatments Online. Cancer Institute NSW

The National Clinical Terminology and Information Service (NCTIS) 2011. Australian Medicines Terminology (AMT). Sydney: National E-Health Transition Authority (NEHTA). AMT releases are provided every month and are available from the NCTIS Secure Website

Australian Medicines Handbook (AMH). Australian Medicines Handbook Pty Ltd

MIMS Medicines Information. St Leonards, New South Wales: UBM Medica Pty Ltd

Relational attributes

Related metadata references:

See also Cancer treatment—chemotherapy completion date, DDMMYYYY Health, Standard 08/05/2014

See also Cancer treatment—chemotherapy cycles administered, number of cycles N[NN] Health, Standard 08/05/2014

See also Cancer treatment—chemotherapy start date, DDMMYYYY Health, Standard 08/05/2014

See also Cancer treatment—hormone therapy completion date, DDMMYYYY Health, Standard 08/05/2014

See also Cancer treatment—hormone therapy start date, DDMMYYYY Health, Standard 08/05/2014

See also Cancer treatment—immunotherapy completion date, DDMMYYYY Health, Standard 08/05/2014

See also Cancer treatment—immunotherapy start date, DDMMYYYY Health, Standard 08/05/2014

See also Cancer treatment—systemic therapy agent or protocol, eviQ protocol identifier NNNNNN Health, Standard 08/05/2014

Supersedes Cancer treatment—systemic therapy agent or protocol, text X[X(149)] Health, Superseded 08/05/2014

Implementation in Data Set Specifications:

Chemotherapy for cancer cluster Health, Standard 08/05/2014

Hormone therapy for cancer cluster Health, Standard 08/05/2014

Immunotherapy for cancer cluster Health, Standard 08/05/2014

◊ Systemic therapy agent or protocol, eviQ

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—systemic therapy agent or protocol, eviQ protocol identifier NNNNNN
METeOR identifier:	561278
Registration status:	Health, Standard 08/05/2014
Definition:	The eviQ protocol identifier for the systemic therapy agent protocol administered during the course of treatment for cancer.
Data Element Concept:	Cancer treatment—systemic therapy agent or protocol

Value domain attributes

Representational attributes

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

Collection and usage attributes

Guide for use:	The eviQ protocol identifier must always be recorded as a six digit number, with leading zeros if applicable, for example, 000123.
Collection methods:	eviQ protocol identifiers are available from the eviQ Cancer Treatments Online website.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Standard Cancer Treatment and Management Pathways Program, Cancer Services and Education Division. eviQ Cancer Treatments Online. Cancer Institute NSW Commission on Cancer, American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision Stedman TL 2006. Stedman's Medical Dictionary. 28th edition. Maryland: Lippincott Williams & Wilkins

Data element attributes

Collection and usage attributes

Guide for use:	eviQ Cancer Treatments Online is a point of care clinical information resource that provides health professionals with current evidence based, peer maintained, best practice cancer treatment protocols and information. It was developed and is maintained by the Cancer Institute NSW.

Record the six digit eviQ protocol identifier (where available) for each systemic therapy agent protocol administered to the patient during the treatment of the cancer.

Systemic therapy agents are drugs that travel through the bloodstream and reach and effect cells all over the body. They are administered orally or intravenously.

Systemic therapy may involve a single agent or a combination regimen of two or more drugs. They are administered in treatment cycles.

A protocol is a precise and detailed plan for therapy that includes the type, quantity, method and length of time of taking the drugs required for any treatment cycle.

The systemic therapy agent eviQ protocol identifier applies to **chemotherapy**, **hormone therapy** and **immunotherapy** administered for the treatment of cancer.

Collection methods: This name of the protocol should be obtained from the patient's medical record.

Comments: The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Source and reference attributes

Submitting organisation: Cancer Australia.

Origin: Cancer Institute NSW, eviQ Cancer Treatments Online.

Reference documents: Standard Cancer Treatment and Management Pathways Program, Cancer Services and Education Division. eviQ Cancer Treatments Online. Cancer Institute NSW.

Relational attributes

Related metadata references: Supersedes Cancer treatment—systemic therapy agent or protocol, eviQ protocol identifier NNNNNN Health, Superseded 08/05/2014

See also Cancer treatment—systemic therapy agent or protocol, text X[X(149)] Health, Standard 08/05/2014

Implementation in Data Set Specifications: Chemotherapy for cancer cluster Health, Standard 08/05/2014

Conditional obligation:
Conditional on the administration of systemic therapy agents according to a prespecified regimen or protocol, and on the availability of the protocol number on the eviQ website.

Hormone therapy for cancer cluster Health, Standard 08/05/2014

Conditional obligation:
Conditional on the administration of systemic therapy agents according to a prespecified regimen or protocol, and on the availability of the protocol number on the eviQ website.

Immunotherapy for cancer cluster Health, Standard 08/05/2014

Conditional obligation:
Conditional on the administration of systemic therapy

agents according to a prespecified regimen or protocol, and on the availability of the protocol number on the eviQ website.

▲ Systemic therapy modification indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—systemic therapy treatment modification indicator, yes/no/unknown code N
METeOR identifier:	546764
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether there was modification made to a patient's planned systemic therapy treatment for cancer, as represented by a code.
Data Element Concept:	Cancer treatment—systemic therapy treatment modification 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:	8	Unknown

Data element attributes

Collection and usage attributes

Guide for use:

Record whether there was a modification made to systemic therapy treatment from the initial treatment plan or systemic therapy schedule for a course of cancer treatment. Systemic therapy encompasses chemotherapy, hormone therapy and immunotherapy and modifications include (but are not limited to):

- Dose decrease
- Drug omission
- Drug delivery interval increase
- Dose increase
- Drug introduction
- Drug delivery interval decrease

Treatment modification is often due to a patient's response to treatment or a change in the extent or pathway of the disease.

Collection methods: Collect from patient medical records.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Cancer Australia Working Group, 2010.

Relational attributes

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is to be recorded for patients who have undergone systemic therapy as part of their cancer treatment. This includes chemotherapy, hormone therapy and immunotherapy.

▲ Systemic therapy modification type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—treatment modification type for cancer-related systemic therapy, code N[N]
METeOR identifier:	424306
Registration status:	Health, Standard 08/05/2014
Definition:	The type of change to a cancer patient's systemic therapy treatment plan, as represented by a code.
Data Element Concept:	Cancer treatment—treatment plan modification

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Dose decrease
02	Drug omission
03	Drug delivery interval increase
04	Dose increase
05	Drug introduction
06	Drug delivery interval decrease
07	Dose increase and interval decrease
88	Other

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:	Systemic therapy encompasses chemotherapy, hormone therapy and immunotherapy.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Cancer Australia Working Group, 2010.

Data element attributes

Collection and usage attributes

Guide for use:	Record the type of modification made to systemic therapy treatment from the initial treatment plan or systemic therapy schedule for a

course of cancer treatment. Systemic therapy encompasses chemotherapy, hormone therapy and immunotherapy.

Collection methods: Collect from patient medical records.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Cancer Australia Working Group, 2010.

Relational attributes

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is to be recorded when Cancer treatment—systemic therapy treatment modification indicator, yes/no/unknown code N indicates a modification to planned systemic therapy treatment.

◊ Systemic therapy procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—systemic therapy procedure, code N[N]
Synonymous names:	Haematologic transplant, endocrine procedures
METeOR identifier:	561612
Registration status:	Health, Standard 08/05/2014
Definition:	The **systemic therapy procedure** administered during the course of treatment for cancer, as represented by a code.
Data Element Concept:	Cancer treatment—systemic therapy procedure

Value domain attributes

Representational attributes

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

Permissible values: / *Supplementary values:*

Value	Meaning
1	A bone marrow transplant procedure was administered but the type was not specified
2	Bone marrow transplant—autologous only
3	Bone marrow transplant—allogeneic only
4	Stem cell harvest and infusion only
5	Endocrine surgery and/or endocrine radiation therapy only
6	Combination of endocrine surgery and/or radiation with a transplant procedure
96	Other systemic therapy procedure
97	Not applicable-no systemic therapy procedures were administered
98	Unknown whether systemic therapy procedures were administered
99	Systemic therapy procedures were administered but were not stated/inadequately described

Collection and usage attributes

Guide for use:	Systemic therapy procedures are medical, surgical or radiation procedures that have an effect on the hormonal or immunological balance of the patient, and refers to haematologic transplant and endocrine procedures.

Source and reference attributes

Submitting organisation:	Cancer Australia.
Reference documents:	American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer, 28D-28E, 182-183.

Data element attributes

Collection and usage attributes

Guide for use:

Systemic therapy procedures refers to haematologic transplant and endocrine procedures. Haematologic transplants are bone marrow or stem cell transplants performed to protect patients from myelosuppression or bone marrow ablation associated with the administration of high-dose chemotherapy or radiotherapy.

Endocrine therapy is cancer therapy that achieves its antitumour effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient (when the cancer occurs at another site) and, therefore, alter or affect the long-term control of the cancer's growth.

Haematologic transplant or endocrine procedures may be provided to prolong a patient's life by controlling symptoms, to alleviate pain, or make the patient more comfortable.

Each systemic therapy procedure delivered to the patient during the treatment for cancer should be recorded.

The procedure code for each treatment episode should be entered separately.

Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.

Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.

Endocrine procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.

Collection methods:

This information should be obtained from the patient's medical record.

Comments:

The collection of specific treatment information is useful to evaluate patterns of care, the effectiveness of different treatment modalities, and treatment by patient outcome.

Note the distinction between the administration of systemic agents or drugs and systemic therapy procedures that affect the hormonal or immunologic balance of the patient.

Source and reference attributes

Submitting organisation:	Cancer Australia
Origin:	Commission on Cancer, American College of Surgeons

Reference documents:	American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Relational attributes

Related metadata references:	See also Cancer treatment—systemic therapy procedure date, DDMMYYYY Health, Standard 08/05/2014 Supersedes Cancer treatment—systemic therapy procedure, code N[N] Health, Superseded 08/05/2014
Implementation in Data Set Specifications:	Systemic therapy procedure for cancer cluster Health, Standard 08/05/2014

◊ Systemic therapy procedure date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—systemic therapy procedure date, DDMMYYYY
METeOR identifier:	561606
Registration status:	Health, Standard 08/05/2014
Definition:	The date on which a **systemic therapy procedure** was administered during the course of treatment for cancer, expressed as DDMMYYYY.
Data Element Concept:	Cancer treatment—systemic therapy procedure date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	The date is collected for all systemic therapy procedures administered to the patient during the treatment for cancer. A systemic therapy procedure is a medical, surgical or radiation procedure that has an effect on the hormonal or immunologic balance of the patient, and refers to haematologic transplant and endocrine procedures. Haematologic transplants are bone marrow or stem cell transplants performed to protect patients from myelosuppression or bone marrow ablation associated with the administration of high-dose chemotherapy or radiotherapy. Endocrine therapy is cancer therapy that achieves its antitumour effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient (when the cancer occurs at another site) and, therefore, alter or affect the long-term control of the cancer's growth. Haematologic transplant or endocrine procedures may be provided to prolong a patient's life by controlling symptoms, to alleviate pain, or make the patient more comfortable. The date of each treatment episode should be entered separately. The date of cancer-directed surgery, radiotherapy and treatment with systemic agents are collected as separate items.
Collection methods:	This information should be obtained from the patient's medical record.

Comments:

Collecting the start and finish dates for treatment modalities will enable an estimate of treatment duration.

Note the distinction between the administration of systemic agents or drugs and systemic therapy procedures that affect the hormonal or immunologic balance of the patient.

Source and reference attributes

Submitting organisation: Cancer Australia

Origin: Commission on Cancer, American College of Surgeons

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

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

Relational attributes

Related metadata references: Supersedes Cancer treatment—systemic therapy procedure date, DDMMYYYY Health, Superseded 08/05/2014

See also Cancer treatment—systemic therapy procedure, code N[N] Health, Standard 08/05/2014

Implementation in Data Set Specifications: Systemic therapy procedure for cancer cluster Health, Standard 08/05/2014

◊ Team Care Arrangement (MBS Item 723) indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—Team Care Arrangement (MBS Item 723) indicator, yes/no code N
METeOR identifier:	504991
Registration status:	Health, Standard 21/11/2013
Definition:	An indicator of whether a Team Care Arrangement (MBS Item 723) has been claimed for a person, as represented by a code.
Data Element Concept:	Person—Team Care Arrangement (MBS Item 723) indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

A Team Care Arrangement has been claimed for a person.

CODE 2 No

A Team Care Arrangement has not been claimed for a person.

Comments:

The Chronic Disease Management Medicare items on the Medicare Benefits Schedule (MBS) enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers. The items are designed for patients who require a structured approach to their care. A 'chronic medical condition' is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular disease, diabetes mellitus and musculoskeletal conditions (Department of Health and Ageing 2011a).

Team Care Arrangements (TCAs) are required by legislation to include a document that describes:

- treatment and service goals for the patient
- treatment and services that collaborating providers will provide

to the patient

- actions to be taken by the patient
- a date to review these matters (Department of Health and Ageing 2011b).

This chronic disease management service is for a patient who:

(a) has at least one medical condition that:

i. has been (or is likely to be) present for at least six months; or

ii. is terminal; and

(b) requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner (Department of Health and Ageing 2011c).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Department of Health and Ageing 2011a. Department of Health and Ageing, Canberra. Viewed 27 May 2011, http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement

Department of Health and Ageing 2011b. Team Care Arrangements (Medicare item 723). Department of Health and Ageing, Canberra. Viewed 27 May 2011, http://www.health.gov.au/internet/main/publishing.nsf/Content/81BB2DB118217838CA2576710015F3B3/$File/Important%20Reminders%20About%20GPMPs%20Nov%2009.pdf

Department of Health and Ageing 2011c. Medicare Benefits Schedule – Item 723. Department of Health and Ageing, Canberra. Viewed 27 May 2011, http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=723

Relational attributes

Related metadata references: Supersedes Person—Team Care Arrangement (MBS Item 723) indicator, yes/no code N Health, Superseded 21/11/2013

Implementation in Data Set Specifications: Indigenous primary health care DSS 2014-15 Health, Standard 21/11/2013
Indigenous, Endorsed 21/11/2013

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
This item is only collected for persons who have Type II diabetes.

Implementation in Indicators: **Used as numerator**
Indigenous primary health care: PI08a-Number of regular clients with a chronic disease for whom a Team Care Arrangement (MBS Item 723) was claimed, 2014 Health, Standard 21/11/2013
Indigenous, Endorsed 21/11/2013
Indigenous primary health care: PI08b-Proportion of regular clients with a chronic disease for whom a Team Care Arrangement (MBS

Item 723) was claimed, 2014 Health, Standard 21/11/2013 Indigenous, Endorsed 21/11/2013

▲ Tissue sample collected indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tissue sample collected indicator, yes/no code N
METeOR identifier:	446565
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether a **tissue sample** has been collected from a person, as represented by a code.
Data Element Concept:	Person—tissue sample collected indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:	Record whether a tissue sample has been collected from a person. This includes tissue that has been collected for either clinical or research purposes and stored in any format, including tissue samples that have been snap frozen, stored with OCT (optimum cutting temperature compound), FFPE (formalin fixed, paraffin embedded), and if RNA and/or DNA has been extracted from tissue and stored.
Collection methods:	Collect from medical, laboratory or biobank records.

Source and reference attributes

Submitting organisation:	Cancer Australia

Relational attributes

Implementation in Data Set Specifications:	Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

◊ 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:	552375
Registration status:	Health, Standard 11/04/2014
Definition:	The sum of the number of days or part days of stay that the person received care as an admitted patient or **resident** within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit.
Data Element Concept:	Episode of care—number of psychiatric care days

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

Public acute care hospitals:

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

Private acute care hospitals:

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

Psychiatric hospitals:

Total psychiatric care days in stand-alone psychiatric hospitals are calculated by counting those days the patient received

specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

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

Community-based residential services:

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

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

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

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

Admitted patients in acute care:

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

Collection methods:

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

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

Comments:

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

Source and reference attributes

Submitting organisation: National Mental Health Information Strategy Committee

Reference documents: *Health Insurance Act 1973* (Commonwealth)

Relational attributes

Related metadata references:

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Final 30/06/2014, National Health Performance Authority, Standard 07/11/2013

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—separation date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Final 01/07/2014

Supersedes Episode of care—number of psychiatric care days, total N[NNNN] Health, Superseded 11/04/2014

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, Superseded 07/02/2013

Implementation in Data Set Specifications:

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:

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

Admitted patient mental health care NMDS 2014-15 Health, Standardisation pending 18/07/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:

Total days in psychiatric care must be greater than or equal to zero;

Total days in psychiatric care must be less than or equal to Length of stay.

▲ Total recurrent expenditure in Australian dollars

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—total recurrent expenditure, total Australian currency N[N(8)]
METeOR identifier:	540165
Registration status:	Health, Standard 11/04/2014
Definition:	All recurrent expenditure incurred by an establishment, including salaries and wages, depreciation, and other non-salary recurrent expenditure (such as lease costs, administration expenses, contracted care and domestic services), measured in Australian dollars.
Data Element Concept:	Establishment—total recurrent expenditure

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Submitting organisation:	Public Hospital Establishments NMDS Working Group

Relational attributes

Related metadata references:	See also Establishment—total recurrent expenditure, National Health Reform Agreement 2011 product streams code N[N] Health, Standard 11/04/2014
Implementation in Data Set Specifications:	Total recurrent expenditure on National Health Reform Agreement product streams data element cluster Health, Standard 11/04/2014 *DSS specific information:* Expenditure reported against this is estimated by jurisdictions. The costing methodology used in preparation of data for the National Hospital Costing Data Collection should also be applied in the generation for data for this item.

◊ Treatment complication description

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—treatment complication type, text X[X(149)]
METeOR identifier:	467640
Registration status:	Health, Standard 08/05/2014
Definition:	The type of **treatment complication** (or complications) experienced by a person with cancer during their treatment for cancer and attributed to that treatment, as represented by text.
Data Element Concept:	Cancer treatment—treatment complication type

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(149)]
Maximum character length:	150

Data element attributes

Collection and usage attributes

Guide for use:	Record any immediate or short-term treatment complications (adverse events or toxicities) that were experienced by a person with cancer during their treatment for cancer. This includes any adverse events or treatment complications taking place within 30 days of treatment.
Collection methods:	Collect from patient medical records.

Source and reference attributes

Submitting organisation:	Cancer Australia

Relational attributes

Implementation in Data Set Specifications:	Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014 *Conditional obligation:* This data element is to be recorded when either Cancer treatment—treatment complication type, gynaecological cancer-related radiotherapy code N or Cancer treatment—treatment complication type, cancer-related primary surgery complication type code N[N] indicates an 'Other' type of treatment complication.

▲ Treatment plan modification description

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—treatment plan modification, text X[X(149)]
METeOR identifier:	568890
Registration status:	Health, Standard 08/05/2014
Definition:	A change made to the patient's cancer treatment plan, as represented by text. A cancer treatment plan may often change due to the patient's response to treatment or a change in the extent or pathway of the disease.
Data Element Concept:	Cancer treatment—treatment plan modification

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(149)]
Maximum character length:	150

Data element attributes

Collection and usage attributes

Guide for use:	Record a textual description of the change (or changes) made to the patient's cancer related treatment. This may include changes to the type of treatment, the dosage of treatment or the frequency of treatment.
Collection methods:	Collect from patient medical records.

Source and reference attributes

Submitting organisation:	Cancer Australia

Relational attributes

Implementation in Data Set Specifications:	Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014 *Conditional obligation:* This data element is to be recorded when Cancer treatment—treatment modification type for cancer-related systemic therapy, code N[N] indicates an 'Other' type of treatment modification.

▲ Tumour outside primary site indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—tumour outside primary site indicator, yes/no/not stated/inadequately described code N
METeOR identifier:	545382
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether there is **macroscopic** evidence of a tumour outside of the primary site of cancer in a person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—tumour outside primary site 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:	Record whether there is evidence of **macroscopic** tumour outside of the primary site of cancer for both patients treated initially with surgery and non-surgical cases. In non-surgical cases, the extent of tumour outside the primary site may be assessed by imaging, for example using a CT scan, or diagnostic procedure, for example an ultrasound guided core biopsy.
Collection methods:	Collect from pathology reports or patient medical records.
Comments:	Although tumour size outside the primary site is not used in the staging process, it is a prognostic factor.

Source and reference attributes

Submitting organisation:	Cancer Australia

Reference documents:	Pecorelli, S. 25th Annual Report on the Results of Treatment in Gynecological Cancer. International Journal of Gynecology & Obstetrics 2003, 83(Supp 1): 1-230 Cancer Australia Project Working Group, 2010

Relational attributes

Implementation in Data Set Specifications:	Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

▲ Tumour residual post-surgery size category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—post-initial surgery residual tumour size category, code N
METeOR identifier:	424302
Registration status:	Health, Standard 08/05/2014
Definition:	The size of the residual tumour remaining after the initial surgery for cancer treatment, as represented by a code.
Data Element Concept:	Cancer treatment—post-initial surgery residual tumour size

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Microscopic but no macroscopic residual disease
2	Residual tumour less than 0.5 cm
3	Residual tumour between 0.5 cm and less than 1 cm
4	Residual tumour between 1 cm and 2 cm
5	Residual tumour greater than 2 cm

Supplementary values:

Value	Meaning
7	Not applicable
8	Unknown/unable to be assessed
9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	This code outlines categories for the largest diameter of tumour residual implants after cancer treatment.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Pecorelli, S. 25th Annual Report on the Results of Treatment in Gynecological Cancer. International Journal of Gynecology & Obstetrics 2003, 83(Supp 1): 1-230.

Data element attributes

Collection and usage attributes

Guide for use:	Record the size of the largest tumour residual remaining after the initial surgery for cancer treatment. The tumour residual size is the

diameter of largest residual implants remaining after surgery.

Collection methods: Collect from patient medical records.

Comments: The residual tumour size after the initial surgery is a prognostic indicator that will impact later treatment pathways.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: Pecorelli, S. 25th Annual Report on the Results of Treatment in Gynecological Cancer. International Journal of Gynecology & Obstetrics 2003, 83(Supp 1): 1-230.

Relational attributes

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
This data element is to be recorded then the data element Cancer treatment—residual (R) tumour indicator, yes/no code N indicates the presence of residual tumour after surgery.

▲ Tumour size outside primary site

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—tumour size outside primary site, code N
METeOR identifier:	424282
Registration status:	Health, Standard 08/05/2014
Definition:	The amount of **macroscopic** tumour outside of the primary site of cancer in a person with cancer, as represented by a code.
Data Element Concept:	Person with cancer—tumour size outside primary site

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Macroscopic disease less than or equal to 2 cm outside the primary tumour site
2	Macroscopic disease between 2 cm and less than 10 cm outside primary tumour site
3	Macroscopic disease equal to or greater than 10 cm outside the primary tumour site

Supplementary values:

8	Unknown
9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Use the appropriate value to indicate the size of macroscopic disease outside of the primary site of cancer.

CODE 8 Unknown

To be used if records have no indications of procedures (surgery or diagnostic biopsy) or imaging (such as CT scans) that would allow macroscopic spread to be seen.

CODE 9 Not stated/inadequately described

To be used if procedures or imaging that allow macroscopic spread to be seen have been undertaken but there is no indication of the size of the tumour outside of the primary site.

Source and reference attributes

Submitting organisation:	Cancer Australia

Data element attributes

Collection and usage attributes

Guide for use:	Record the amount of **macroscopic** tumour outside of the primary site of cancer for both patients treated initially with surgery and non-surgical cases. In non-surgical cases, the extent of tumour outside the primary site may be assessed by imaging, for example using a CT scan, or diagnostic procedure, for example an ultrasound guided core biopsy.
Collection methods:	Collect from pathology reports or patient medical records.
Comments:	Although tumour size outside the primary site is not used in the staging process, it is a prognostic factor.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Pecorelli, S. 25th Annual Report on the Results of Treatment in Gynecological Cancer. International Journal of Gynecology & Obstetrics 2003, 83(Supp 1): 1-230 Cancer Australia Project Working Group, 2010

Relational attributes

Implementation in Data Set Specifications:	Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

◊ Type of maintenance care provided

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—type of maintenance care provided, code N[N]
METeOR identifier:	496467
Registration status:	Health, Standard 11/04/2014 Independent Hospital Pricing Authority, Standard 11/10/2012
Definition:	The type of maintenance care provided to an admitted patient during an episode of care, as represented by a code. Maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment.
Data Element Concept:	Episode of admitted patient care—type of maintenance care provided

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Convalescent care
2	Respite care
3	Nursing home type care
8	Other maintenance care

Supplementary values:

Value	Meaning
98	Unknown
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Convalescent care

Following assessment and/or treatment, the patient does not require further complex assessment or stabilisation but continues to require care over an indefinite period. Under normal circumstances the patient would be discharged but due to factors in the home environment, such as access issues or lack of available community services, the patient is unable to be discharged. Examples may include:

- Patients awaiting the completion of home modifications essential for discharge.
- Patients awaiting the provision of specialised equipment

essential for discharge.

- Patients awaiting rehousing.
- Patients awaiting supported accommodation such as hostel or group home bed.
- Patients for whom community services are essential for discharge but are not yet available.

CODE 2 Respite care

An episode where the primary reason for admission is the short-term unavailability of the patient's usual care. Examples may include:

- Admission due to carer illness or fatigue.
- Planned respite due to carer unavailability.
- Short term closure of care facility.
- Short term unavailability of community services.

CODE 3 Nursing home type care

The patient does not have a current acute care certificate and is awaiting placement in a residential aged care facility.

CODE 8 Other maintenance care

Any other reason the patient may require a maintenance episode other than those already stated.

CODE 98 Unknown

It is not known what type of maintenance care the patient is receiving.

CODE 99 Not stated/inadequately described

The type of maintenance care has not been reported.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Origin: Eagar K. et al (1997). The Australian National Sub-acute and Non-acute Patient Classification (AN-SNAP): Report of the National Sub-acute and Non-acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong.

Data element attributes

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Reference documents: Eagar K. et al (1997) The Australian National Sub-acute and Non-acute Patient Classification (AN-SNAP): Report of the National Sub-acute and Non-acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong.

Relational attributes

Related metadata references: Supersedes Episode of admitted patient care—type of maintenance care provided, code N Independent Hospital Pricing Authority, Superseded 11/10/2012

Implementation in Data Set Activity based funding: Admitted sub-acute and non-acute

Specifications:

hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Standard 11/10/2012

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:

Only required to be reported for episodes of admitted patient care with hospital service-care type, code N[N].N recorded as 6.0 maintenance care.

Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

Only required to be reported for episodes of admitted patient care with Hospital service—care type, code N[N] recorded as Code 6, Maintenance care.

Only required to be reported when the Episode of admitted patient care—assessment only indicator, yes/no code N value is recorded as Code 2, No.

Not required to be reported for patients aged 16 years and under at admission.

◊ Type of visit to emergency department

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—type of visit to emergency department, code N
METeOR identifier:	550725
Registration status:	Health, Standard 11/04/2014
Definition:	The reason the patient presents to an **emergency department**, as represented by a code.
Context:	Emergency department care.
Data Element Concept:	Emergency department stay—type of visit to emergency department

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Emergency presentation
2	Return visit, planned
3	Pre-arranged admission
5	Dead on arrival

Collection and usage attributes

Guide for use:

CODE 1 Emergency presentation

Where a patient presents to the emergency department for an actual or suspected condition which is sufficiently serious to require acute unscheduled care. This includes patients awaiting transit to another facility who receive clinical care in the emergency department, and patients for whom resuscitation is attempted.

Exclusion: Where patients are awaiting transit to another facility and do not receive clinical care in the emergency department, the patient should not be recorded.

CODE 2 Return visit, planned

Where a patient presents to the emergency department for a return visit, as a result of a previous emergency department presentation (Code 1) or return visit (Code 2). The return visit may be for planned follow-up treatment, as a consequence of test results becoming available indicating the need for further treatment, or as a result of a care plan initiated at discharge.

Exclusion: Where a visit follows general advice to return if

feeling unwell, this should not be recorded as a planned visit.

CODE 3 Pre-arranged admission

Where a patient presents to the emergency department for an admission to either a non-emergency department ward or other admitted patient care unit that has been arranged prior to the patient's arrival, and the patient receives clinical care in the emergency department.

Exclusion: Where a patient presents for a pre-arranged admission and only clerical services are provided by the emergency department, the patient should not be recorded.

CODE 5 Dead on arrival

Where a patient is dead on arrival and an emergency department clinician certifies the death of the patient.

Exclusion: Where resuscitation of the patient is attempted, this should be recorded as an emergency presentation (Code 1).

Note: Where Code 5 is recorded for a patient, an Episode end status Code 7 (Dead on arrival) should also be recorded.

Data element attributes

Collection and usage attributes

Comments: Required for analysis of emergency department services.

Source and reference attributes

Submitting organisation: National Health Information Standards and Statistics Committee

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Emergency department stay—type of visit to emergency department, code N Health, Superseded 11/04/2014

Implementation in Data Set Specifications: Activity based funding: Emergency service care DSS 2014-2015 Independent Hospital Pricing Authority, Candidate 02/01/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Non-admitted patient emergency department care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

▲ Unintentional weight loss indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—unintentional weight loss indicator, yes/no/unknown code N
METeOR identifier:	428841
Registration status:	Health, Standard 08/05/2014
Definition:	An indicator of whether a person experienced unintentional weight loss of greater than 10% in the previous six months, as represented by a code.
Data Element Concept:	Person—unintentional weight loss 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:

8	Unknown

Data element attributes

Collection and usage attributes

Guide for use:	Weight loss is a reduction of the total body mass, due to a mean loss of fluid, body fat or adipose tissue and/or lean mass. It can occur unintentionally due to an underlying disease such as cancer. Patients with medical causes of weight loss usually have signs or symptoms that suggest involvement of a particular organ system. Record whether a person experienced unintentional weight loss of greater than 10% occurring in the previous six months.
Collection methods:	This information is based on the patient's self report and should be sought from their medical record.
Comments:	Marked weight loss is an important prognostic indicator and may influence treatment decisions. For example, cancer patients with weight loss have decreased performance status, impaired responses to chemotherapy and reduced median survival.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Fauci AS et al (Editors) 2008. Harrison's Principles of Internal

Medicine, 17th edition, New York: McGraw-Hill Medical

Relational attributes

Implementation in Data Set Specifications:

Lung cancer (clinical) DSS Health, Standard 08/05/2014

DSS specific information:
This item should be recorded at diagnosis when recorded in the context of this Data Set Specification.

◊ Urgency related group major diagnostic block

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—urgency related group major diagnostic block, code N[AA]
Synonymous names:	URG major diagnostic block
METeOR identifier:	547612
Registration status:	Health, Standard 11/04/2014
Definition:	The **urgency related group** (URG) major diagnostic block category into which the patient's **emergency department** diagnosis is grouped, as represented by a code.
Data Element Concept:	Emergency department stay—urgency related group major diagnostic block

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	N[AA]
Maximum character length:	3

Permissible values:

Value	Meaning
1	Poisoning
1C	Drug reaction
1D	Alcohol/drug abuse and alcohol/drug induced mental disorders
2A	Injury, multiple sites
2B	Injury, single site, major
2Ba	Injury, single site, minor
3A	Circulatory system illness
3B	Respiratory system illness
3C	Digestive system illness
3D	Urological system illness
3E	Neurological system illness
3F	Illness of the eyes
3G	Illness of the ear, nose and throat
3H	Musculoskeletal/connective tissue system illness
3I	Illness of skin, subcutaneous tissue, breast
3J	Blood/immune system illness
3K	Obstetric illness
3L	Gynaecological illness

	3M	Male reproductive system illness
	3N	System infection/parasites
	3O	Illness of other and unknown systems
	3P	Newborn/neonate illness
	3Q	Hepatobiliary system illness
	3R	Endocrine, nutritional and metabolic system illness
	3S	Allergy
	4	Psychiatric illness
	5	Social problem
	6	Other presentation
Supplementary values:	9	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Reference documents: Jelinek G (1994). Case-mix Classification of Patients Attending Hospital Emergency Departments in Perth Western Australia. Doctor of Medicine Thesis. Perth Australia. University of Western Australia.

Data element attributes

Collection and usage attributes

Guide for use: This data element uses the patient's principal diagnosis, as reported in Emergency department stay—principal diagnosis, code X(9). The principal diagnosis code is then grouped to a major diagnostic block.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references: Supersedes Emergency department stay—urgency related group major diagnostic block, code N[AA] Health, Superseded 11/04/2014, Independent Hospital Pricing Authority, Standard 31/10/2012

Implementation in Data Set Specifications: Non-admitted patient emergency department care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Non-admitted patient emergency department care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

◊ Use of formal complaints mechanism for carer participation arrangements indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—use of formal complaints mechanism for carer participation arrangements indicator, code N
Synonymous names:	Carer participation arrangements indicator—formal complaints mechanism
METeOR identifier:	529233
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a specialised mental health service organisation has a formal internal complaints mechanism in which complaints can be made by carers and are regularly reviewed by a committee that includes carers, in order to include the participation of **mental health carers** in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—use of formal complaints mechanism for carer participation arrangements 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:

Value	Meaning
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

Relational attributes

Related metadata references: Supersedes Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Superseded 07/03/2014

Has been superseded by Specialised mental health service

organisation—use of formal complaints mechanism for carer participation arrangements indicator, code N Health, Standardisation pending 23/09/2014

Implementation in Data Set Specifications:

Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

◊ Use of formal complaints mechanism for consumer participation arrangements indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—use of formal complaints mechanism for consumer participation arrangements indicator, code N
Synonymous names:	Consumer participation arrangements indicator—formal complaints mechanism
METeOR identifier:	529180
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a specialised mental health service organisation has a formal internal complaints mechanism in which complaints can be made by consumers and are regularly reviewed by a committee that includes consumers, in order to include the participation of **mental health consumers** in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—use of formal complaints mechanism for consumer participation arrangements 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

Relational attributes

Related metadata references:	Supersedes Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Superseded 07/03/2014

Has been superseded by Specialised mental health service organisation—use of formal complaints mechanism for consumer participation arrangements indicator, code N Health, Standardisation pending 23/09/2014

Implementation in Data Set Specifications:

Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

◊ Use of formal participation policy for carer participation arrangements indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—use of formal participation policy for carer participation arrangements indicator, code N
Synonymous names:	Carer participation arrangements indicator—formal participation policy
METeOR identifier:	529235
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a specialised mental health service organisation has a formal and documented policy on participation by carers, in order to include the participation of **mental health carers** in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—use of formal participation policy for carer participation arrangements 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

Relational attributes

Related metadata references:	Supersedes Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Superseded 07/03/2014
Implementation in Data Set Specifications:	Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Standardisation pending 23/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Use of formal participation policy for consumer participation arrangements indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—use of formal participation policy for consumer participation arrangements indicator, code N
Synonymous names:	Consumer participation arrangements indicator—formal participation policy
METeOR identifier:	529185
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a specialised mental health service organisation has a formal and documented policy on participation by consumers, in order to include the participation of **mental health consumers** in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—use of formal participation policy for consumer participation arrangements 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

Relational attributes

Related metadata references:	Supersedes Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Superseded 07/03/2014
Implementation in Data Set Specifications:	Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Standardisation pending 23/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Use of regular carer experience surveys for carer participation arrangements indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—use of regular carer experience surveys for carer participation arrangements indicator, code N
Synonymous names:	Carer participation arrangements indicator—carer experience surveys
METeOR identifier:	529231
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a specialised mental health service organisation conducts regular (at least once over the reporting period) system level focused **mental health carer** experience surveys, as represented as a code.
Data Element Concept:	Specialised mental health service organisation—use of regular carer experience surveys for carer participation arrangements 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

Relational attributes

Related metadata references:	Supersedes Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Superseded 07/03/2014
Implementation in Data Set Specifications:	Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Standardisation pending 23/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Use of regular consumer experience surveys for consumer participation arrangements indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—use of regular consumer experience surveys for consumer participation arrangements indicator, code N
Synonymous names:	Consumer participation arrangements indicator—consumer experience surveys
METeOR identifier:	529170
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a specialised mental health service organisation conducts regular (at least once over the reporting period) system level focused **mental health consumer** experience surveys, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—use of regular consumer experience surveys for consumer participation arrangements 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

Relational attributes

Related metadata references:	Supersedes Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Superseded 07/03/2014
Implementation in Data Set Specifications:	Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Standardisation pending 23/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Use of regular discussion groups for carer participation arrangements indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—use of regular discussion groups for carer participation arrangements indicator, code N
Synonymous names:	Carer participation arrangements indicator—regular discussion groups
METeOR identifier:	529237
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a specialised mental health service organisation holds regular (at least once over the reporting period) discussion groups to seek the views of carers about the service, in order to include the participation of **mental health carers** in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—use of regular discussion groups for carer participation arrangements 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

Relational attributes

Related metadata references:	Supersedes Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Superseded 07/03/2014
Implementation in Data Set Specifications:	Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Standardisation pending 23/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Use of regular discussion groups for consumer participation arrangements indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—use of regular discussion groups for consumer participation arrangements indicator, code N
Synonymous names:	Consumer participation arrangements indicator—regular discussion groups
METeOR identifier:	529224
Registration status:	Health, Standard 07/03/2014
Definition:	An indicator of whether a specialised mental health service organisation holds regular (at least once over the reporting period) consumer discussion groups to seek the views of consumers about the service in order to include the participation of **mental health consumers** in the planning, delivery and evaluation of services, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—use of regular discussion groups for consumer participation arrangements 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

Relational attributes

Related metadata references:	Supersedes Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Superseded 07/03/2014
Implementation in Data Set	Mental health establishments NMDS 2014-15 Health, Standard

Specifications:

07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Standardisation pending 23/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

National minimum data sets

Admitted patient care NMDS 2014-15

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	535047
Registration status:	Health, Standard 11/04/2014
DSS type:	National Minimum Data Set (NMDS)
Scope:	The purpose of the Admitted patient care national minimum data set (APC NMDS) is to collect information about care provided to admitted patients in Australian hospitals. The scope of the APC NMDS is episodes of care for admitted patients in all public and private acute and psychiatric hospitals, free standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories may also be included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included. Hospital boarders and still births are not included as they are not admitted to hospital. Posthumous organ procurement episodes are also not included.

Collection and usage attributes

Statistical unit:	Episodes of care for admitted patients
Collection methods:	Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant state or territory health authority on a regular basis (e.g. monthly). *National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year.
Implementation start date:	01/07/2014
Implementation end date:	30/06/2015
Comments:	*Scope links with other NMDSs* Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in

public psychiatric hospitals:

- Admitted patient mental health care NMDS.

Episodes of care for admitted patients where care type is palliative care:

- Admitted patient palliative care NMDS.

Glossary items

Glossary terms that are relevant to this National minimum data set are included here.

Admission
Clinical intervention
Clinical review
Diagnosis
Elective surgery
Episode of acute care
Geographic indicator
Hospital boarder
Hospital-in-the-home care
Intensive care unit
Live birth
Neonate
Newborn qualification status
Organ procurement - posthumous
Resident
Residential mental health care service
Same-day patient
Separation

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references:

Supersedes Activity based funding: Admitted acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013

See also Activity based funding: Emergency service care DSS 2014-15 Health, Standardisation pending 01/10/2014, Independent Hospital Pricing Authority, Candidate 02/01/2014

Supersedes Admitted patient care NMDS 2013-14 Health, Superseded 11/04/2014

Has been superseded by Admitted patient care NMDS 2015-16 Health, Standardisation pending 24/09/2014

Implementation in Data Set Specifications:

Admitted patient mental health care cluster Health, Standardisation pending 26/09/2014

Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Elective surgery waiting times cluster	Conditional	99
-	Activity when injured	Mandatory	99
-	Additional diagnosis	Conditional	99
-	Admission date	Mandatory	1
-	Admitted patient election status	Mandatory	1
-	Area of usual residence (SA2)	Mandatory	1
-	Australian postcode (address)	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Care type	Mandatory	1
-	Condition onset flag	Mandatory	99
-	Contract establishment identifier	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Duration of continuous ventilatory support	Conditional	1
-	Establishment number	Mandatory	1
-	Establishment sector	Mandatory	1
-	External cause	Mandatory	99
-	Funding source for hospital patient	Mandatory	1
-	Geographic remoteness—admitted patient care	Mandatory	1
-	Hospital insurance status	Mandatory	1
-	Indigenous status	Mandatory	1
-	Intended length of hospital stay	Mandatory	1
-	Inter-hospital contracted patient	Mandatory	1
-	Length of stay in intensive care unit	Conditional	1
-	Medicare eligibility status	Mandatory	1
-	Mental health legal status	Mandatory	1
-	Mode of admission	Mandatory	1
-	Mode of separation	Mandatory	1
-	Number of days of hospital-in-the-home care	Mandatory	1
-	Number of qualified days for newborns	Conditional	1
-	Person identifier	Mandatory	1
-	Place of occurrence of external cause of injury (ICD-10-AM)	Mandatory	99
-	Principal diagnosis—episode of care	Mandatory	1
-	Procedure	Mandatory	99
-	Record identifier (80 character maximum)	Mandatory	1
-	Region code	Mandatory	1
-	Separation date	Mandatory	1
-	Sex	Mandatory	1

-	Source of referral to public psychiatric hospital	Conditional	1
-	Total leave days	Mandatory	1
-	Total psychiatric care days	Mandatory	1
-	Urgency of admission	Mandatory	1
-	Weight in grams (measured)	Conditional	1

Community mental health care NMDS 2014-15

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	549878
Registration status:	Health, Standard 07/03/2014
DSS type:	National Minimum Data Set (NMDS)
Scope:	The Community mental health care national minimum data set (CMHC NMDS) includes data about service contacts provided by specialised mental health services for patients/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24 hour staffed specialised residential mental health services.

Collection and usage attributes

Statistical unit:	Mental health service contact
Implementation start date:	01/07/2014
Implementation end date:	30/06/2015
Comments:	*Glossary items* Glossary terms that are relevant to this National minimum data set are included here. **Admitted patient mental health care service** **Ambulatory care** **Ambulatory mental health care service** **Geographic indicator** **Resident** **Residential mental health care service** **Separation**

Relational attributes

Related metadata references:	Supersedes Community mental health care NMDS 2013-14 Health, Superseded 07/03/2014 Has been superseded by Community mental health care NMDS 2015-16 Health, Standardisation pending 22/09/2014
Implementation in Data Set Specifications:	Ambulatory patient mental health care cluster Health, Standardisation pending 26/09/2014 *Conditional obligation:* Reporting of these data elements is mandatory for service contacts provided by specialised mental health services. Reporting is optional for service contacts provided by specialised mental health services from non-government organisations that receive state or territory government funding. Reporting is optional for service events provided by non-specialised mental health services.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Ambulatory service unit identifier	Mandatory	1
-	Ambulatory service unit name	Mandatory	1
-	Area of usual residence (SA2)	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Establishment sector	Mandatory	1
-	Indigenous status	Mandatory	1
-	Marital status	Mandatory	1
-	Mental health legal status	Mandatory	1
-	Mental health service contact date	Mandatory	1
-	Mental health service contact duration	Mandatory	1
-	Mental health service contact—patient/client participation indicator	Mandatory	1
-	Mental health service contact—session type	Mandatory	1
-	Organisation identifier	Mandatory	1
-	Organisation name—specialised mental health service	Mandatory	1
-	Person identifier	Mandatory	1
-	Person identifier flag	Mandatory	2
-	Principal diagnosis—episode of care	Mandatory	1
-	Region code	Mandatory	1
-	Region name	Mandatory	1
-	Service unit cluster identifier	Mandatory	1
-	Service unit cluster name	Mandatory	1
-	Sex	Mandatory	1
-	Specialised mental health service target population	Mandatory	1

Mental health establishments NMDS 2014-15

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	546889
Registration status:	Health, Standard 07/03/2014
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of the Mental health establishments national minimum data set (MHE NMDS) is all Specialised mental health services managed or funded by state or territory health authorities. The concept of a specialised mental health service is not dependent on the inclusion of the service within the state or territory mental health budget. Services funded by government from non-mental health specific budgets are considered in-scope for collection if they meet the definition of a Specialised mental health service. Services funded wholly by the Australian Government are considered out-of-scope for the MHE NMDS. All services operated within the budget of a Specialised mental health service organisation are considered in-scope for the MHE NMDS. These services are also expected to report client level data, that is, reporting to the Community mental health care NMDS, Residential mental health care NMDS, Admitted patient care NMDS and the Mental Health National Outcomes and Casemix Collection. There are some services reporting to the MHE NMDS for which the collection of client level data is not warranted, however, these services are uncommon and any omission of client level data must be justified by jurisdictions. Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both 'specialised' and 'serving a mental health care function'. A service is not defined as a specialised mental health service solely because its clients include people affected by a mental illness or psychiatric disability. The definition excludes specialist drug and alcohol services and services for people with intellectual disabilities, except where they are specifically established to assist people affected by a mental disorder who also have drug and alcohol related disorders or intellectual disability. The services can be sub-units of hospitals that are not, themselves, specialised mental health establishments (e.g. designated psychiatric units and wards, outpatient clinics etc). There is a hierarchy of statistical units used within the MHE NMDS. Information is provided at each level: State/Territory; Region; Organisation; Hospital/Service unit cluster; and Service unit (Admitted patient services, Residential services and Ambulatory services). Each level has a unique set of attributes which comprise the NMDS data elements and additional

supplementary information.

The statistical units are specialised mental health services. These are the specialised mental health components of the state and territory health authorities, and of regions within states and territories; specialised mental health service organisations; service units within those organisations; hospitals or service unit clusters; service units; and specialised mental health services provided by private hospitals, and non-government residential service units in receipt of state or territory government funding.

Specialised mental health services provided by private hospitals and non-government residential mental health services that receive state or territory government funding are included as service units for this NMDS.

Ambulatory services managed by non-government organisations (NGOs) are not defined as statistical units for this NMDS.

Collection and usage attributes

Statistical unit: Specialised mental health service

Collection methods: *National reporting arrangements*

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated

Financial years ending 30 June each year.

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Comments: *Glossary items*

Glossary terms that are relevant to this national minimum data set are included here.

Administrative and clerical staff
Admitted patient mental health care service
Ambulatory care
Ambulatory mental health care service
Consultant psychiatrist
Diagnostic and health professional
Domestic and other staff
Enrolled nurse
Episode of residential care end
Episode of residential care start
Geographic indicator
Hospital-in-the-home care
Mental health carer
Mental health carer workers
Mental health consumer
Mental health consumer workers

Mental health-funded non-government organisation
Occupational therapist
Other diagnostic and health professional
Other medical officer
Other personal care staff
Psychiatrist
Psychiatry registrar or trainee
Psychologist
Registered nurse
Resident
Residential mental health care service
Salaried medical officer
Separation
Social Worker
Visiting medical officer

Relational attributes

Related metadata references:

Supersedes Mental health establishments NMDS 2013-14 Health, Superseded 07/03/2014

Has been superseded by Mental health establishments NMDS 2015-16 Health, Standardisation pending 23/09/2014

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Accrued mental health care days	Mandatory	1
-	Admitted patient service unit identifier	Mandatory	1
-	Admitted patient service unit name	Mandatory	1
-	Ambulatory service unit identifier	Mandatory	1
-	Ambulatory service unit name	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Average available beds for overnight-stay patients	Mandatory	1
-	Average available beds for residential mental health patients	Mandatory	1
-	Carer participation arrangements—carer consultants employed	Mandatory	1
-	Carer representation arrangements indicator	Mandatory	1
-	Co-location status of mental health service	Mandatory	1
-	Consumer committee representation arrangements	Mandatory	1
-	Consumer participation arrangements—consumer consultants employed	Mandatory	1
-	Consumer representation arrangements indicator	Mandatory	1
-	Establishment sector	Mandatory	1
-	Full-time equivalent staff—administrative and clerical staff	Mandatory	1
-	Full-time equivalent staff—consultant psychiatrists and psychiatrists	Mandatory	1
-	Full-time equivalent staff—diagnostic and health professionals	Mandatory	1

-	Full-time equivalent staff—domestic and other staff	Mandatory	1
-	Full-time equivalent staff—enrolled nurses	Mandatory	1
-	Full-time equivalent staff—mental health carer workers	Mandatory	1
-	Full-time equivalent staff—mental health consumer and carer workers	Mandatory	1
-	Full-time equivalent staff—mental health consumer workers	Mandatory	1
-	Full-time equivalent staff—nurses	Mandatory	1
-	Full-time equivalent staff—occupational therapists	Mandatory	1
-	Full-time equivalent staff—other diagnostic and health professionals	Mandatory	1
-	Full-time equivalent staff—other medical officers	Mandatory	1
-	Full-time equivalent staff—other personal care staff	Mandatory	1
-	Full-time equivalent staff—psychiatry registrars and trainees	Mandatory	1
-	Full-time equivalent staff—psychologists	Mandatory	1
-	Full-time equivalent staff—registered nurses	Mandatory	1
-	Full-time equivalent staff—salaried medical officers	Mandatory	1
-	Full-time equivalent staff—social workers	Mandatory	1
-	Grants to non-government organisations—accommodation services	Mandatory	1
-	Grants to non-government organisations—advocacy services	Mandatory	1
-	Grants to non-government organisations—community awareness/health promotion services	Mandatory	1
-	Grants to non-government organisations—counselling services	Mandatory	1
-	Grants to non-government organisations—independent living skills support services	Mandatory	1
-	Grants to non-government organisations—other and unspecified mental health services	Mandatory	1
-	Grants to non-government organisations—pre-vocational training services	Mandatory	1
-	Grants to non-government organisations—psychosocial support services	Mandatory	1
-	Grants to non-government organisations—recreation services	Mandatory	1
-	Grants to non-government organisations—respite services	Mandatory	1
-	Grants to non-government organisations—self-help support group services	Mandatory	1
-	Hospital identifier	Mandatory	1
-	Hospital name	Mandatory	1
-	Local Hospital Network identifier	Mandatory	1
-	Mental health services grants to non-government organisations by non-health departments	Mandatory	1
-	National standards for mental health services review status	Mandatory	1
-	Non-government non-profit indicator	Mandatory	1
-	Number of clients receiving services	Mandatory	1

-	Number of episodes of residential care	Mandatory	1
-	Number of service contacts	Mandatory	1
-	Organisation identifier	Mandatory	1
-	Organisation name—specialised mental health service	Mandatory	1
-	Recurrent expenditure (mental health)—non-salary operating costs	Mandatory	1
-	Recurrent expenditure (mental health)—salaries and wages	Mandatory	1
-	Recurrent expenditure (salaries and wages)—administrative and clerical staff	Mandatory	1
-	Recurrent expenditure (salaries and wages)—consultant psychiatrists and psychiatrists	Mandatory	1
-	Recurrent expenditure (salaries and wages)—domestic and other staff	Mandatory	1
-	Recurrent expenditure (salaries and wages)—enrolled nurses	Mandatory	1
-	Recurrent expenditure (salaries and wages)—mental health carer workers	Mandatory	1
-	Recurrent expenditure (salaries and wages)—mental health consumer workers	Mandatory	1
-	Recurrent expenditure (salaries and wages)—occupational therapists	Mandatory	1
-	Recurrent expenditure (salaries and wages)—other diagnostic and health professionals	Mandatory	1
-	Recurrent expenditure (salaries and wages)—other medical officers	Mandatory	1
-	Recurrent expenditure (salaries and wages)—other personal care staff	Mandatory	1
-	Recurrent expenditure (salaries and wages)—psychiatry registrars and trainees	Mandatory	1
-	Recurrent expenditure (salaries and wages)—psychologists	Mandatory	1
-	Recurrent expenditure (salaries and wages)—registered nurses	Mandatory	1
-	Recurrent expenditure (salaries and wages)—social workers	Mandatory	1
-	Recurrent expenditure—administrative expenses	Mandatory	1
-	Recurrent expenditure—Department of Veterans' Affairs funded	Mandatory	1
-	Recurrent expenditure—depreciation	Mandatory	1
-	Recurrent expenditure—domestic services	Mandatory	1
-	Recurrent expenditure—drug supplies	Mandatory	1
-	Recurrent expenditure—food supplies	Mandatory	1
-	Recurrent expenditure—interest payments	Mandatory	1
-	Recurrent expenditure—medical and surgical supplies	Mandatory	1
-	Recurrent expenditure—other Commonwealth Government funded	Mandatory	1
-	Recurrent expenditure—other patient revenue funded	Mandatory	1
-	Recurrent expenditure—other recurrent expenditure	Mandatory	1
-	Recurrent expenditure—other revenue funded	Mandatory	1

-	Recurrent expenditure—other State or Territory funded	Mandatory	1
-	Recurrent expenditure—patient transport	Mandatory	1
-	Recurrent expenditure—payments to visiting medical officers	Mandatory	1
-	Recurrent expenditure—recoveries funded	Mandatory	1
-	Recurrent expenditure—repairs and maintenance	Mandatory	1
-	Recurrent expenditure—State or Territory health authority funded	Mandatory	1
-	Recurrent expenditure—superannuation employer contributions	Mandatory	1
-	Region code	Mandatory	1
-	Region name	Mandatory	1
-	Residential service unit identifier	Mandatory	1
-	Residential service unit name	Mandatory	1
-	Residual expenditure (mental health service)—academic positions	Mandatory	1
-	Residual expenditure (mental health service)—education and training	Mandatory	1
-	Residual expenditure (mental health service)—insurance	Mandatory	1
-	Residual expenditure (mental health service)—Mental Health Act Regulation or related legislation	Mandatory	1
-	Residual expenditure (mental health service)—mental health promotion	Mandatory	1
-	Residual expenditure (mental health service)—mental health research	Mandatory	1
-	Residual expenditure (mental health service)—other indirect expenditure	Mandatory	1
-	Residual expenditure (mental health service)—patient transport services	Mandatory	1
-	Residual expenditure (mental health service)—program administration	Mandatory	1
-	Residual expenditure (mental health service)—property leasing costs	Mandatory	1
-	Residual expenditure (mental health service)—service development	Mandatory	1
-	Residual expenditure (mental health service)—superannuation	Mandatory	1
-	Residual expenditure (mental health service)—support services	Mandatory	1
-	Residual expenditure (mental health service)—workers compensation	Mandatory	1
-	Separations	Mandatory	1
-	Service unit cluster identifier	Mandatory	1
-	Service unit cluster name	Mandatory	1
-	Specialised mental health service program type	Mandatory	1
-	Specialised mental health service setting	Mandatory	1
-	Specialised mental health service target population	Mandatory	4
-	Specialised mental health service—hours staffed	Mandatory	1
-	Statistical area level 2 (SA2)	Mandatory	1

-	Supported mental health housing places	Mandatory	1
-	Use of formal complaints mechanism for carer participation arrangements indicator	Mandatory	1
-	Use of formal complaints mechanism for consumer participation arrangements indicator	Mandatory	1
-	Use of formal participation policy for carer participation arrangements indicator	Mandatory	1
-	Use of formal participation policy for consumer participation arrangements indicator	Mandatory	1
-	Use of regular carer experience surveys for carer participation arrangements indicator	Mandatory	1
-	Use of regular consumer experience surveys for consumer participation arrangements indicator	Mandatory	1
-	Use of regular discussion groups for carer participation arrangements indicator	Mandatory	1
-	Use of regular discussion groups for consumer participation arrangements indicator	Mandatory	1

Non-admitted patient care hospital aggregate NMDS 2014-15

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 547686

Registration status: Health, Standard 11/04/2014

DSS type: National Minimum Data Set (NMDS)

Scope: The scope of the Non-admitted patient care hospital aggregate national minimum data set specification (NMDS) is non-admitted patient service events involving non-admitted patients in public hospitals.

The NMDS is intended to capture instances of service provision from the point of view of the patient.

For the purpose of this NMDS, a non-admitted service is a specialty unit or organisational arrangement under which a hospital provides non-admitted services.

The NMDS scope includes:

All arrangements made to deliver non-admitted patient service events (not covered by the national minimum data sets listed below) to non-admitted patients:

- irrespective of location (includes on-campus and off-campus),
- whose treatment has been funded through the hospital, regardless of the source from which the hospital derives these funds. In particular, Department of Veterans' Affairs, compensable and other patients funded through the hospital (including Medicare ineligible patients) are included; and
- regardless of setting or mode.

Excluded from the NMDS scope are:

All services covered by:

- the Admitted patient care NMDS,
- the Admitted patient mental health care NMDS,
- the Non-admitted patient emergency department care NMDS, e.g. all non-admitted services provided to admitted patients or emergency department patients are excluded; and
- service events which deliver non-clinical care, e.g. activities such as home cleaning, meals on wheels or home maintenance.

Collection and usage attributes

Statistical unit: Non-admitted patient service event

Guide for use: A non-admitted patient service event is defined as an interaction between one or more health care provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record.

Counting rules:

1. Non-admitted service events involving multiple health professionals are counted as one non-admitted patient service event.

2. Patients can be counted as having multiple non-admitted patient service events in one day, provided that every visit meets each of the criteria in the definition of a non-admitted patient service event.

3. Patient education services can be counted as non-admitted patient service events, provided that they meet the criteria included in the definition of a non-admitted patient service event.

4. Each patient attending a group session is counted as a non-admitted patient service event, providing that the session included the provision of therapeutic/clinical advice for each patient and that this was recorded using dated entry in each patient's medical record. A group flag is included in the NMDS to record this type of service event.

5. Telephone and other telehealth consultations can be counted as service events if they substitute for a face to face consultation, provided that they meet all the criteria included in the definition of non-admitted patient service event. A telephone/telehealth consultation is only counted as one non-admitted patient service event, irrespective of the number of health professionals/locations participating in the consultation.

6. Services provided to admitted and emergency department patients (including services provided by staff working in non-admitted services who visit admitted patients in wards or emergency departments, or other types of consultation and liaison services involving admitted or emergency department patients) are not counted as non-admitted patient service events.

7. Travel by a health professional is not counted as a non-admitted patient service event.

8. All non-admitted services that meet the criteria in the definition of non-admitted patient service events must be counted, irrespective of funding source (including Medicare Benefits Schedule) for the non-admitted service. A funding source flag is included in the NMDS.

9. For activity based funding purposes, services from stand-alone diagnostic services are not counted as non-admitted patient service events; these are an integral part of the requesting clinic's non-admitted patient service event.

10. Renal dialysis, total parenteral nutrition, home enteral nutrition and ventilation performed by the patient in their own home without the presence of a health care provider may be counted as a non-admitted patient service event, provided there is documentation of the procedures in the patient's medical record.

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Comments: *Interaction with the Non-admitted patient care Local Hospital Network*

aggregate DSS 2014-15.

The Non-admitted patient care Local Hospital Network aggregate DSS and Non-admitted patient care hospital aggregate NMDS work together to collect data on the public hospital system. The two data set specifications collect the same non-admitted activity data items, but at different levels of the system:

Hierarchical level	*Data collected through*
Public hospital	Non-admitted patient care hospital aggregate NMDS
Local Hospital Network	Non-admitted patient care Local Hospital Network aggregate DSS
Jurisdictional health authority	Non-admitted patient care Local Hospital Network aggregate DSS

It is intended that once the Non-admitted patient care Local Hospital Network aggregate DSS is established, the two collections will be merged into a single NMDS.

In the Non-admitted care patient hospital aggregate NMDS and the Non-admitted patient care Local Hospital Network aggregate DSS, the term 'establishment' is used to refer to entities reporting at each of the hierarchical levels (that is, public hospital, Local Hospital Network and jurisdictional health authority). Thus, for the purposes of this NMDS, the term 'establishment' refers to a public hospital unless specifically identified differently.

The principle should be applied that no activity is to be double-counted or included in both the Non-admitted patient care hospital aggregate NMDS and the Non-admitted patient care Local Hospital Network aggregate DSS.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Reference documents: Independent Hospital Pricing Authority 2014. Tier 2 Non-Admitted Services Compendium, Version 3.0. Independent Hospital Pricing Authority, Sydney. Viewed 4 April 2014, http://ihpa.gov.au/internet/ihpa/publishing.nsf/Content/tier2-non-admitted-services-compendium-2014%E2%80%932015-html

Independent Hospital Pricing Authority 2014. Tier 2 Non-Admitted Services Definitions Manual, Version 3.0. Independent Hospital Pricing Authority, Sydney. Viewed 4 April 2014, http://ihpa.gov.au/internet/ihpa/publishing.nsf/Content/tier-2-non-admitted-services-definition-manual-2014%E2%80%9315-html

Relational attributes

Related metadata references: Supersedes Activity based funding: Non-admitted patient care aggregate DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013

See also Non-admitted patient care Local Hospital Network

aggregate DSS 2014-15 Health, Standard 11/04/2014

Supersedes Non-admitted patient care aggregate NMDS 2013-14 Health, Superseded 11/04/2014

Has been superseded by Non-admitted patient care hospital aggregate NMDS 2015-16 Health, Standardisation pending 30/10/2014

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Establishment identifier	Mandatory	1
-	Funding source for hospital patient	Mandatory	1
-	Local Hospital Network identifier	Mandatory	1
-	Non-admitted service type	Mandatory	1
-	Number of group session non-admitted patient service events	Mandatory	1
-	Number of group sessions	Mandatory	1
-	Number of individual session non-admitted patient service events	Mandatory	1

Non-admitted patient emergency department care NMDS 2014-15

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 566909

Registration status: Health, Standard 11/04/2014

DSS type: National Minimum Data Set (NMDS)

Scope: The scope of the Non-admitted patient emergency department care national minimum data set specification (NAPEDC NMDS) is patients registered for care in emergency departments in public hospitals where the emergency department meets the following criteria:

- Purposely designed and equipped area with designated assessment, treatment and resuscitation areas.
- Ability to provide resuscitation, stabilisation and initial management of all emergencies.
- Availability of medical staff in the hospital 24 hours a day.
- Designated emergency department nursing staff 24 hours a day, 7 days a week, and a designated emergency department nursing unit manager.

Patients who were dead on arrival are in scope if an emergency department clinician certified the death of the patient. Patients who leave the emergency department after being triaged and then advised of alternative treatment options are in scope.

The scope includes only physical presentations to emergency departments. Advice provided by telephone or videoconferencing is not in scope, although it is recognised that advice received by telehealth may form part of the care provided to patients physically receiving care in the emergency department.

The care provided to patients in emergency departments is, in most instances, recognised as being provided to non-admitted patients. Patients being treated in emergency departments may subsequently become admitted (including admission to a short stay unit, admission to elsewhere in the emergency department, admission to another hospital ward, or admission to hospital-in-the-home). All patients remain in-scope for this collection until they are recorded as having physically departed the emergency department, regardless of whether they have been admitted. For this reason there is an overlap in the scope of this NMDS and the Admitted patient care national minimum data set (APC NMDS).

Excluded from the scope of the NMDS is:

- Care provided to patients in General Practitioner co-located units.

Collection and usage attributes

Statistical unit: Emergency department stay

Guide for use:	The definition of a 'short stay unit' is as per clause C48 of the National Health Reform Agreement—National Partnership Agreement on Improving Public Hospital Services (NPA IPHS), as follows: a) Designated and designed for the short term treatment, observation, assessment and reassessment of patients initially triaged and assessed in the emergency department (ED); b) Have specific admission and discharge criteria and policies; c) Designed for short term stays no longer than 24 hours; d) Physically separated from the ED acute assessment area; e) Have a static number of beds with oxygen, suction, patient ablution facilities; and f) Not a temporary ED overflow area nor used to keep patients solely awaiting an inpatient bed nor awaiting treatment in the ED.
Collection methods:	*National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on a quarterly basis within one month of the end of a reporting period and an annual basis within three months of the reporting period. The Institute and the Commonwealth Department of Health will agree on a data quality and timeliness protocol. Once cleaned, a copy of the data and a record of the changes made will be forwarded by the Institute to the Commonwealth Department of Health. A copy of the cleaned data for each jurisdiction should also be returned to that jurisdiction on request. *Periods for which data are collected and nationally collated* Quarterly and financial year. Extraction of data for each quarter or year should be based on the date of the end of the emergency department stay. For example, a presentation that commences at 11pm on 30 June and ends at 2am 1 July is not in scope for the April to June quarter.
Implementation start date:	01/07/2014
Implementation end date:	30/06/2015
Comments:	*Scope links with other metadata sets* Episodes of care for admitted patients are reported through the Admitted patient care NMDS. National Health Reform Agreement—National Partnership Agreement on Improving Public Hospital Services The scope for reporting against the National Emergency Access Target is all hospitals reporting to the NAPEDC NMDS (Peer groups A, B and other) as at August 2011 (when the Agreement was signed). For the duration of the Agreement, hospitals that have not previously reported to the NAPEDC NMDS can come into scope, subject to agreement between the jurisdiction and the Commonwealth. *Glossary items* Glossary terms that are relevant to this National minimum data set are included here.

Admission
Compensable patient
Emergency department
Registered nurse
Triage

Urgency related groups

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references: See also Non-admitted patient emergency department care DSS 2014-15 Health, Standard 11/04/2014

Supersedes Non-admitted patient emergency department care NMDS 2013-14 Health, Superseded 11/04/2014

Has been superseded by Non-admitted patient emergency department care NMDS 2015-16 Health, Standardisation pending 26/09/2014

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of usual residence (SA2)	Mandatory	1
-	Australian postcode (address)	Mandatory	1
-	Compensable status	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of triage	Conditional	1
-	Date patient presents—emergency department stay	Mandatory	1
-	Department of Veterans' Affairs patient	Mandatory	1
-	ED additional diagnosis code	Conditional	2
-	ED diagnosis classification type	Conditional	1
-	ED principal diagnosis code	Conditional	1
-	Emergency department arrival mode - transport	Mandatory	1
-	Emergency department clinical care commencement date	Conditional	1
-	Emergency department clinical care commencement time	Conditional	1
-	Emergency department episode end date	Mandatory	1
-	Emergency department episode end time	Mandatory	1
-	Emergency department physical departure date	Mandatory	1
-	Emergency department physical departure time	Mandatory	1
-	Emergency department service episode end status	Mandatory	1
-	Emergency department waiting time to clinical care commencement	Conditional	1
-	Establishment identifier	Mandatory	1

-	Indigenous status	Mandatory	1
-	Length of non-admitted patient emergency department service episode	Mandatory	1
-	Person identifier	Mandatory	1
-	Record identifier (80 character maximum)	Mandatory	1
-	Sex	Mandatory	1
-	Time of triage	Conditional	1
-	Time patient presents	Mandatory	1
-	Triage category	Conditional	1
-	Type of visit to emergency department	Mandatory	1
-	Urgency related group major diagnostic block	Mandatory	1

Perinatal NMDS 2014-

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	517456
Registration status:	Health, Standard 07/03/2014
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of the Perinatal national minimum data set (NMDS) is all births in Australia in hospitals, birth centres and the community. The data set includes information on all births, both **live births** and **stillbirths**, of at least 20 weeks gestation or 400 grams birth weight. These data have two dimensions, which are the baby and the mother. All data relevant to the birth are conveyed in relation to one of these.

Collection and usage attributes

Collection methods:	*National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. Data are managed by the National Perinatal Epidemiology and Statistics Unit. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year.
Implementation start date:	01/07/2014
Implementation end date:	30/06/2015
Comments:	*Glossary items* Glossary terms that are relevant to this National minimum data set are included here. **Anaesthesia** **Analgesia** **Antenatal care visit** **Birthweight** **Geographic indicator** **Hospital-in-the-home care** **Live birth** **Registered nurse** **Separation** **Stillbirth (fetal death)**

Relational attributes

Related metadata references:	Supersedes Perinatal NMDS 2013-14 Health, Superseded 07/03/2014
Implementation in Data Set Specifications:	Perinatal DSS 2014-15 Health, Standard 07/03/2014 *Implementation start date:* 01/07/2014

Implementation end date: 30/06/2015

Perinatal DSS 2015-16 Health, Standardisation pending 22/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Actual place of birth	Mandatory	1
-	Anaesthesia administered indicator	Mandatory	1
-	Analgesia administered indicator	Mandatory	1
-	Antenatal care visits	Mandatory	1
-	Apgar score at 5 minutes	Mandatory	1
-	Area of usual residence (SA2)	Mandatory	1
-	Birth order	Mandatory	1
-	Birth plurality	Mandatory	1
-	Caesarean section at most recent previous birth indicator	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	2
-	Establishment identifier	Mandatory	1
-	Gestational age	Mandatory	1
-	Indigenous status	Mandatory	2
-	Infant weight, neonate, stillborn	Mandatory	1
-	Labour onset type	Mandatory	1
-	Method of birth	Mandatory	1
-	Number of tobacco cigarettes smoked per day after 20 weeks of pregnancy	Conditional	1
-	Parity	Mandatory	1
-	Person identifier	Mandatory	2
-	Postpartum perineal status	Mandatory	2
-	Pregnancy duration at the first antenatal care visit	Mandatory	1
-	Presentation at birth	Mandatory	1
-	Separation date	Mandatory	2
-	Sex	Mandatory	1
-	State/Territory of birth	Mandatory	1
-	Status of the baby	Mandatory	1
-	Tobacco smoking indicator, after 20 weeks of pregnancy	Mandatory	1
-	Tobacco smoking indicator, first 20 weeks of pregnancy	Mandatory	1
-	Type of anaesthesia administered during a birth event	Conditional	7
-	Type of analgesia administered during a birth event	Conditional	6

Public hospital establishments NMDS 2014-15

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 540101

Registration status: Health, Standard 11/04/2014

DSS type: National Minimum Data Set (NMDS)

Scope: The scope of the Public hospital establishments national minimum data set (PHE NMDS) is establishment-level data for public acute and psychiatric hospitals, and alcohol and drug treatment centres.

Similar data for private hospitals and free standing day hospital facilities are collected by the Australian Bureau of Statistics in the Private Health Establishments Collection.

Hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

Collection and usage attributes

Statistical unit: Public hospital establishment

Guide for use: The following are principles of the collection. Jurisdictions should consider these principles when providing data.

1. The NMDS should capture and differentiate between in-scope and out-of-scope of the *National Health Reform Agreement*.
2. The NMDS must specify where financial data elements are reporting actual data and where they are reporting estimated data.
3. Where possible, the NMDS should align so that it acts as a subset of the Government health expenditure NMDS.
4. Reporting on expenditure relating to contracted care requires less detail than other expenditure.
5. Where possible, the changes to the NMDS should maintain the ability to report time series data from previous years.

Expenditure and revenue data reported to the PHE NMDS should reconcile with published financial statements.

Expenditure data are reported in two ways:

- as it would appear in the general ledger line items (Establishment—recurrent non-salary expenditure, public hospital expenditure categories code N[N] and Establishment—staffing categories, health code N)
- by National Health Reform Agreement product streams (Establishment—total recurrent expenditure, National Health Reform Agreement 2011 product streams code N[N]). These are estimated data.

The total expenditure by product stream should equal the total

expenditure by general ledger line item.

For the purposes of the PHE NMDS, funding from the Commonwealth, National Health Funding Body, state and territory health authorities and other state and territory government departments is considered to be revenue and should be reported as such.

Collection methods:

Some data for this NMDS are sourced from the state or territory health authority general ledger. Some other data are maintained at the LHN or hospital and are forwarded to the relevant state or territory health authority for inclusion.

National reporting arrangements

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated

Financial years ending 30 June each year.

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Comments:

Interaction with the Local Hospital Networks data set specification (LHN DSS)

The PHE NMDS and the Local Hospital Networks data set specification (LHN DSS) work together to collect data on the public hospital system. The two data set specifications collect the same expenditure and revenue data items, but at different levels of the system:

Hierarchical level	*Data collected through*
Public hospital establishments	PHE NMDS
Local hospital network	LHN DSS
Jurisdictional health authority	LHN DSS

It is expected that expenditure and revenue data will be reported at the level at which they occur.

In addition to the shared expenditure and revenue data items, each collection has a number of unique items. The PHE NMDS includes items such as establishment location, establishment type and specialised service indicators that do not appear in the LHN DSS. Similarly, the LHN DSS includes gross and net capital expenditure items that do not appear in the PHE NMDS.

It is intended that once the LHN DSS is firmly established, the two collections should be merged into a single NMDS.

Scope links with other NMDSs

The PHE NMDS shares scope with other hospital NMDSs as well as other establishment and expenditure collections:

- Admitted patient care NMDS
- Admitted patient mental health care NMDS
- Admitted patient palliative care NMDS
- Alcohol and other drug treatment services NMDS
- Government health expenditure NMDS

- Mental health establishments NMDS
- Non-admitted patient care aggregated NMDS
- Non-admitted patient emergency department care NMDS

Source and reference attributes

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Local Hospital Networks DSS 2014-15 Health, Standard 11/04/2014

See also Public hospital establishment address details DSS Health, Standard 07/12/2011

Supersedes Public hospital establishments NMDS 2013-14 Health, Superseded 11/04/2014

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Full-time equivalent staffing data element cluster	Mandatory	1
-	Recurrent contracted care expenditure data element cluster	Mandatory	1
-	Recurrent non-salary expenditure data element cluster	Mandatory	1
-	Recurrent salaries and wages expenditure data element cluster	Mandatory	1
-	Revenue data element cluster	Mandatory	1
-	Total recurrent expenditure on National Health Reform Agreement product streams data element cluster	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Average available beds for admitted contracted care	Mandatory	1
-	Average available beds for overnight-stay patients	Mandatory	1
-	Average available beds for same-day patients	Mandatory	1
-	Establishment number	Mandatory	1
-	Establishment sector	Mandatory	1
-	Establishment type	Mandatory	1
-	Estimated data indicator	Mandatory	1
-	Geographical location of establishment	Mandatory	1
-	Independent Hospital Pricing Authority funding designation	Mandatory	1
-	Local Hospital Network identifier	Mandatory	1
-	Specialised service indicators—acquired immune deficiency syndrome unit	Mandatory	1
-	Specialised service indicators—acute renal dialysis unit	Mandatory	1
-	Specialised service indicators—acute spinal cord injury unit	Mandatory	1
-	Specialised service indicators—alcohol and drug unit	Mandatory	1
-	Specialised service indicators—bone marrow transplantation unit	Mandatory	1
-	Specialised service indicators—burns unit (level III)	Mandatory	1
-	Specialised service indicators—cardiac surgery unit	Mandatory	1

-	Specialised service indicators—clinical genetics unit	Mandatory	1
-	Specialised service indicators—comprehensive epilepsy centre	Mandatory	1
-	Specialised service indicators—coronary care unit	Mandatory	1
-	Specialised service indicators—diabetes unit	Mandatory	1
-	Specialised service indicators—domiciliary care service	Mandatory	1
-	Specialised service indicators—geriatric assessment unit	Mandatory	1
-	Specialised service indicators—heart, lung transplantation unit	Mandatory	1
-	Specialised service indicators—hospice care unit	Mandatory	1
-	Specialised service indicators—in-vitro fertilisation unit	Mandatory	1
-	Specialised service indicators—infectious diseases unit	Mandatory	1
-	Specialised service indicators—intensive care unit (level III)	Mandatory	1
-	Specialised service indicators—liver transplantation unit	Mandatory	1
-	Specialised service indicators—maintenance renal dialysis centre	Mandatory	1
-	Specialised service indicators—major plastic/reconstructive surgery unit	Mandatory	1
-	Specialised service indicators—neonatal intensive care unit (level III)	Mandatory	1
-	Specialised service indicators—neurosurgical unit	Mandatory	1
-	Specialised service indicators—nursing home care unit	Mandatory	1
-	Specialised service indicators—obstetric/maternity	Mandatory	1
-	Specialised service indicators—oncology unit, cancer treatment	Mandatory	1
-	Specialised service indicators—pancreas transplantation unit	Mandatory	1
-	Specialised service indicators—psychiatric unit/ward	Mandatory	1
-	Specialised service indicators—rehabilitation unit	Mandatory	1
-	Specialised service indicators—renal transplantation unit	Mandatory	1
-	Specialised service indicators—sleep centre	Mandatory	1
-	Specialised service indicators—specialist paediatric	Mandatory	1
-	Statistical area level 2 (SA2)	Mandatory	1
-	Teaching status	Mandatory	1

Residential mental health care NMDS 2014-15

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	525052
Registration status:	Health, Standard 07/03/2014
DSS type:	National Minimum Data Set (NMDS)
Scope:	Episodes of residential care for residents in all government-funded residential mental health care services in Australia, except those residential care services that are in receipt of funding under the *Aged Care Act* and subject to Commonwealth reporting requirements (i.e. report to the System for the payment of Aged Residential Care (SPARC) collection).

Collection and usage attributes

Statistical unit:	**Episodes of residential care.** Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.
Collection methods:	Data are collected at each service from resident administrative and care related record systems. Services forward data to the relevant state or territory health authority on a regular basis (e.g. monthly). *National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collection, on an annual basis. Government-operated services that employ mental health trained staff on-site 24 hours per day are to be included from 1 July 2004. Government-funded, non-government operated services and non 24-hour staffed services can be included from 1 July 2004, optionally. For non 24-hour staffed services to be included they must employ mental health-trained staff on-site at least 50 hours per week with at least 6 hours staffing on any single day. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year. The reference period starts on 1 July and ends on 30 June each year.
Implementation start date:	01/07/2014
Implementation end date:	30/06/2015
Comments:	Some admitted patient care services may meet the definition of a residential mental health service. However, as they are admitted patient care services, relevant data on their patients are reported to the National Minimum Data Set for Admitted Patient Care. *Glossary items* **Episode of residential care end** **Episode of residential care start**

Geographic indicator
Resident
Residential mental health care service
Separation

Relational attributes

Related metadata references:

Supersedes Residential mental health care NMDS 2013-14 Health, Superseded 07/03/2014

Has been superseded by Residential mental health care NMDS 2015-16 Health, Standardisation pending 22/09/2014

Implementation in Data Set Specifications:

Residential patient mental health care cluster Health, Standardisation pending 26/09/2014

Conditional obligation:
Reporting of these data elements is mandatory for residential mental health care services that are included in the General list of in-scope public hospital services, which have been developed under the National Health Reform Agreement (2011). Reporting is optional for episodes of residential mental health care provided by government-funded, non-government operated services.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Additional diagnosis	Mandatory	1
-	Area of usual residence (SA2)	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Episode of residential care end date	Mandatory	1
-	Episode of residential care end mode	Mandatory	1
-	Episode of residential care start date	Mandatory	1
-	Episode of residential care start mode	Mandatory	1
-	Establishment sector	Mandatory	1
-	Indigenous status	Mandatory	1
-	Leave days from residential care	Mandatory	1
-	Marital status	Mandatory	1
-	Mental health care referral destination	Mandatory	1
-	Mental health legal status	Mandatory	1
-	Organisation identifier	Mandatory	1
-	Organisation name—specialised mental health service	Mandatory	1
-	Person identifier	Mandatory	1
-	Principal diagnosis—episode of care	Mandatory	1
-	Region code	Mandatory	1
-	Region name	Mandatory	1
-	Residential service unit identifier	Mandatory	1

-	Residential service unit name	Mandatory	1
-	Residential stay start date	Mandatory	1
-	Service unit cluster identifier	Mandatory	1
-	Service unit cluster name	Mandatory	1
-	Sex	Mandatory	1

Data set specifications

Admitted subacute and non-acute hospital care DSS 2014-15

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	556874
Registration status:	Health, Standard 11/04/2014
DSS type:	Data Set Specification (DSS)
Scope:	The Admitted subacute and non-acute hospital care data set specification (DSS) aims to ensure national consistency in relation to defining and collecting information about care provided to subacute and non-acute admitted public and private patients in **activity based funded** public hospitals. Subacute care in this DSS is identified as admitted episodes in rehabilitation care, palliative care, geriatric evaluation and management care and psychogeriatric care, whereas maintenance care is identified as non-acute care. The scope of the DSS is: • Same day and overnight admitted subacute and non-acute care episodes. • Admitted public patients provided on a contracted basis by private hospitals. • Admitted patients in rehabilitation care, palliative care, geriatric evaluation and management, psychogeriatric and maintenance care treated in the hospital-in-the-home. Excluded from the scope are: • Hospitals operated by the Australian Defence Force, correctional authorities and Australia's external territories.

Collection and usage attributes

Statistical unit:	Episodes of care for admitted patients
Collection methods:	Hospitals forward data to the relevant state or territory health authority. *National reporting arrangements* State and territory health authorities provide the data to the Independent Hospital Pricing Authority (IHPA) for national collection, on a quarterly basis as required under national health reform arrangements. For designated palliative care type episodes, data elements for each change in phase of care will be required to be reported. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year. Quarterly data collection commencing 1 July each year.

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Comments:

Scope links with other NMDSs

The Admitted subacute and non-acute hospital care data set specification includes the collection and reporting of additional metadata which forms part of the broader Admitted patient care NMDS.

Data collected using this DSS can be related to national data collections:

Admitted patient care NMDS

Admitted patient palliative care NMDS

Admitted patient mental health NMDS

Glossary items

Glossary terms that are relevant to this data set specification are included here.

Activity based funding

Functional Independence Measure

Health of the Nation Outcome Scale 65+

Palliative care phase

Resource Utilisation Groups - Activities of Daily Living

Source and reference attributes

Reference documents: Eagar K. et al (1997). The Australian National Sub-acute and Non-acute Patient Classification (AN-SNAP): Report of the National Sub-acute and Non-acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong. Viewed 26 October 2012, http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/documents/doc/uow082315.pdf

Relational attributes

Related metadata references: Supersedes Activity based funding: Admitted sub-acute and non-acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Standard 11/10/2012

Has been superseded by Admitted subacute and non-acute hospital care DSS 2015-16 Health, Standardisation pending 25/09/2014

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Admitted patient care NMDS 2014-15	Mandatory	1
-	Clinical assessment only indicator	Conditional	1
-	Level of functional independence (FIM™ score)	Conditional	18
-	Level of functional independence (RUG-ADL score)	Conditional	44
-	Level of psychiatric symptom severity (HoNOS 65+ score)	Conditional	12
-	Palliative care phase	Conditional	11
-	Palliative care phase end date	Conditional	11

-	Palliative care phase start date	Conditional	11
-	Primary impairment type (AROC 2012 code)	Conditional	1
-	Type of maintenance care provided	Conditional	1

Cancer (clinical) DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	560813
Registration status:	Health, Standard 08/05/2014
DSS type:	Data Set Specification (DSS)
Scope:	The purpose of the Cancer (clinical) data set specification (C(C)DSS) is to define data standards for the national collection of clinical cancer data so that data collected is consistent and reliable. Collection of this data set specification is not mandated but it is recommended as best practice if clinical cancer data are to be collected. It will facilitate more consistent data collection while enabling individual treatment centres or health service areas to develop data extraction and collection processes and policies that are appropriate for their service settings. Mandatory reporting regulations have enabled population-based cancer registries in Australia to collect standard information on all incident cases of cancer apart from non-melanoma skin cancers, from which incidence, mortality and overall survival have been determined and trends monitored. The Cancer (clinical) data set specification provides a framework for the collection of more detailed and comprehensive clinical data such as stage of cancer at diagnosis, other prognostic characteristics, cancer treatment and patient outcomes. The Cancer (clinical) data set specification will support prospective data collection from the time a person with cancer symptoms is referred or first presents to a hospital or specialist through the entire duration of their illness. The majority of data items in the Cancer (clinical) data set specification are applicable to most solid tumours while many are also relevant to the haematopoietic malignancies such as leukaemia and lymphoma. Data set specifications for specialist tumour streams are also under development and these will contain supplementary data elements that will capture the special features of specific cancer types. The definitions used in this data set specification are designed to capture the provision of cancer care on a day-to-day level. They relate to the cancer care pathway and the need to optimise care by correctly diagnosing, evaluating and managing patients with cancer. In addition, end-points and patterns of care can be monitored to understand both the appropriateness and effectiveness of cancer care. The data elements specified provide a framework for: • promoting the delivery of evidence-based care to patients with cancer • facilitating the ongoing improvement in the quality and safety of cancer management in treatment settings • improving the epidemiological and public health understanding of cancer

- informing treatment guidelines and professional education
- guiding resource planning and the evaluation of cancer control activities

They will facilitate the aggregation of data across different treatment centres.

The underlying long-term goal is to provide data support to improve outcomes for patients by increasing the quality and length of life. For example, a comparison of the actual management of patients with best practice guidelines may identify shortfalls in treatment and limitations in access to treatment modalities for some patients.

The working group formed under the stewardship of Cancer Australia was diverse and included representation from the following organisations: Cancer Australia, University of Sydney-Department of Gynaecological Oncology, Westmead Institute for Cancer Research, Cancer Council Victoria, Royal Brisbane & Women's Hospital, National Breast and Ovarian Cancer Centre, The Royal Women's Hospital, Queensland Health, Ministry of Health, NSW Health, TROG Cancer Research, and the Cancer Institute NSW.

To ensure the broad acceptance of the data set specification, the proposed list of data items was circulated to members of Cancer Australia's National Cancer Data Strategy Advisory Group, a multidisciplinary group with a broad spectrum of epidemiological knowledge and expertise, and the inter-governmental Strategic Forum, comprising clinicians and senior health department officials from the Australian Government and from each state and territory government, and with strong community representation. The working group also sought consultation from cancer registry data managers, clinical leaders, pathologists, medical oncologists and radiation oncologists to achieve consensus when required.

The Cancer (clinical) data set specification is intended to only describe data collected in relation to the **initial course of cancer treatment**. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

Collection and usage attributes

Guide for use:

The Cancer (clinical) data set specification contains six data clusters relating to cancer treatment. To ensure a complete description of the clinical management of cancer, it is recommended that if the patient has had the specific treatment modality the cluster refers to, each data item within the cluster should be completed.

The data clusters are as follows:

- Chemotherapy for cancer cluster
- Hormone therapy for cancer cluster
- Immunotherapy for cancer cluster
- Radiotherapy for cancer cluster
- Surgery for cancer cluster

- Systemic therapy procedure for cancer cluster

Collection methods:

Data is to be collected for the initial course of cancer treatment. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

This data set is primarily directed at the clinical and clinical epidemiological use of cancer data. Treatment centres such as hospitals, radiotherapy centres and cancer specialist practices are the settings in which implementation of the core Cancer (clinical) data set specification should be considered. The data set specification can also be used by a wider range of health and health-related establishments that create, use, or maintain records on health-care clients.

Source and reference attributes

Submitting organisation: Cancer Australia

Relational attributes

Related metadata references: Supersedes Cancer (clinical) DSS Health, Superseded 08/05/2014

Implementation in Data Set Specifications: Gynaecological cancer (clinical) DSS Health, Standard 08/05/2014

DSS specific information:
The Cancer (clinical) data set specification is intended to only describe data collected in relation to the initial course of cancer treatment. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

Lung cancer (clinical) DSS Health, Standard 08/05/2014

DSS specific information:
The Cancer (clinical) data set specification is intended to only describe data collected in relation to the initial course of cancer treatment. The initial course of treatment includes all treatments administered to the patient from diagnosis and before disease progression or recurrence.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Chemotherapy for cancer cluster	Conditional	1
-	Hormone therapy for cancer cluster	Conditional	1
-	Immunotherapy for cancer cluster	Conditional	1
-	Radiotherapy for cancer cluster	Conditional	1
-	Surgery for cancer cluster	Conditional	1
-	Systemic therapy procedure for cancer cluster	Conditional	1
-	Address line (person)	Mandatory	1
-	Cancer staging scheme source edition number	Mandatory	1
-	Cancer staging—M stage code	Mandatory	1
-	Cancer staging—N stage code	Mandatory	1

-	Cancer staging—stage grouping other	Mandatory	1
-	Cancer staging—T stage code	Mandatory	1
-	Cancer staging—TNM stage grouping code	Mandatory	1
-	Cancer status	Mandatory	1
-	Cancer treatment type	Mandatory	1
-	Date accuracy indicator	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of death	Conditional	1
-	Date of diagnosis of cancer	Mandatory	1
-	Date of diagnosis of first recurrence as distant metastasis	Conditional	1
-	Date of diagnosis of first recurrence as locoregional cancer	Conditional	1
-	Date of last contact—cancer patient	Mandatory	1
-	Establishment number	Mandatory	1
-	Family name	Mandatory	1
-	Given name(s)	Mandatory	1
-	Histopathological grade	Mandatory	1
-	HPI-O	Mandatory	1
-	Indigenous status	Mandatory	1
-	Laterality of primary cancer	Mandatory	1
-	Medicare card number	Mandatory	1
-	Morphology of cancer	Mandatory	1
-	Most valid basis of diagnosis of cancer	Mandatory	1
-	Most valid basis of diagnosis of recurrence	Conditional	1
-	Number of regional lymph nodes examined	Conditional	1
-	Other cancer treatment description	Conditional	99
-	Outcome of treatment	Mandatory	1
-	Person identifier	Mandatory	1
-	Primary site of cancer (ICD-O-3 code)	Mandatory	1
-	Region of first recurrence as distant metastasis	Conditional	99
-	Region of first recurrence as locoregional cancer	Conditional	99
-	Regional lymph nodes positive	Conditional	1
-	Sex	Mandatory	1
-	Staging basis of cancer	Mandatory	1
-	Staging scheme source	Mandatory	1
-	Tumour size at diagnosis (solid tumours)	Conditional	1
-	Underlying cause of death	Conditional	1

Gynaecological cancer (clinical) DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	421105
Registration status:	Health, Standard 08/05/2014
DSS type:	Data Set Specification (DSS)
Scope:	The purpose of the Gynaecological cancer (clinical) data set specification (DSS) is to define data standards for the national collection of gynaecological cancer data so that data collected is consistent and reliable. The data set specification is not mandated for collection but is recommended as best practice if gynaecological cancer data is to be collected. It enables individual treatment centres or health service areas to develop collection methods and policies appropriate for their service. The Gynaecological cancer (clinical) data set specification is used in conjunction with the Cancer (clinical) data set specification (CCDSS). The data elements with obligations described as mandatory or conditional for collection are recommended as best practice, while the data items described as optional are for collection at the discretion of the treating centre and may be contingent, for example, on the availability of resources. The scope for the Gynaecological cancer (clinical) DSS is to collect comprehensive data encompassing the time a person is first referred for the investigation of symptoms and for the entire duration of their illness so that treatment and outcomes are captured. The definitions used in this data set specification are designed to capture the provision of cancer care on a day-to-day level. They relate to the realities of cancer care and the need to optimise care by correctly diagnosing, evaluating and managing patients with gynaecological cancer. The data elements specified provide a framework for: • providing a systematic foundation and promoting the delivery of evidence-based care to patients with gynaecological cancer • informing treatment guidelines and professional education • informing quality assurance • guiding resource planning and the evaluation of cancer control activities Many of the data elements in this data set specification may also be used in the collection of data for other types of cancer. This data set specification is primarily directed at the clinical and clinical epidemiological use of cancer data. Treatment centres such as hospitals, radiotherapy centres and cancer specialist practices are the settings in which implementation of the Gynaecological cancer (clinical) data set specification should be considered. The data set specification can also be used by a wider range of health and health-related establishments that create, use or maintain records on health-care clients.

Source and reference attributes

Submitting organisation: Cancer Australia

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Cytopathology result	Mandatory	29
2	Lymphovascular invasion indicator	Mandatory	1
3	Cervical lymphovascular invasion location	Conditional	5
4	Corpus uteri lymphovascular invasion location	Conditional	5
5	FIGO cervical cancer stage	Conditional	1
6	FIGO endometrial cancer stage	Conditional	1
7	FIGO ovarian cancer stage	Conditional	1
8	Distant metastatic site indicator	Mandatory	1
9	Distant metastatic site(s) at diagnosis	Conditional	20
10	Depth of myometrial invasion	Conditional	1
11	Myometrial thickness	Conditional	1
12	Depth of cervical cancer invasion	Conditional	1
13	Tumour outside primary site indicator	Mandatory	1
14	Tumour size outside primary site	Mandatory	1
15	Multiple primary tumours indicator	Mandatory	1
16	Multiple primary tumours descriptor	Conditional	1
17	Tissue sample collected indicator	Mandatory	30
18	Organisation name	Conditional	10
19	Surgical specialty gynaecological cancer	Conditional	10
20	Tumour residual post-surgery size category	Conditional	20
21	Residual tumour indicator	Conditional	1
22	Surgical treatment complication indicator	Mandatory	1
23	Surgical treatment complication type	Conditional	10
24	Radiotherapy treatment complication indicator	Conditional	1
25	Radiotherapy treatment complication type	Conditional	10
26	Treatment complication description	Conditional	10
27	Systemic therapy modification indicator	Conditional	1
28	Systemic therapy modification type	Conditional	10
29	Treatment plan modification description	Conditional	10
30	Delay in primary course of chemotherapy indicator	Conditional	5
31	Primary course of chemotherapy delay reason	Conditional	10
32	Cancer treatment type	Conditional	5
33	Other cancer treatment description	Conditional	10
34	Outcome of treatment	Conditional	5
35	Cancer (clinical) DSS	Mandatory	1

Indigenous primary health care DSS 2014-15

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	504325
Registration status:	Health, Standard 21/11/2013 Indigenous, Endorsed 21/11/2013
DSS type:	Data Set Specification (DSS)
Scope:	The Indigenous primary health care data set specification (IPHC DSS) is primarily designed to support the collection of aggregate information from Indigenous-specific primary health care services. The IPHC DSS describes the aggregate data to be reported by those Indigenous-specific primary health care services. Only the data, which services aggregate using cohort definitions and specialised software, will be supplied through the OATSIH Community Health Reporting Environment (OCHRE), a web-based reporting tool. No individual level client data will be supplied to either the Australian Institute of Health and Welfare (AIHW) or the Commonwealth Department of Health. For the purposes of the IPHC DSS, Aboriginal and Torres Strait Islander primary health care is defined as: "…socially and culturally appropriate, universally accessible, scientifically sound, first level care. It is provided by health services and systems with a suitably trained workforce comprised of multidisciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control and; involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment, and care of the sick, community development, advocacy, and rehabilitation services." This definition has been endorsed by the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), the Australian General Practice Network (AGPN), the Australian Primary Health Care Research Institute (APHCRI), and the Australian Medical Association (AMA). Aboriginal and Torres Strait Islander primary health care services include: 1. Aboriginal Community Controlled Health Service (ACCHS): primary health care services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it (through a locally elected Board of Management); and 2. Other Aboriginal and Torres Strait Islander primary health care services: health services funded principally to provide services to Aboriginal and Torres Strait Islander individuals with funding provided by the federal and/or state or territory governments.

These non community-controlled services mainly exist in the Northern Territory and northern part of Queensland.

Services use a clinical audit tool program for extracting and aggregating data from their patient information and recall systems. The IPHC DSS has been written to inform this program. Once aggregated, the data will be sent to the AIHW via the OATSIH Community Health Reporting Environment (OCHRE), a web-based reporting tool with an 'in-confidence' security classification.

The IPHC DSS includes aggregate data only; it does not include data elements describing any details relating to or arising from individual client visits, at the client visit level, e.g. blood pressure measurements, body mass index (BMI) values and so on.

Aggregate data will initially be collected from a limited number of primary health care services, i.e. those funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) via the Healthy for Life program. From mid-2012, data collection was extended to the remainder of services funded by OATSIH to deliver primary health care. From mid-2013, data collection will be expanded to also include state- and territory-funded Indigenous-specific primary health care services not funded by OATSIH.

Collection and usage attributes

Statistical unit: Each unit represents aggregated data from an individual Indigenous-specific primary health care service.

Collection methods: The IPHC DSS describes only the aggregated data. Patient Information Referral Systems (PIRS) contain many variables related to individual clients. The Clinical Audit Tool (CAT) is programmed to extract variables determined in data elements and counting how many clients have these variables. Services will then authorise transmission of these de-individualised data extracted by CAT to AIHW through the OCHRE web-based tool.

The regular client status of a client will be determined by the service on the PIRS and will need to be reviewed on a twice-yearly basis.

National reporting arrangements

Each service funded to provide Indigenous-specific primary health care should record service provision in clinical information management systems that allow the electronic transmission of data for reporting.

Periods for which data are collected and nationally collated

Data collections and data reporting will be on a 6-monthly basis.

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Source and reference attributes

Submitting organisation: Department of Health

Australian Institute of Health and Welfare

Reference documents: Pen Computer Systems, 2009. Clinical Audit Tool - User Guide, Pen Computer Systems Pty Ltd, Sydney. Viewed 7 November

2011, http://help.pencs.com.au/cat.htm

Relational attributes

Related metadata references: Supersedes Indigenous primary health care DSS 2012-14 Health, Superseded 21/11/2013, Indigenous, Archived 21/11/2013

See also Indigenous primary health care key performance indicators (2014) Health, Standard 21/11/2013, Indigenous, Endorsed 21/11/2013

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Absolute cardiovascular disease risk assessment recorded indicator	Mandatory	1
-	Address line (service provider organisation)	Mandatory	1
-	Age	Mandatory	1
-	Alcohol consumption status recorded indicator	Conditional	1
-	Australian state/territory identifier (service provider organisation)	Mandatory	1
-	Birth weight	Mandatory	1
-	Birth weight recorded indicator	Conditional	1
-	Blood pressure measurement result less than or equal to 130/80 mmHg indicator	Conditional	1
-	Blood pressure measurement result recorded indicator	Conditional	1
-	Body mass index recorded indicator	Conditional	1
-	Body mass index—classification	Conditional	1
-	Building/complex sub-unit number (service provider organisation)	Mandatory	1
-	Building/property name (service provider organisation)	Mandatory	1
-	Cardiovascular disease recorded indicator	Mandatory	1
-	Cervical screening indicator	Mandatory	3
-	Chronic obstructive pulmonary disease recorded indicator	Mandatory	1
-	Day of operation	Mandatory	7
-	Diabetes status	Mandatory	1
-	Electronic communication address (service provider organisation)	Mandatory	7
-	Electronic communication medium (service provider organisation)	Mandatory	7
-	Estimated glomerular filtration rate (eGFR) recorded indicator	Mandatory	1
-	Estimated glomerular filtration rate result	Conditional	1
-	Full-time equivalent paid staff	Mandatory	1
-	Fully immunised recorded indicator	Mandatory	1
-	Glycosylated haemoglobin level	Conditional	2
-	Glycosylated haemoglobin measurement result recorded indicator	Conditional	2
-	GP Management Plan indicator	Conditional	1

-	Hysterectomy indicator	Mandatory	1
-	Indigenous status	Mandatory	1
-	Influenza immunisation indicator	Conditional	1
-	MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) indicator	Conditional	2
-	Microalbumin urine test result	Mandatory	1
-	Name type (service provider organisation)	Mandatory	1
-	Organisation name	Mandatory	1
-	Postcode—Australian (service provider organisation)	Mandatory	1
-	Regular client indicator	Mandatory	1
-	Service operation days	Mandatory	1
-	Service operation hours	Mandatory	1
-	Service operation weeks	Mandatory	1
-	Sex	Mandatory	1
-	Smoking status recorded indicator	Conditional	1
-	Standards assessment indicator	Mandatory	1
-	Standards assessment level	Mandatory	1
-	Street name (service provider organisation)	Mandatory	1
-	Street type code (service provider organisation)	Mandatory	1
-	Suburb/town/locality name (service provider organisation)	Mandatory	1
-	Team Care Arrangement (MBS Item 723) indicator	Conditional	1

Local Hospital Networks DSS 2014-15

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 555334

Registration status: Health, Standard 11/04/2014

DSS type: Data Set Specification (DSS)

Scope: The scope of the Local Hospital Networks data set specification (LHN DSS) is:

- **Local Hospital Networks**
- all public hospital services that are managed by a state or territory health authority and are included in the *General list of In-scope Public Hospital Services,* which has been developed under the *National Health Reform Agreement* (2011).

Excluded from the DSS scope are establishments which report to the Public hospital establishments NMDS.

Local Hospital Networks are defined as those entities recognised as such by the relevant state or territory health authority.

Collection and usage attributes

Statistical unit: There is a hierarchy of statistical units used within the LHN DSS. Information is provided at each level:

- Local Hospital Network
- State or territory health authority

In the LHN DSS, the term 'establishment' is used to refer to entities reporting at each of the hierarchical levels. Thus, for the purposes of this collection, 'establishment' refers to Local Hospital Networks and state and territory health authorities.

Guide for use: The following are principles of the collection. Jurisdictions should consider these principles when providing data.

6. Data should be reported by jurisdictions at the level relevant to service management and/or provision.
7. The DSS should capture and differentiate between in-scope and out-of-scope of the *National Health Reform Agreement*.
8. The DSS must specify where data elements are reporting actual data and where they are reporting estimated data.
9. Where possible, the DSS should align so that it acts as a subset of the Government health expenditure NMDS.
10. Reporting on expenditure and activity delivered under contract requires less detail than other expenditure and activity.

Actual expenditure and revenue data are expected to be reported at the level at which they appear in the general ledger. Expenditure and revenue data are not expected to be apportioned to a lower level.

Expenditure and revenue data reported to the LHN DSS should

reconcile with published financial statements.

Expenditure data are reported in two ways:

- as it would appear in the general ledger line items (Establishment—recurrent non-salary expenditure, public hospital expenditure categories code N[N] and Establishment—staffing categories, health code N)
- by National Health Reform Agreement product streams (Establishment—total recurrent expenditure, National Health Reform Agreement 2011 product streams code N[N]). These are estimated data.

The total expenditure by product stream should equal the total expenditure by general ledger line item at both levels of the hierarchy.

For the purposes of the LHN DSS, funding from the Commonwealth, National Health Funding Body, state and territory health authorities and other state and territory government departments is considered to be revenue and should be reported as such.

Collection methods:

Some data for this DSS are sourced from the state or territory health authority general ledger. Some other data are maintained by the LHN and are forwarded to the relevant state or territory health authority for inclusion.

National reporting arrangements

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated

Financial years ending 30 June each year.

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Comments:

Interaction with the Public hospital establishments NMDS

The Public hospital establishments national minimum data set (PHE NMDS) and the LHN DSS work together to collect data on the public hospital system. The two data set specifications collect the same expenditure and revenue data items, but at different levels of the system:

Hierarchical level	*Data collected through*
Public hospital establishments	PHE NMDS
Local hospital network	LHN DSS
Jurisdictional health authority	LHN DSS

It is expected that expenditure and revenue data will be reported at the level at which they occur.

In addition to the shared expenditure and revenue data items, each collection has a number of unique items. The PHE NMDS includes items such as establishment location, establishment type and specialised service indicators that do not appear in the LHN DSS. Similarly, the LHN DSS includes gross and net capital expenditure items that do not appear in the PHE NMDS.

It is intended that once the LHN DSS is firmly established, the two collections should be merged into a single NMDS.

Scope links with Health NMDSs

The LHN DSS shares scope with the Government health expenditure NMDS.

Source and reference attributes

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Public hospital establishments NMDS 2014-15 Health, Standard 11/04/2014

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Full-time equivalent staffing data element cluster	Mandatory	10
-	Recurrent contracted care expenditure data element cluster	Mandatory	1
-	Recurrent non-salary expenditure data element cluster	Mandatory	1
-	Recurrent salaries and wages expenditure data element cluster	Mandatory	1
-	Revenue data element cluster	Mandatory	1
-	Total recurrent expenditure on National Health Reform Agreement product streams data element cluster	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Average available beds for admitted contracted care	Mandatory	1
-	Establishment number	Mandatory	1
-	Estimated data indicator	Mandatory	1
-	Gross capital expenditure (accrual accounting)—buildings and building services	Mandatory	1
-	Gross capital expenditure (accrual accounting)—constructions	Mandatory	1
-	Gross capital expenditure (accrual accounting)—equipment	Mandatory	1
-	Gross capital expenditure (accrual accounting)—information technology	Mandatory	1
-	Gross capital expenditure (accrual accounting)—intangible assets	Mandatory	1
-	Gross capital expenditure (accrual accounting)—land	Mandatory	1
-	Gross capital expenditure (accrual accounting)—major medical equipment	Mandatory	1
-	Gross capital expenditure (accrual accounting)—other equipment	Mandatory	1
-	Gross capital expenditure (accrual accounting)—transport	Mandatory	1
-	Gross capital expenditure—computer equipment/installations	Mandatory	1
-	Gross capital expenditure—intangible assets	Mandatory	1
-	Gross capital expenditure—land and buildings	Mandatory	1
-	Gross capital expenditure—major medical equipment	Mandatory	1
-	Gross capital expenditure—other	Mandatory	1

-	Gross capital expenditure—plant and other equipment	Mandatory	1
-	Local Hospital Network identifier	Mandatory	1
-	Net capital expenditure (accrual accounting)—buildings and building services	Mandatory	1
-	Net capital expenditure (accrual accounting)—constructions	Mandatory	1
-	Net capital expenditure (accrual accounting)—equipment	Mandatory	1
-	Net capital expenditure (accrual accounting)—information technology	Mandatory	1
-	Net capital expenditure (accrual accounting)—intangible assets	Mandatory	1
-	Net capital expenditure (accrual accounting)—land	Mandatory	1
-	Net capital expenditure (accrual accounting)—major medical equipment	Mandatory	1
-	Net capital expenditure (accrual accounting)—other equipment	Mandatory	1
-	Net capital expenditure (accrual accounting)—transport	Mandatory	1

Lung cancer (clinical) DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	430950
Registration status:	Health, Standard 08/05/2014
DSS type:	Data Set Specification (DSS)
Scope:	The purpose of the Lung cancer (clinical) data set specification (LCCDSS) is to define data standards for the national collection of lung cancer clinical data so that data collected is consistent and reliable. Collection of this data set specification is not mandated but it is recommended as best practice if clinical cancer data are to be collected. It will facilitate more consistent data collection while enabling individual treatment centres or health service areas to develop data extraction and collection processes and policies that are appropriate for their service settings. The Lung cancer (clinical) data set specification is used in conjunction with the Cancer (clinical) data set specification (CCDSS). Mandatory reporting regulations have enabled population-based cancer registries in Australia to collect standard information on all incident cases of cancer apart from non-melanoma skin cancers, from which incidence, mortality and overall survival have been determined and trends monitored. The CCDSS provides a framework for the collection of more detailed and comprehensive clinical data such as stage of cancer at diagnosis, other prognostic characteristics, cancer treatment and patient outcomes. The Lung cancer (clinical) data set specification will support prospective data collection from the time a person with cancer symptoms is referred or first presents to a hospital or specialist through the entire duration of their illness. The definitions used in this data set specification are designed to capture the provision of cancer care on a day-to-day level. They relate to the cancer care pathway and the need to optimise care by correctly diagnosing, evaluating and managing patients with cancer. In addition, end-points and patterns of care can be monitored to understand both the appropriateness and effectiveness of cancer care. The data elements specified provide a framework for: • promoting the delivery of evidence-based care to patients with cancer • facilitating the ongoing improvement in the quality and safety of cancer management in treatment settings • improving the epidemiological and public health understanding of cancer • informing treatment guidelines and professional education • guiding resource planning and the evaluation of cancer control activities They will facilitate the aggregation of data across different treatment centres. The underlying long-term goal is to provide data support to improve

outcomes for patients by increasing the quality and length of life. For example, a comparison of the actual management of patients with best practice guidelines may identify shortfalls in treatment and limitations in access to treatment modalities for some patients.

Collection and usage attributes

Guide for use: The data elements in the Lung cancer (clinical) data set specification with obligations described as mandatory or conditional for collection are recommended as best practice, while the data items described as optional are for collection at the discretion of the treating centre and may be contingent, for example, on the availability of resources.

Collection methods: This data set specification is primarily directed at the clinical and clinical epidemiological use of cancer data. Treatment centres such as hospitals, radiotherapy centres and cancer specialist practices are the settings in which implementation of the Lung cancer (clinical) data set specification should be considered. The data set specification can also be used by a wider range of health and health-related establishments that create, use, or maintain records on health-care clients.

Comments: *Glossary items*

Glossary terms that are relevant to this data set specification are included here.

Address
Adoption
Asbestos
Chemotherapy
Clinical trial
Family
Hormone therapy
Immunohistochemistry
Immunotherapy
Medical imaging
Molecular pathology
Palliative care
Psychosocial services
Radiotherapy
Record linkage
Second-line treatment
Systemic therapy procedure

Source and reference attributes

Submitting organisation: Cancer Australia

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Closest surgical margin	Conditional	1
2	Surgical margin qualifier (lung cancer)	Conditional	1
3	Multidisciplinary team review indicator	Mandatory	1

4	Radiotherapy target site (lung cancer)	Conditional	1
5	Residual tumour indicator	Conditional	1
6	Residual tumour type	Conditional	1
7	First health service contact date	Conditional	1
8	Intention of treatment	Mandatory	1
9	Country identifier (person)	Mandatory	1
10	Basis of diagnostic investigation	Mandatory	1
11	Clinical trial entry status	Optional	1
12	Clinical trial name and number	Conditional	99
13	Colinet comorbidities	Mandatory	7
14	Date clinical trial entered	Optional	1
15	Date of referral to palliative care services	Conditional	1
16	Date of referral to psychosocial services	Conditional	1
17	Distant metastatic site(s) at diagnosis (ICD-O-3 code)	Conditional	99
18	Immunohistochemistry type description	Conditional	99
19	Lung cancer immunohistochemistry	Conditional	9
20	Molecular test results (lung cancer)	Conditional	14
21	Lymphovascular invasion indicator	Mandatory	1
22	Lymphovascular invasion type	Conditional	3
23	Molecular pathology indicator	Mandatory	1
24	Molecular pathology test date	Conditional	99
25	Molecular test results description	Conditional	99
26	Multiple primary tumours descriptor	Conditional	1
27	Multiple primary tumours indicator	Mandatory	1
28	ECOG score	Mandatory	1
29	Perineural invasion indicator	Optional	1
30	Psychosocial services referral type	Optional	1
31	Reason(s) second-line treatment administered	Conditional	4
32	Reason(s) treatment not administered (cancer)	Optional	6
33	Referral to palliative care services indicator	Optional	1
34	Referral to psychosocial services indicator	Mandatory	1
35	Second-line treatment intention	Conditional	1
36	Second-line treatment type	Conditional	5
37	Asbestos exposure indicator	Optional	1
38	Asbestos exposure setting	Conditional	1
39	Diagnostic imaging type (lung cancer)	Optional	16
40	Individual Healthcare Identifier	Mandatory	1
41	Diagnostic procedure type (lung cancer)	Optional	20
42	Tobacco smoking—consumption/quantity (cigarettes)	Conditional	1
43	Tobacco smoking—product	Conditional	1
44	Tobacco smoking—duration (daily smoking)	Conditional	1

45	Tobacco smoking—quit age (daily smoking)	Conditional	1
46	Tobacco smoking—start age (daily smoking)	Conditional	1
47	Tobacco smoking status	Mandatory	1
48	Unintentional weight loss indicator	Mandatory	1
49	Cancer (clinical) DSS	Mandatory	1

Medical indemnity DSS 2014-

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	531844
Registration status:	Health, Standard 21/11/2013
DSS type:	Data Set Specification (DSS)
Scope:	The Medical indemnity data set specification (DSS) updates the description of the data items and standardised data outputs for medical indemnity claims for the Medical Indemnity National Collection (MINC). The MINC contains information on medical indemnity claims against health providers. These are claims for compensation for harm or other loss allegedly due to the delivery of health care. This health care may occur in settings such as hospitals, outpatient clinics, general practitioner surgeries, community health centres, residential aged care or mental health care establishments or during the delivery of ambulatory care. Adverse events or harm due to medical treatment, which do not result in a medical indemnity claim, are not included in the MINC. In 2002, Australia's Health Ministers decided that a 'national database for medical negligence claims' should be established. In 2003, the Medical Indemnity Data Working Group (MIDWG) came into existence with its membership drawn from health authorities, the Department of Health and Ageing and the Australian Institute of Health and Welfare (AIHW). The MIDWG collaborated on establishing a Medical Indemnity National Collection (Public Sector), comprising data from the jurisdictions. In 2006, private medical indemnity insurers agreed to have their data on medical indemnity claims included in the MINC. In 2008, the Australian Health Ministers' Advisory Council approved funding for data development work. The data items and recording specifications proposed for DSS development are based on those endorsed by the MIDWG for the 2009-10 data transmission period. Medical indemnity claims fit into two categories, i.e. actual claims (on which legal activity has commenced via a letter of demand, the issue of a writ or a court proceeding) and potential claims (where the health authority or private medical indemnity insurer has placed a reserve against a health-care incident in the expectation that it may eventuate to an actual medical indemnity claim). Information in the MINC relates to actual and potential medical indemnity claims and the alleged or reported health-care incidents leading to medical indemnity claims. The MINC includes basic demographic information on the patient at the centre of the alleged health-care incident; related information such as the type of incident or allegation and the clinical specialties involved; the reserve amount set against the likely cost of settling the medical indemnity claim; the time between setting the reserve and closing the medical indemnity

claim; and the cost of closing the medical indemnity claim and the nature of any compensatory payments.

Compensatory payments may be made to the patient and/or to another party claiming collateral loss as a result of the loss or harm experienced by the patient.

As a general guide, the main steps in the management of public sector medical indemnity claims are:

1. An incident that could lead to a medical indemnity claim is notified to the relevant claims management body. In some jurisdictions medical indemnity claims are managed by the relevant state or territory health authority; however, in others, most of the claims management process is handled by a body external to the health authority. Occasionally, some of the legal work may be outsourced to private law firms.

2. If the likelihood of a medical indemnity claim eventuating is considered sufficiently high, a reserve is placed, based on an estimate of the likely cost of the claim when closed.

3. Various events can signal the start of a medical indemnity claim, for example, a writ or letter of demand may be issued by the claimant's solicitor (this can occur before an incident has been notified) or the defendant may make an offer to the claimant to settle the matter before a writ or letter has been issued. In some cases no action is taken by the claimant or the defendant.

4. The medical indemnity claim is investigated. This can involve liaising with clinical risk management staff within the health facility concerned and seeking expert medical advice.

5. As the medical indemnity claim progresses the reserve is monitored and adjusted if necessary.

6. A medical indemnity claim is closed when, in the opinion of the health authority, there will be no future unforeseen costs associated with the claim's investigation, litigation or a payment to a claimant. If a claim is closed and the possibility of future costs arises, the claim may be reopened.

7. A medical indemnity claim may be finalised through several processes—through state/territory-based complaints processes, court-based alternative dispute resolution processes, or in court. In some jurisdictions settlement via statutorily mandated conference processes must be attempted before a medical indemnity claim can go to court. In some cases settlement is agreed between claimant and defendant, independent of any formal process. A medical indemnity claim file that has remained inactive for a long time may be finalised through discontinuation.

The detail of this process varies between jurisdictions, and in some jurisdictions there are different processes for small and large medical indemnity claims. Private medical indemnity insurers follow a similar process in managing claims reported to them that are covered by the insurance they provide to private medical practitioners.

Collection and usage attributes

Guide for use:

The following terminology is used in the Medical indemnity DSS:

- 'Claim' refers to a medical indemnity claim

- 'Claimant' could be another party or parties alleging loss due to the incident, rather than or in addition to the patient.

Collection methods: State and territory health authorities provide data on medical indemnity claims to the AIHW for national collation, annually. Data is for the financial year ending 30 June. Private medical indemnity insurers provide data on the same annual basis for a subset of the data items provided by public sector health authorities.

Implementation start date: 01/07/2014

Comments: The Medical indemnity DSS has been developed by the AIHW in conjunction with the MIDWG.

Glossary items

Glossary terms that are relevant to this data set specification are included here.

Class action

Geographic indicator

Reserve

Urban Centre

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Medical indemnity DSS 2012-14 Health, Superseded 21/11/2013

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Medical indemnity claim state/territory identifier	Mandatory	1
2	Medical indemnity claim identifier	Mandatory	1
3	Type of compensatory payment to patient	Mandatory	1
4	Type of compensatory payment to other party	Mandatory	1
5	Date of birth	Mandatory	1
6	Sex	Mandatory	1
7	Indigenous status	Mandatory	1
8	Primary incident or allegation type	Mandatory	1
9	Additional incident or allegation type	Conditional	3
10	Clinical service context	Mandatory	1
11	Clinical service context text	Conditional	1
12	Primary body function or structure of patient affected	Mandatory	1
13	Additional body function or structure of patient affected	Conditional	3
14	Extent of harm from a health-care incident	Mandatory	1
15	Date health-care incident occurred	Mandatory	1

16	Geographic remoteness	Mandatory	1
17	Health service setting	Mandatory	1
18	Patient relationship to health-care service provider	Mandatory	1
19	Principal clinician specialty involved in health-care incident	Mandatory	1
20	Additional clinician specialty involved in health-care incident	Conditional	3
21	Reserve placement date	Mandatory	1
22	Medical indemnity claim reserve amount	Mandatory	1
23	Medical indemnity claim legal and investigative expenses amount	Mandatory	1
24	Medical indemnity claimant payment amount	Mandatory	1
25	Medical indemnity claim amount	Mandatory	1
26	Medical indemnity claim commencement date	Conditional	1
27	Medical indemnity claim finalisation date	Conditional	1
28	Mode of medical indemnity claim finalisation	Mandatory	1
29	Medical indemnity claim status	Mandatory	1
30	Medical indemnity payment recipient	Mandatory	1
31	Class action indicator	Mandatory	1
-	Date accuracy indicator	Mandatory	5

Non-admitted patient DSS 2014-15

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 548176

Registration status: Health, Standard 07/03/2014

DSS type: Data Set Specification (DSS)

Scope: The scope of the Non-admitted patient DSS is non-admitted patient service events involving non-admitted patients in **activity based funded** hospitals.

The DSS is intended to capture instances of service provision from the point of view of the patient.

For the purpose of this DSS, a non-admitted service is a specialty unit or organisational arrangement under which a hospital provides non-admitted services.

The scope of the DSS includes:

All arrangements made to deliver non-admitted patient service events (not covered by the national minimum data sets listed below) to non-admitted patients:

- irrespective of location (includes on-campus and off-campus),
- whose treatment has been funded through the hospital, regardless of the source from which the hospital derives these funds. In particular, Department of Veterans' Affairs, compensable and other patients funded through the hospital (including Medicare ineligible patients) are included; and
- regardless of setting or mode.

Excluded from the scope of the DSS are:

All services covered by:

- the Admitted patient care NMDS,
- the Admitted patient mental health care NMDS,
- the Non-admitted patient emergency department care NMDS, e.g. all non-admitted services provided to admitted patients or emergency department patients are excluded; and
- service events which deliver non-clinical care, e.g. activities such as home cleaning, meals on wheels or home maintenance.

Collection and usage attributes

Statistical unit: Non-admitted patient service event

Guide for use: A non-admitted patient service event is defined as an interaction between one or more health care provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record.

Counting rules:

1. Non-admitted service events involving multiple health professionals are counted as one non-admitted patient service

event.

2. Patients can be counted as having multiple non-admitted patient service events in one day, provided that every visit meets each of the criteria in the definition of a non-admitted patient service event.

3. Patient education services can be counted as non-admitted patient service events, provided that they meet the criteria included in the definition of a non-admitted patient service event.

4. Each patient attending a group session is counted as a non-admitted patient service event, providing that the session included the provision of therapeutic/clinical advice for each patient and that this was recorded using dated entry in each patient's medical record. A group flag is included in the NMDS to record this type of service event.

5. Telephone and other telehealth consultations can be counted as service events if they substitute for a face to face consultation, provided that they meet all the criteria included in the definition of non-admitted patient service event. A telephone/telehealth consultation is only counted as one non-admitted patient service event, irrespective of the number of health professionals/locations participating in the consultation.

6. Services provided to admitted and emergency department patients (including services provided by staff working in non-admitted services who visit admitted patients in wards or emergency departments, or other types of consultation and liaison services involving admitted or emergency department patients) are not counted as non-admitted patient service events.

7. Travel by a health professional is not counted as a non-admitted patient service event.

8. All non-admitted services that meet the criteria in the definition of non-admitted patient service events must be counted, irrespective of funding source (including Medicare Benefits Schedule) for the non-admitted service. A funding source flag is included in the NMDS.

9. For activity based funding purposes, services from stand-alone diagnostic services are not counted as non-admitted patient service events; these are an integral part of the requesting clinic's non-admitted patient service event.

10. Renal dialysis, total parenteral nutrition, home enteral nutrition and ventilation performed by the patient in their own home without the presence of a health care provider may be counted as a non-admitted patient service event, provided there is documentation of the procedures in the patient's medical record.

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Comments: *Glossary items*

Glossary terms that are relevant to this data set specification are listed below.

Activity based funding
Local Hospital Network

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Steward: Independent Hospital Pricing Authority

Reference documents: Independent Hospital Pricing Authority 2014. Tier 2 Non-Admitted Services Compendium, Version 3.0. Independent Hospital Pricing Authority, Sydney. Viewed 4 April 2014, http://ihpa.gov.au/internet/ihpa/publishing.nsf/Content/tier2-non-admitted-services-compendium-2014%E2%80%932015-html

Independent Hospital Pricing Authority 2014. Tier 2 Non-Admitted Services Definitions Manual, Version 3.0. Independent Hospital Pricing Authority, Sydney. Viewed 4 April 2014, http://ihpa.gov.au/internet/ihpa/publishing.nsf/Content/tier-2-non-admitted-services-definition-manual-2014%E2%80%9315-html

Relational attributes

Related metadata references:

Supersedes Activity based funding: Non-admitted patient care DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013

See also Appointment—care type, code AAA *No registration status*

See also Appointment—date, DDMMYYYY *No registration status*

See also Appointment—group session indicator, yes/no code N *No registration status*

See also Appointment—principal source of funding, patient funding source code AAA *No registration status*

See also Appointment—service delivery mode, code AAA *No registration status*

See also Appointment—service delivery setting, code A *No registration status*

See also Clinic—non-admitted service type, code (Tier 2 v3.0) NN.NN *No registration status*

See also Clinic—outpatient clinic tier 1 type, code NNN.NNN *No registration status*

See also Clinic—outpatient clinic type, code N[N] *No registration status*

Supersedes Non-admitted patient DSS 2013-14 Health, Superseded 07/03/2014

Has been superseded by Non-admitted patient DSS 2015-16 Health, Standardisation pending 30/09/2014

See also Person—indigenous status, code AAA *No registration status*

See also Person—person identifier, X(8) *No registration status*

See also Person—sex, code A *No registration status*

See also Referral—referral received date, DDMMYYYY *No registration status*

See also Referral—referral source, code AAA *No registration status*

Implementation in Data Set Specifications:

Ambulatory patient mental health care cluster Health, Standardisation pending 26/09/2014

Conditional obligation:
Reporting of these data elements is mandatory for service events provided by non-specialised mental health services. Reporting is not required for service contacts provided by specialised mental health services or service contacts provided by specialised mental health services from non-government organisations that receive state or territory government funding.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of usual residence (SA2)	Mandatory	1
-	Care type, derived	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Funding source for hospital patient	Mandatory	1
-	Group session indicator	Mandatory	1
-	Indigenous status	Mandatory	1
-	Local Hospital Network identifier	Mandatory	1
-	Non-admitted service type	Mandatory	1
-	Outpatient clinic type—non-admitted patient	Mandatory	1
-	Person identifier	Mandatory	1
-	Record identifier (80 character maximum)	Mandatory	1
-	Service delivery mode	Mandatory	1
-	Service delivery setting	Mandatory	1
-	Service event date	Mandatory	1
-	Service request received date	Mandatory	1
-	Service request source	Mandatory	1
-	Sex	Mandatory	1

Non-admitted patient care Local Hospital Network aggregate DSS 2014-15

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 557824

Registration status: Health, Standard 11/04/2014

DSS type: Data Set Specification (DSS)

Scope: The scope of the Non-admitted patient care Local Hospital Network aggregate data set specification (DSS) is non-admitted patient service events involving non-admitted patients provided by:

- **Local Hospital Networks**
- other public hospital services that are managed by a state or territory health authority and are included in the *General list of in-scope public hospital services*, which have been developed under the *National Health Reform Agreement (2011).*

Excluded from the DSS scope are non-admitted patient service events reported to the Non-admitted patient care hospital aggregate national minimum data set (NMDS).

Local Hospital Networks are defined as those entities recognised as such by the relevant state or territory health authority.

The DSS is intended to capture instances of service provision from the point of view of the patient.

For the purpose of this DSS, a non-admitted service is a specialty unit or organisational arrangement under which a Local Hospital Network provides non-admitted services.

The NMDS scope includes:

All arrangements made to deliver non-admitted patient service events (not covered by the national minimum data sets listed below) to non-admitted patients:

- irrespective of location (includes on-campus and off-campus),
- whose treatment has been funded through the Local Hospital Network, regardless of the source from which the Local Hospital Network derives these funds. In particular, Department of Veterans' Affairs, compensable and other patients funded through the hospital (including Medicare ineligible patients) are included; and
- regardless of setting or mode.

Excluded from the DSS scope are:

All services covered by:

- the Admitted patient care NMDS;
- the Admitted patient mental health care NMDS;
- the Non-admitted patient emergency department care NMDS, e.g. all non-admitted services provided to admitted patients are excluded;
- the Non-admitted patient care hospital aggregate NMDS;

and

- service events which deliver non-clinical care, e.g. activities such as home cleaning, meals on wheels or home maintenance.

Collection and usage attributes

Statistical unit: Non-admitted patient service event

Guide for use: A non-admitted patient service event is defined as an interaction between one or more health care provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record.

Counting rules:

1. All non-admitted services that meet the criteria of a non-admitted patient service event should be counted, and be counted only once regardless of the number of health care providers present.

2. Patients can be counted as having multiple non-admitted patient service events in one day, provided that every visit meets each of the criteria in the definition of a non-admitted patient service event.

3. Patient education services can be counted as non-admitted patient service events, provided that they meet the criteria included in the definition of a non-admitted patient service event.

4. Non-admitted services involving multiple health professionals are counted as one non-admitted patient service event.

5. Each patient attending a group session is counted as a non-admitted patient service event, providing that the session included the provision of therapeutic/clinical advice for each patient and that this was recorded using a dated entry in each patient's medical record. A group flag is included in the NMDS to record this type of service event.

6. Telephone and other telehealth consultations can be counted as service events if they substitute for a face to face consultation, provided that they meet all the criteria included in the definition of a non-admitted patient service event. A telephone/telehealth consultation is only counted as one non-admitted patient service event, irrespective of the number of health professionals or locations participating in the consultation.

7. Services provided to inpatients (including services provided by staff working in non-admitted services who visit admitted patients in wards, or other types of consultation and liaison services involving inpatients) are not counted as non-admitted patient service events.

8. Travel by a health professional is not counted as a non-admitted patient service event.

9. All non-admitted services that meet the criteria in the definition of non-admitted patient service events must be counted, irrespective of funding source (including Medicare Benefits Schedule) for the non-admitted service. A funding

source flag is included in the NMDS.

10. For activity based funding purposes, services from stand-alone diagnostic services are not counted as non-admitted patient service events; these are an integral part of the requesting clinic's non-admitted patient service event.

11. Renal dialysis, total parenteral nutrition and home enteral nutrition performed by the patient in their own home without the presence of a health care provider may be counted as a non-admitted patient service event, provided there is documentation of the procedures in the patient's medical record.

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Comments: *Interaction with the Non-admitted patient care hospital aggregate NMDS.*

The Non-admitted patient care hospital aggregate NMDS and Non-admitted patient care Local Hospital Network aggregate DSS work together to collect data on the public hospital system. The two data set specifications collect the same non-admitted activity data items, but at different levels of the system:

Hierarchical level	*Data collected through*
Public hospital	Non-admitted patient care hospital aggregate NMDS
Local Hospital Network	Non-admitted patient care Local Hospital Network aggregate DSS
Jurisdictional health authority	Non-admitted patient care Local Hospital Network aggregate DSS

It is intended that once the Non-admitted patient care Local Hospital Network aggregate DSS is established, the two collections will be merged into a single NMDS.

In the Non-admitted patient care Local Hospital Network aggregate DSS and the Non-admitted patient care hospital aggregate NMDS, the term 'establishment' is used to refer to entities reporting at each of the hierarchical levels (that is, public hospital, Local Hospital Network and jurisdictional health authority). Thus, for the purposes of this DSS, the term 'establishment' refers to a Local Hospital Network or a jurisdictional health authority unless specifically identified differently.

The principle should be applied that no activity is to be double-counted or included in both the Non-admitted patient care Local Hospital Network aggregate DSS and the Non-admitted patient care hospital aggregate NMDS.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Reference documents: Independent Hospital Pricing Authority 2014. Tier 2 Non-Admitted Services Compendium, Version 3.0. Independent

Hospital Pricing Authority, Sydney. Viewed 4 April 2014, http://ihpa.gov.au/internet/ihpa/publishing.nsf/Content/tier2-non-admitted-services-compendium-2014%E2%80%932015-html

Independent Hospital Pricing Authority 2014. Tier 2 Non-Admitted Services Definitions Manual, Version 3.0. Independent Hospital Pricing Authority, Sydney. Viewed 4 April 2014, http://ihpa.gov.au/internet/ihpa/publishing.nsf/Content/tier-2-non-admitted-services-definition-manual-2014%E2%80%9315-html

Relational attributes

Related metadata references:

Has been superseded by Non-admitted patient care Local Hospital Network aggregate DSS 2015-16 Health, Standardisation pending 30/10/2014

See also Non-admitted patient care hospital aggregate NMDS 2014-15 Health, Standard 11/04/2014

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Establishment identifier	Mandatory	1
-	Funding source for hospital patient	Mandatory	1
-	Local Hospital Network identifier	Mandatory	1
-	Non-admitted service type	Mandatory	1
-	Number of group session non-admitted patient service events	Mandatory	1
-	Number of group sessions	Mandatory	1
-	Number of individual session non-admitted patient service events	Mandatory	1

Non-admitted patient emergency department care DSS 2014-15

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 567462

Registration status: Health, Standard 11/04/2014

DSS type: Data Set Specification (DSS)

Scope: The scope of the Non-admitted patient emergency department care data set specification (NAPEDC DSS) is patients registered for care in emergency departments in public hospitals where the emergency department meets the following criteria:

- Purposely designed and equipped area with designated assessment, treatment and resuscitation areas.
- Ability to provide resuscitation, stabilisation and initial management of all emergencies.
- Availability of medical staff in the hospital 24 hours a day.
- Designated emergency department nursing staff 24 hours a day, 7 days a week, and a designated emergency department nursing unit manager.

Patients who were dead on arrival are in scope if an emergency department clinician certified the death of the patient. Patients who leave the emergency department after being triaged and then advised of alternative treatment options are in scope.

The scope includes only physical presentations to emergency departments. Advice provided by telephone or videoconferencing is not in scope, although it is recognised that advice received by telehealth may form part of the care provided to patients physically receiving care in the emergency department.

The care provided to patients in emergency departments is, in most instances, recognised as being provided to non-admitted patients. Patients being treated in emergency departments may subsequently become admitted (including admission to a short stay unit, admission to elsewhere in the emergency department, admission to another hospital ward, or admission to hospital-in-the-home). All patients remain in-scope for this collection until they are recorded as having physically departed the emergency department, regardless of whether they have been admitted. For this reason there is an overlap in the scope of this DSS and the Admitted patient care national minimum data set (APC NMDS).

Excluded from the scope of the DSS are:

- Care provided to patients in General Practitioner co-located units;
- Where only a clerical service is provided to people supporting a pre-arranged admission; and
- Where people are awaiting transit to another facility and receive no clinical care.

Collection and usage attributes

Statistical unit:

Emergency department stay

Guide for use:

The definition of a 'short stay unit' is as per clause C48 of the National Health Reform Agreement—National Partnership Agreement on Improving Public Hospital Services (NPA IPHS), as follows:

a) Designated and designed for the short term treatment, observation, assessment and reassessment of patients initially triaged and assessed in the emergency department (ED);

b) Have specific admission and discharge criteria and policies;

c) Designed for short term stays no longer than 24 hours;

d) Physically separated from the ED acute assessment area;

e) Have a static number of beds with oxygen, suction, patient ablution facilities; and

f) Not a temporary ED overflow area nor used to keep patients solely awaiting an inpatient bed nor awaiting treatment in the ED.

Collection methods:

National reporting arrangements

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on a quarterly basis within one month of the end of a reporting period and an annual basis within three months of the reporting period.

The Institute and the Commonwealth Department of Health will agree on a data quality and timeliness protocol. Once cleaned, a copy of the data and a record of the changes made will be forwarded by the Institute to the Commonwealth Department of Health. A copy of the cleaned data for each jurisdiction should also be returned to that jurisdiction on request.

Periods for which data are collected and nationally collated

Quarterly and financial year. Extraction of data for each quarter or year should be based on the date of the end of the emergency department stay. For example, a presentation that commences at 11pm on 30 June and ends at 2am 1 July is not in scope for the April to June quarter.

Implementation start date:

01/07/2014

Implementation end date:

30/06/2015

Comments:

Scope links with other metadata sets

Episodes of care for admitted patients are reported through the Admitted patient care NMDS.

National Health Reform Agreement—National Partnership Agreement on Improving Public Hospital Services

The scope for reporting against the National Emergency Access Target is all hospitals reporting to the NAPEDC NMDS (Peer groups A, B and other) as at August 2011 (when the Agreement was signed). For the duration of the Agreement, hospitals that have not previously reported to the NAPEDC NMDS can come into scope, subject to agreement between the jurisdiction and the Commonwealth.

Glossary items

Glossary terms that are relevant to this data set specification are included here.

Admission
Compensable patient
Emergency department
Registered nurse
Triage
Urgency related groups

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references: See also Non-admitted patient emergency department care NMDS 2014-15 Health, Standard 11/04/2014

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Area of usual residence (SA2)	Mandatory	1
-	Australian postcode (address)	Mandatory	1
-	Compensable status	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of triage	Conditional	1
-	Date patient presents—emergency department stay	Mandatory	1
-	Department of Veterans' Affairs patient	Mandatory	1
-	ED additional diagnosis code	Conditional	2
-	ED diagnosis classification type	Conditional	1
-	ED principal diagnosis code	Conditional	1
-	Emergency department arrival mode - transport	Mandatory	1
-	Emergency department clinical care commencement date	Conditional	1
-	Emergency department clinical care commencement time	Conditional	1
-	Emergency department episode end date	Mandatory	1
-	Emergency department episode end time	Mandatory	1
-	Emergency department physical departure date	Mandatory	1
-	Emergency department physical departure time	Mandatory	1
-	Emergency department waiting time to clinical care commencement	Conditional	1
-	Episode end status	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Indigenous status	Mandatory	1
-	Length of non-admitted patient emergency department service	Mandatory	1

	episode		
-	Person identifier	Mandatory	1
-	Record identifier (80 character maximum)	Mandatory	1
-	Sex	Mandatory	1
-	Time of triage	Conditional	1
-	Time patient presents	Mandatory	1
-	Triage category	Conditional	1
-	Type of visit to emergency department	Mandatory	1
-	Urgency related group major diagnostic block	Mandatory	1

Perinatal DSS 2014-15

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	510127
Registration status:	Health, Standard 07/03/2014
DSS type:	Data Set Specification (DSS)
Scope:	The scope of the Perinatal data set specification (DSS) is all births in Australia in hospitals, birth centres and the community. The data set includes information on all births, both **live births** and **stillbirths**, of at least 20 weeks gestation or 400 grams birth weight. These data have two dimensions, which are the baby and the mother. All data relevant to the birth are conveyed in relation to one of these.

Collection and usage attributes

Guide for use:	This data set specification is intended as an interim standard only. If jurisdictions are able to report the optional data elements from 1 July 2014 then they should do so. It is expected that some data elements will be included as mandatory data elements in future Perinatal national minimum data sets (NMDS).
Collection methods:	*National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare's National Perinatal Epidemiology and Statistics Unit for national collation, on an annual basis. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year.
Implementation start date:	01/07/2014
Implementation end date:	30/06/2015
Comments:	Glossary items Glossary terms that are relevant to this data set specification are included here: **Anaesthesia** **Analgesia** **Antenatal care visit** **Birthweight** **Geographic indicator** **Gestational diabetes mellitus** **Hospital-in-the-home care** **Hypertensive disorder during pregnancy** **Live birth** **Primary postpartum haemorrhage** **Registered nurse** **Separation** **Still birth (fetal death)**

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee
Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Has been superseded by Perinatal DSS 2015-16 Health, Standardisation pending 22/09/2014

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
999	Perinatal NMDS 2014-	Mandatory	1
-	Additional indications for caesarean section	Conditional	2
-	Blood transfusion for primary PPH	Conditional	1
-	Diabetes during pregnancy	Mandatory	1
-	Diabetes mellitus type during pregnancy	Conditional	1
-	Diabetes therapy type during pregnancy	Conditional	3
-	Height (measured)	Mandatory	1
-	Height (self-reported)	Conditional	1
-	Hypertension during pregnancy	Mandatory	1
-	Hypertension type during pregnancy	Conditional	3
-	Main indication for caesarean section	Conditional	1
-	PPH blood loss	Conditional	1
-	Primary postpartum haemorrhage indicator	Mandatory	1
-	Weight (self-reported)	Conditional	1
-	Weight in kilograms (measured)	Mandatory	1

Data element clusters

Chemotherapy for cancer cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	561228
Registration status:	Health, Standard 08/05/2014
DSS type:	Data Element Cluster
Scope:	Chemotherapy is cancer treatment that achieves its antitumour effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis. The chemotherapy cluster consists of those data elements recommended for collection as best practice when the patient is administered chemotherapy as part of the course of treatment for cancer. The chemotherapy cluster collects information on the chemotherapy agent or protocol, the number of cycles administered and the start and finish dates of treatment. Information on the agent and number of cycles of chemotherapy treatment is required to evaluate patterns of care, the effectiveness of different treatment modalities and treatment by patient outcome. Collecting the start and finish dates will enable an estimate of the duration of chemotherapy and the time interval from diagnosis to treatment. The use of standard definitions and formats supports the consistent collection and management of data and enables the integration of data from different sources. It provides a common language facilitating the interpretation and analysis of results, data linkage for statistical purposes, longitudinal studies and patient patterns of care and outcome studies. These results may then inform professional guidelines and training, quality assurance and the planning and evaluation of cancer control activities, potentially improving outcomes for patients.

Collection and usage attributes

Guide for use:	Capturing chemotherapy agents and cycles can be problematic. Chemotherapy agents are administered in treatment cycles, either singly or in a combination regimen or protocol of two or more chemotherapy drugs. Treatment may be administered prior to surgery or radiotherapy to reduce the tumour burden (neoadjuvant), concurrent with radiotherapy, following surgery or radiotherapy (adjuvant) or on its own. Regimens may be

complex involving many drugs given at different times during a course of treatment. In addition, if a patient has an adverse reaction, one of the agents in a combination regimen may be changed.

Furthermore, chemotherapy regimens are often expressed as acronyms identifying the agents used in combination. However, the letters used are not consistent across regimens, and in some cases (for example, "BEACOPP") the same letter is used to represent two different treatments. Finally, treatment protocols may be specific to the treatment centre.

Standard protocols are available online at eviQ Cancer Treatments Online (www.eviQ.org.au). This website is powered by the Cancer Institute NSW and endorsed by Cancer Australia, and provides current, evidence based, best practice cancer treatment protocols and information. It is recommended that only regimen or protocol names listed in eviQ be used to record chemotherapy agents; in all other cases, record the full generic name of each individual chemotherapy agent for each course of treatment.

Collection methods:

Chemotherapy agents and cycles are recorded for each course of chemotherapy administered during the course of treatment regardless of treatment intent or timing.

The data element *Healthcare provider – organisation identifier, N(16)* may be recorded for each treatment/cycle. It is recommended that, wherever possible, the database be configured to allow entry of different healthcare provider identifiers for each therapeutic mode/course of treatment/cycle.

The start date and completion date of chemotherapy are recorded once only for chemotherapy administered during the course of treatment.

This information should be collected from the patient's medical record.

Source and reference attributes

Submitting organisation:

Cancer Australia

Origin:

Australian Institute of Health and Welfare (AIHW) 2010. National health data dictionary. Version 15. National health data dictionary series. Cat. no. HWI 107. Canberra: AIHW

American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Standard Cancer Treatment and Management Pathways Program, Cancer Services and Education Division, eviQ Cancer Treatments Online. Cancer Institute NSW

Relational attributes

Related metadata references:

See also Cancer treatment—cancer treatment type, code N[N] Health, Standard 08/05/2014

Supersedes Chemotherapy for cancer cluster Health, Superseded 08/05/2014

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on patient receiving chemotherapy.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Chemotherapy completion date	Mandatory	1
-	Chemotherapy cycles administered	Mandatory	99
-	Chemotherapy start date	Mandatory	1
-	Systemic therapy agent or protocol	Mandatory	99
-	Systemic therapy agent or protocol, eviQ	Conditional	3

Elective surgery waiting times cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	545693
Registration status:	Health, Standard 11/04/2014
DSS type:	Data Element Cluster
Scope:	The scope of the Elective surgery waiting times data element cluster is patients on elective surgery waiting lists managed by public acute hospitals, in either category 1 or 2 of the 'Reason for removals from elective surgery waiting list' data element. This will include private patients treated in public hospitals, and may include public patients treated in private hospitals. Hospitals may also collect information for other care (as defined in the 'Waiting list category' data element), but this is not part of the national minimum data set (NMDS) for Elective surgery waiting times. Patients on waiting lists managed by hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included.

Collection and usage attributes

Guide for use:	Outsourced or contracted patients Public hospitals managing elective surgery waiting lists may either outsource elective surgery work to another hospital (public or private) or contract another hospital (public or private) to provide elective surgery on their behalf. In such cases, the hospital where the outsourced or contracted elective surgery occurs is required to include the '*Establishment – organisation identifier (Australian), NNX[X]NNNNN*' data element for the hospital managing the elective surgery waiting list as part of the Elective surgery waiting times data cluster.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Elective surgery waiting times cluster Health, Superseded 11/04/2014
Implementation in Data Set Specifications:	Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
This data element cluster is to be reported for patients on waiting lists for elective surgery, which are managed by public acute hospitals and have a category 1 or 2 assigned for the reason for removal from the elective surgery waiting list.

Admitted patient care NMDS 2015-16 Health, Standardisation pending 24/09/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

Conditional obligation:
This data element cluster is to be reported for patients on waiting lists for elective surgery, which are managed by public acute hospitals and have a category 1 or 2 assigned for the reason for removal from the elective surgery waiting list.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Clinical urgency	Mandatory	1
-	Establishment identifier	Conditional	1
-	Extended wait patient	Mandatory	1
-	Indicator procedure	Mandatory	1
-	Listing date for care	Mandatory	1
-	Overdue patient	Mandatory	1
-	Reason for removal from elective surgery waiting list	Mandatory	1
-	Surgical specialty	Mandatory	1
-	Waiting time at removal from elective surgery waiting list	Mandatory	1

Full-time equivalent staffing data element cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 552430

Registration status: Health, Standard 11/04/2014

DSS type: Data Element Cluster

Scope: These data elements are used in conjunction with each other to describe full-time equivalent staff in establishments.

Collection and usage attributes

Guide for use: The Full-time equivalent staffing data element cluster comprises two data elements that describe the number of full-time equivalent staff working within an establishment.

The Full-time equivalent staffing data element cluster describes the following information for an establishment:

Staffing category	Full-time equivalent staff
Administrative and clerical staff	N[NNN.{N}]
Diagnostic and health professionals	N[NNN.{N}]
Domestic and other staff	N[NNN.{N}]
Enrolled nurses	N[NNN.{N}]
Other personal care staff	N[NNN.{N}]
Registered nurses	N[NNN.{N}]
Specialist salaried medical officers (SMOs)	N[NNN.{N}]
Other salaried medical officers (SMOs)	N[NNN.{N}]
Student nurses	N[NNN.{N}]
Trainee/pupil nurses	N[NNN.{N}]

Relational attributes

Implementation in Data Set Specifications: Local Hospital Networks DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Public hospital establishments NMDS 2014-15 Health, Standard

11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Average number of full-time equivalent staff	Mandatory	10
-	Establishment staffing categories	Mandatory	10

Health professional graduate trainee cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 544932

Registration status: Health, Standard 07/03/2014

DSS type: Data Element Cluster

Scope: These data elements are used in conjunction with each other to describe the volume of health professional graduate trainees within an establishment.

For the purposes of this data element cluster, health professional graduate trainees include any person who has graduated from a course and gained a qualification to practice as a health professional in Australia, does not qualify as a new health professional graduate, and is commencing or undertaking postgraduate training in the health professional field.

Health professional graduate trainees may be employed by an establishment while undertaking clinical/professional education and training requirements for an accredited course.

For the purposes of this data element cluster, health professional graduate trainees include the following medical, dental, nursing, allied health and other diagnostic professions:

- Aboriginal and Torres Strait Islander health worker
- Audiology
- Chiropractic
- Dentistry
- Dietetics
- Exercise physiology
- Medicine
  - Any person undertaking medical vocational training in a recognised medical speciality training program accredited by the Australian Medical Council. These trainees are also known as registrars.
  - Registrars in hospitals or health services undertaking medical vocational training in non-accredited training positions.
  - Any person undertaking training for a certificate or diploma qualification from a specialist medical college accredited by the Australian Medical Council.
- Medical laboratory science
- Midwifery
- Nursing
- Occupational therapy
- Optometry
- Oral health
- Orthoptics

- Orthotics and prosthetics
- Osteopathy
- Paramedicine
- Pharmacy
- Physiotherapy
- Podiatry
- Psychology
- Radiation science
- Social work
- Sonography
- Speech pathology

Collection and usage attributes

Guide for use:

The Health professional graduate trainee cluster comprises three data elements that provide information on the total number of graduate trainee full time equivalents (FTEs) and the profession of those trainees. In the case of medical graduate trainees, the cluster also describes the medical specialty.

The Health professional graduate trainee cluster describes the following information for an establishment:

Profession	**Total number of FTEs**
Aboriginal and Torres Strait Islander health worker	N[NNN{.N}]
Audiology	N[NNN{.N}]
Chiropractic	N[NNN{.N}]
Dentistry	N[NNN{.N}]
Dietetics	N[NNN{.N}]
Exercise physiology	N[NNN{.N}]
Medicine	N[NNN{.N}]
• Addiction medicine	N[NNN{.N}]
• Anaesthesia	N[NNN{.N}]
• Dermatology	N[NNN{.N}]
• etc.	N[NNN{.N}]
Medical laboratory science	N[NNN{.N}]
Midwifery	N[NNN{.N}]
Nursing	N[NNN{.N}]

Occupational therapy	N[NNN{.N}]
Optometry	N[NNN{.N}]
Oral health	N[NNN{.N}]
Orthoptics	N[NNN{.N}]
Orthotics and prosthetics	N[NNN{.N}]
Osteopathy	N[NNN{.N}]
Paramedicine	N[NNN{.N}]
Pharmacy	N[NNN{.N}]
Physiotherapy	N[NNN{.N}]
Podiatry	N[NNN{.N}]
Psychology	N[NNN{.N}]
Radiation science	N[NNN{.N}]
Social work	N[NNN{.N}]
Sonography	N[NNN{.N}]
Speech pathology	N[NNN{.N}]

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references: Has been superseded by Health professional postgraduate and vocational trainee cluster Health, Standardisation pending 19/09/2014

Implementation in Data Set Specifications: Hospital teaching and training activities DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
The data elements in this data element cluster are only required to be reported for establishments able to collect data on health professional graduate trainees.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Number of health professional graduate trainees (FTE)	Mandatory	55
2	Qualified profession (health professional graduate trainee)	Mandatory	30
3	Medical speciality of medical graduate trainees	Mandatory	25

Hormone therapy for cancer cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	561324
Registration status:	Health, Standard 08/05/2014
DSS type:	Data Element Cluster
Scope:	Hormone therapy is cancer treatment that achieves its antitumour effect through changes in hormonal balance. It includes the administration of hormones, agents acting via hormonal mechanisms, antihormones and steroids. The hormone therapy cluster consists of those data elements recommended for collection as best practice when the patient is administered hormone therapy as part of the course of treatment for cancer. The hormone therapy cluster collects information on the hormone therapy agent or protocol and the start and finish dates of treatment. Information on the hormone therapy agent is required to evaluate patterns of care, the effectiveness of different treatment modalities and treatment by patient outcome. Collecting the start and finish dates will enable an estimate of the duration of hormone therapy and the time interval from diagnosis to treatment. The use of standard definitions and formats supports the consistent collection and management of data and enables the integration of data from different sources. It provides a common language facilitating the interpretation and analysis of results, data linkage for statistical purposes, longitudinal studies and patient patterns of care and outcome studies. These results may then inform professional guidelines and training, quality assurance and the planning and evaluation of cancer control activities, potentially improving outcomes for patients.

Collection and usage attributes

Guide for use:	Standard protocols are available online at eviQ Cancer Treatments Online (www.eviQ.org.au). This website is powered by the Cancer Institute NSW and endorsed by Cancer Australia, and provides current, evidence based, best practice cancer treatment protocols and information. It is recommended that only regimen or protocol names listed in eviQ be used to record hormone therapy agents; in all other cases, record the full generic name of each individual hormone therapy agent for each course of treatment.
Collection methods:	Hormone therapy agents are recorded for each course of hormone therapy administered during the course of treatment

regardless of treatment intent or timing.

The data element *Healthcare provider – organisation identifier, N(16)* may be recorded for each treatment/cycle. It is recommended that, wherever possible, the database be configured to allow entry of different healthcare provider identifiers for each therapeutic mode/course of treatment/cycle.

The start date and completion date of hormone therapy are recorded once only for hormone therapy administered during the course of treatment.

This information should be collected from the patient's medical record.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Australian Institute of Health and Welfare 2010. National health data dictionary. Version 15. National health data dictionary series. Cat. no. HWI 107. Canberra: AIHW

Standard Cancer Treatment and Management Pathways Program, Cancer Services and Education Division, eviQ Cancer Treatments Online. Cancer Institute NSW

Relational attributes

Related metadata references: See also Cancer treatment—cancer treatment type, code N[N] Health, Superseded 08/05/2014

See also Cancer treatment—cancer treatment type, code N[N] Health, Standard 08/05/2014

Supersedes Hormone therapy for cancer cluster Health, Superseded 08/05/2014

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on patient receiving hormone therapy.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Hormone therapy completion date	Mandatory	1
-	Hormone therapy start date	Mandatory	1
-	Systemic therapy agent or protocol	Mandatory	99
-	Systemic therapy agent or protocol, eviQ	Conditional	3

Immunotherapy for cancer cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	561356
Registration status:	Health, Standard 08/05/2014
DSS type:	Data Element Cluster
Scope:	Immunotherapy, also known as biological therapy, biotherapy or biological response modifier therapy, is cancer treatment that achieves its antitumour effect by altering the immune system or changing the host's response to the tumour cells. The immunotherapy cluster consists of those data elements recommended for collection as best practice when the patient is administered immunotherapy as part of the course of treatment for cancer. The immunotherapy cluster collects information on the immunotherapy agent or protocol and the start and finish dates of treatment. Information on the immunotherapy agent is required to evaluate patterns of care, the effectiveness of different treatment modalities and treatment by patient outcome. Collecting the start and finish dates will enable an estimate of the duration of immunotherapy and the time interval from diagnosis to treatment. The use of standard definitions and formats supports the consistent collection and management of data and enables the integration of data from different sources. It provides a common language facilitating the interpretation and analysis of results, data linkage for statistical purposes, longitudinal studies and patient patterns of care and outcome studies. These results may then inform professional guidelines and training, quality assurance and the planning and evaluation of cancer control activities; potentially improving outcomes for patients.

Collection and usage attributes

Guide for use:	Standard protocols are available online at eviQ Cancer Treatments Online (www.eviQ.org.au). This website is powered by the Cancer Institute NSW and endorsed by Cancer Australia, and provides current, evidence based, best practice cancer treatment protocols and information. It is recommended that only regimen or protocol names listed in eviQ be used to record immunotherapy agents; in all other cases, record the full generic name of each individual immunotherapy agent for each course of treatment.
Collection methods:	Immunotherapy agents and cycles are recorded for each course of immunotherapy administered during the course of treatment

regardless of treatment intent or timing.

The data element *Healthcare provider – organisation identifier, N(16)* may be recorded for each treatment/cycle. It is recommended that, wherever possible, the database be configured to allow entry of different healthcare provider identifiers for each therapeutic mode/course of treatment/cycle.

The start date and completion date of immunotherapy are recorded once only for immunotherapy administered during the course of treatment.

This information should be collected from the patient's medical record.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Australian Institute of Health and Welfare 2010. National health data dictionary. Version 15. National health data dictionary series. Cat. no. HWI 107. Canberra: AIHW

Standard Cancer Treatment and Management Pathways Program, Cancer Services and Education Division, eviQ Cancer Treatments Online. Cancer Institute NSW

Relational attributes

Related metadata references: See also Cancer treatment—cancer treatment type, code N[N] Health, Standard 08/05/2014

Supersedes Immunotherapy for cancer cluster Health, Superseded 08/05/2014

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on patient receiving immunotherapy.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Immunotherapy completion date	Mandatory	1
-	Immunotherapy start date	Mandatory	1
-	Systemic therapy agent or protocol	Conditional	99
-	Systemic therapy agent or protocol, eviQ	Conditional	3

New health professional graduate cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	544868
Registration status:	Health, Standard 07/03/2014
DSS type:	Data Element Cluster
Scope:	These data elements are used in conjunction with each other to describe the volume of new health professional graduates within an establishment. For the purposes of this data element cluster, new health professional graduates include any person who has graduated from a course and gained a qualification to practice as a health professional in Australia. Dental, nursing, allied health and other diagnostic profession graduates who are in an existing new graduate training program and in their first or second year post graduation are considered new graduates. Medical graduates that have graduated from a university medical school and are undertaking postgraduate prevocational medical training are considered new graduates. This first year is sometimes known as the intern year or postgraduate year one. Many junior doctors work for one or more years after their intern year to gain more experience. This is sometimes known as the postgraduate year two or postgraduate year three. New health professional graduates may be employed by an establishment while undertaking clinical/professional education and training requirements as part of a new graduate program. For the purposes of this data element cluster, new health professional graduates include the following medical, dental, nursing, allied health and other diagnostic professions: • Aboriginal and Torres Strait Islander health worker • Audiology • Chiropractic • Dentistry • Dietetics • Exercise physiology • Medicine • Medical laboratory science • Midwifery • Nursing • Occupational therapy • Optometry • Oral health • Orthoptics

- Orthotics and prosthetics
- Osteopathy
- Paramedicine
- Pharmacy
- Physiotherapy
- Podiatry
- Psychology
- Radiation science
- Social work
- Sonography
- Speech pathology

Collection and usage attributes

Guide for use:

The New health professional graduate cluster comprises two data elements that provide information on the total number of new graduate full-time equivalents (FTEs) and the profession of those students. In the case of new medical graduates, the cluster also describes the year of their postgraduate training.

The New health professional graduate cluster describes the following information for an establishment:

Profession	**Total number of FTEs**
Aboriginal and Torres Strait Islander health worker	N[NNN{.N}]
Audiology	N[NNN{.N}]
Chiropractic	N[NNN{.N}]
Dentistry	N[NNN{.N}]
Dietetics	N[NNN{.N}]
Exercise physiology	N[NNN{.N}]
Medicine	N[NNN{.N}]
Medical laboratory science	N[NNN{.N}]
Midwifery	N[NNN{.N}]
Nursing	N[NNN{.N}]
Occupational therapy	N[NNN{.N}]
Optometry	N[NNN{.N}]
Oral health	N[NNN{.N}]
Orthoptics	N[NNN{.N}]

Orthotics and prosthetics	N[NNN{.N}]
Osteopathy	N[NNN{.N}]
Paramedicine	N[NNN{.N}]
Pharmacy	N[NNN{.N}]
Physiotherapy	N[NNN{.N}]
Podiatry	N[NNN{.N}]
Psychology	N[NNN{.N}]
Radiation science	N[NNN{.N}]
Social work	N[NNN{.N}]
Sonography	N[NNN{.N}]
Speech pathology	N[NNN{.N}]

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references: Has been superseded by New health professional graduate cluster Health, Standardisation pending 18/09/2014

Implementation in Data Set Specifications: Hospital teaching and training activities DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
The data elements in this data element cluster are only required to be reported for establishments able to collect data on new health professional graduates.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Number of new health professional graduates (FTE)	Mandatory	33
2	Qualified profession (new health professional graduate)	Mandatory	33

Professional entry health professional student cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	544763
Registration status:	Health, Standard 07/03/2014
DSS type:	Data Element Cluster
Scope:	These data elements are used in conjunction with each other to describe the hours of clinical placement activity undertaken within an establishment by professional entry health professional students. For the purposes of this data element cluster, professional entry health professional students include any person commencing or undertaking a course in a higher education facility - including those offering Vocational Education Training (VET) - where the course is required for initial registration for, or qualification to, practice as a health professional in Australia. The course may be at a certificate, diploma, undergraduate, graduate-entry or postgraduate level. For the purposes of this data element cluster, professional entry health professional students include the following medical, dental, nursing, allied health and other diagnostic professions: • Aboriginal and Torres Strait Islander health worker • Audiology • Chiropractic • Dentistry • Dietetics • Exercise physiology • Medicine • Medical laboratory science • Midwifery • Nursing • Occupational therapy • Optometry • Oral health • Orthoptics • Orthotics and prosthetics • Osteopathy • Paramedicine • Pharmacy • Physiotherapy • Podiatry • Psychology • Radiation science • Social work • Sonography

- Speech pathology

Collection and usage attributes

Guide for use:

The Professional entry health professional student cluster comprises two data elements that provide information on the total number of student clinical placement hours and the qualifying profession of those students.

The Professional entry health professional student cluster describes the following information for an establishment:

Qualifying profession	**Total clinical placement hours**
Aboriginal and Torres Strait Islander health worker	N(7)
Audiology	N(7)
Chiropractic	N(7)
Dentistry	N(7)
Dietetics	N(7)
Exercise physiology	N(7)
Medicine	N(7)
Medical laboratory science	N(7)
Midwifery	N(7)
Nursing	N(7)
Occupational therapy	N(7)
Optometry	N(7)
Oral health	N(7)
Orthoptics	N(7)
Orthotics and prosthetics	N(7)
Osteopathy	N(7)
Paramedicine	N(7)
Pharmacy	N(7)
Physiotherapy	N(7)
Podiatry	N(7)

Psychology	N(7)
Radiation science	N(7)
Social work	N(7)
Sonography	N(7)
Speech pathology	N(7)

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references: Has been superseded by Professional entry health professional student cluster Health, Standardisation pending 19/09/2014

Implementation in Data Set Specifications: Hospital teaching and training activities DSS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
The data elements in this data element cluster are only required to be reported for establishments able to collect data on professional entry health professional students.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Clinical placement hours (students)	Mandatory	29
2	Intended profession (professional entry health professional student)	Mandatory	29

Radiotherapy for cancer cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	561380
Registration status:	Health, Standard 08/05/2014
DSS type:	Data Element Cluster
Scope:	The radiotherapy cluster consists of those data elements recommended for collection as best practice when the patient receives radiotherapy as part of the course of treatment for cancer. The radiotherapy cluster collects information on the radiotherapy type, dose, fractions, target site and the start and finish dates for each course of treatment. Information on the type, dose, fractions and target site of radiotherapy is required to evaluate patterns of care, the effectiveness of different treatment modalities and treatment by patient outcome. Collecting the start and finish dates will enable an estimate of the duration of radiotherapy and the time interval from diagnosis to treatment. The use of standard definitions and formats supports the consistent collection and management of data and enables the integration of data from different sources. It provides a common language facilitating the interpretation and analysis of results, data linkage for statistical purposes, longitudinal studies and patient patterns of care and outcome studies. These results may then inform professional guidelines and training, quality assurance and the planning and evaluation of cancer control activities, potentially improving outcomes for patients.

Collection and usage attributes

Guide for use:	Capturing the radiotherapy dose and fractions is problematic at some target sites, for example, head and neck cancers and breast cancers. In these cases, treatment is complex with the use of multiple treatment fields and the overall total dose may need to be determined manually by the radiation oncologist.
Collection methods:	The radiotherapy type, dose, fractions, target site and start and finish dates are recorded for each course of radiotherapy the patient received during the course of treatment for cancer regardless of treatment intent or timing. The data element *Healthcare provider – organisation identifier, N(16)* may be recorded for each treatment. It is recommended that, wherever possible, the database be configured to allow entry of different healthcare provider identifiers for each therapeutic course of treatment.

Information regarding radiotherapy will typically be found in the radiation oncologist's summary letter for the course of treatment

Determining the total dose, number of fractions and target site of radiotherapy may require assistance from the radiation oncologist for consistent coding.

Source and reference attributes

Submitting organisation: Cancer Australia

Relational attributes

Related metadata references: See also Cancer treatment—cancer treatment type, code N[N] Health, Standard 08/05/2014

Supersedes Radiotherapy for cancer cluster Health, Superseded 08/05/2014

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on the patient receiving radiotherapy.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Radiation dose administered	Mandatory	99
-	Radiotherapy completion date	Mandatory	99
-	Radiotherapy fractions administered	Mandatory	99
-	Radiotherapy start date—cancer treatment	Mandatory	99
-	Radiotherapy target site	Mandatory	99
-	Radiotherapy treatment type	Mandatory	99

Recurrent contracted care expenditure data element cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 552604

Registration status: Health, Standard 11/04/2014

DSS type: Data Element Cluster

Scope: These data elements are used in conjunction with each other to describe recurrent contracted care expenditure broken down by National Health Reform Agreement (2011) product streams in establishments.

Collection and usage attributes

Guide for use: All data reported in this cluster are estimated.

The Recurrent contracted care expenditure data element cluster comprises two data elements that describe recurrent contracted care expenditure by National Health Reform Agreement product streams by an establishment.

The Recurrent contracted care expenditure data element cluster describes the following information for an establishment:

Product stream	Total Australian dollars
Admitted acute	N(8)
Admitted subacute	N(8)
Other admitted	N(8)
Emergency care services	N(8)
Non-admitted (in scope for NHRA)	N(8)
Direct teaching, training and research	N(8)
Commonwealth funded aged care	N(8)
Other aged care	N(8)
Non-admitted (out of scope for NHRA)	N(8)
Other (out of scope for NHRA)	N(8)

Source and reference attributes

Submitting organisation: PHE NMDS Working Group

Relational attributes

Implementation in Data Set Specifications:

Local Hospital Networks DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Public hospital establishments NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Recurrent contracted care expenditure in Australian dollars	Mandatory	10
-	Recurrent contracted care expenditure product streams	Mandatory	10

Recurrent non-salary expenditure data element cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 552346

Registration status: Health, Standard 11/04/2014

DSS type: Data Element Cluster

Scope: These data elements are used in conjunction with each other to describe recurrent non-salary expenditure by establishments. These data elements exclude expenditure relating to salaries and wages.

Collection and usage attributes

Guide for use: The Recurrent non-salary expenditure data element cluster comprises three data elements that provide information on the categories of recurrent non-salary expenditure, the total amount of recurrent non-salary expenditure in Australian dollars and whether these data are estimated.

The Recurrent non-salary expenditure data element cluster describes the following information for an establishment:

Recurrent non-salary expenditure category	Total Australian Dollars	Estimated data indicator
Administrative expenses - insurance	N(8)	1. Yes 2. No
Administrative expenses - other	N(8)	1. Yes 2. No
Depreciation - building	N(8)	1. Yes 2. No
Depreciation - other	N(8)	1. Yes 2. No
Domestic services	N(8)	1. Yes 2. No
Interest payments	N(8)	1. Yes 2. No
Lease costs	N(8)	1. Yes 2. No
Patient transport costs	N(8)	1. Yes 2. No
Repairs and maintenance	N(8)	1. Yes

		2. No
Superannuation employer contributions	N(8)	1. Yes 2. No
Other on-costs	N(8)	1. Yes 2. No
Supplies - drug	N(8)	1. Yes 2. No
Supplies - food	N(8)	1. Yes 2. No
Supplies - medical and surgical	N(8)	1. Yes 2. No
Visiting medical officer payments	N(8)	1. Yes 2. No
Not elsewhere recorded	N(8)	1. Yes 2. No

The reported expenditure must be prepared using accrual basis of accounting as per the Australian Accounting Standards Board, Standard 101.

Relational attributes

Implementation in Data Set Specifications:

Local Hospital Networks DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Public hospital establishments NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Estimated data indicator	Mandatory	16
-	Recurrent non-salary expenditure total dollars	Mandatory	16
-	Recurrent non-salary public hospital expenditure categories	Mandatory	16

Recurrent salaries and wages expenditure data element cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 552475

Registration status: Health, Standard 11/04/2014

DSS type: Data Element Cluster

Scope: These data elements are used in conjunction with each other to describe expenditure on recurrent salaries and wages for staff in establishments.

Collection and usage attributes

Guide for use: The Recurrent salaries and wages expenditure data element cluster comprises three data elements that describe the expenditure on staff working within an establishment and whether the data are estimated.

The Recurrent salaries and wages expenditure data element cluster describes the following information for an establishment:

Staffing category	Total Australian dollars	Estimated data indicator
Administrative and clerical staff	N(8)	1. Yes 2. No
Diagnostic and health professionals	N(8)	1. Yes 2. No
Domestic and other staff	N(8)	1. Yes 2. No
Enrolled nurses	N(8)	1. Yes 2. No
Other personal care staff	N(8)	1. Yes 2. No
Registered nurses	N(8)	1. Yes 2. No
Specialist salaried medical officers (SMOs)	N(8)	1. Yes 2. No
Other salaried medical officers (SMOs)	N(8)	1. Yes 2. No

Student nurses	N(8)	1. Yes 2. No
Trainee/pupil nurses	N(8)	1. Yes 2. No

Generally, salary data by staffing categories should be broadly consistent with full-time equivalent staffing numbers. Where staff provide services to more than one hospital, their salaries should be apportioned between all hospitals to whom services are provided on the basis of hours worked in each hospital.

Salary payments for contract staff employed through an agency should be included under salaries for the appropriate staff category provided they are included in full-time equivalent staffing. If they are not, salary payments should be shown separately.

The reported expenditure must be prepared using accrual basis of accounting as per the Australian Accounting Standards Board, Standard 101.

Relational attributes

Implementation in Data Set Specifications:

Local Hospital Networks DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Public hospital establishments NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Establishment staffing categories	Mandatory	10
-	Estimated data indicator	Mandatory	10
-	Salaries and wages	Mandatory	10

Revenue data element cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 552502

Registration status: Health, Standard 11/04/2014

DSS type: Data Element Cluster

Scope: These data elements are used in conjunction with each other to describe the revenue received by establishments.

Collection and usage attributes

Guide for use: The Revenue data element cluster comprises three data elements that provide information on the categories of revenue received by establishments, the total amount of revenue and whether these data are estimated.

The Revenue data element cluster describes the following information for an establishment:

Revenue streams	**Total Australian dollars**	**Estimated data indicator**
Department of Veterans' Affairs	N(8)	1. Yes 2. No
Compensable schemes	N(8)	1. Yes 2. No
Other patient	N(8)	1. Yes 2. No
Commonwealth funding/subsidies	N(8)	1. Yes 2. No
State or territory health authority funding	N(8)	1. Yes 2. No
Other state or territory funding	N(8)	1. Yes 2. No
National Health Funding Pool - state or territory government component	N(8)	1. Yes 2. No
National Health Funding Pool - Commonwealth government	N(8)	1. Yes 2. No

component		
Infrastructure/facility fees	N(8)	1. Yes 2. No
Other recoveries	N(8)	1. Yes 2. No
Revenue not elsewhere reported	N(8)	1. Yes 2. No

The reported revenue must be prepared using accrual basis of accounting as per the Australian Accounting Standards Board, Standard 101.

Relational attributes

Implementation in Data Set Specifications:

Local Hospital Networks DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Public hospital establishments NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Estimated data indicator	Mandatory	11
-	Public hospital related revenue categories	Mandatory	11
-	Public hospital related revenue in Australian dollars	Mandatory	11

Surgery for cancer cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	561539
Registration status:	Health, Standard 08/05/2014
DSS type:	Data Element Cluster
Scope:	Cancer-directed surgery is surgery that destroys or modifies cancer tissue anywhere in the body and includes biopsies that remove the entire tumour and/or leave only microscopic margins. It may be palliative, (to control symptoms, alleviate pain, or make the patient more comfortable), or curative. The surgery treatment cluster consists of those data elements recommended for collection as best practice when cancer-directed surgery is performed as part of the course of treatment for cancer. The surgery treatment cluster collects information on the target sites of surgery, the procedure types and the date of each procedure. Information on target sites and procedures is required to evaluate patterns of care, the effectiveness of different treatment modalities and treatment by patient outcome. Collecting the procedure dates will enable an estimate of the time interval from diagnosis to treatment. The use of standard definitions and formats supports the consistent collection and management of data and enables the integration of data from different sources. It provides a common language facilitating the interpretation and analysis of results, data linkage for statistical purposes, longitudinal studies and patient patterns of care and outcome studies. These results may then inform professional guidelines and training, quality assurance and the planning and evaluation of cancer control activities, potentially improving outcomes for patients.

Collection and usage attributes

Collection methods:	All cancer-directed surgery performed during the course of treatment is recorded regardless of treatment intent or timing. The data element *Healthcare provider – organisation identifier, N(16)* may be recorded for each treatment. It is recommended that, wherever possible, the database be configured to allow entry of different healthcare provider identifiers for each therapeutic course of treatment. This information should be collected from the patient's medical record.

Source and reference attributes

Submitting organisation: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Relational attributes

Related metadata references: See also Cancer treatment—cancer treatment type, code N[N] Health, Standard 08/05/2014

Supersedes Surgery for cancer cluster Health, Superseded 08/05/2014

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on the patient receiving cancer-directed surgery.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Surgery target site	Mandatory	99
-	Surgical procedure date	Mandatory	99
-	Surgical procedure for cancer	Mandatory	99

Systemic therapy procedure for cancer cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	561601
Registration status:	Health, Standard 08/05/2014
DSS type:	Data Element Cluster
Scope:	Systemic therapy procedures refers to haematologic transplant and endocrine procedures. Haematologic transplants are bone marrow or stem cell transplants performed to protect patients from myelosuppression or bone marrow ablation associated with the administration of high-dose chemotherapy or radiotherapy. Endocrine therapy is cancer therapy that achieves its antitumour effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient (when the cancer occurs at another site) and, therefore, alter or affect the long-term control of the cancer's growth. The systemic therapy procedure cluster consists of those data elements recommended for collection as best practice when the patient receives a systemic therapy procedure as part of the course of treatment for cancer. The systemic therapy procedure cluster collects information on the systemic therapy procedure type and the dates of treatment. Information on the systemic procedure type is required to evaluate patterns of care, the effectiveness of different treatment modalities and treatment by patient outcome. Collecting the procedure dates will enable an estimate of the time interval from diagnosis to treatment. The use of standard definitions and formats supports the consistent collection and management of data and enables the integration of data from different sources. It provides a common language facilitating the interpretation and analysis of results, data linkage for statistical purposes, longitudinal studies and patient patterns of care and outcome studies. These results may then inform professional guidelines and training, quality assurance and the planning and evaluation of cancer control activities, potentially improving outcomes for patients.

Collection and usage attributes

Guide for use:	Systemic therapy procedures captures those infrequent instances whereby a medical, surgical, or radiation procedure is performed on a patient that has an effect on their hormonal or immunological balance. • Haematologic procedures, such as bone marrow transplants

or stem cell harvests, are typically used in conjunction with the administration of a systemic therapy agent(s), usually chemotherapy.

- Endocrine procedures, either radiological or surgical, may be administered in conjunction with systemic therapy agent(s), usually hormone therapy agents.
- As therapy during a course of treatment for cancer, haematologic procedures will rarely be administered in conjunction with endocrine radiation or surgery.

Collection methods:

Each systemic therapy procedure and procedure date delivered to the patient during the course of treatment for cancer should be recorded.

The data element *Healthcare provider—organisation identifier, N(16)* may be recorded for each treatment. It is recommended that, wherever possible, the database be configured to allow entry of different healthcare provider identifiers for each therapeutic course of treatment.

This information should be collected from the patient's medical record.

Source and reference attributes

Origin: Cancer Australia

Reference documents: American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Relational attributes

Related metadata references:

See also Cancer treatment—cancer treatment type, code N[N] Health, Standard 08/05/2014

Supersedes Systemic therapy procedure for cancer cluster Health, Superseded 08/05/2014

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Standard 08/05/2014

Conditional obligation:
Conditional on the patient receiving a systemic therapy procedure.

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Systemic therapy procedure	Mandatory	99
-	Systemic therapy procedure date	Mandatory	99

Total recurrent expenditure on National Health Reform Agreement product streams data element cluster

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 552494

Registration status: Health, Standard 11/04/2014

DSS type: Data Element Cluster

Scope: These data elements are used in conjunction with each other to describe total recurrent expenditure broken down by National Health Reform Agreement (2011) product streams in establishments.

Collection and usage attributes

Guide for use: All data reported in this cluster are estimated.

The Total recurrent expenditure on National Health Reform Agreement (NHRA) product streams data element cluster comprises two data elements that describe total recurrent expenditure by National Health Reform Agreement product streams by an establishment.

The Total recurrent expenditure on National Health Reform Agreement product streams data element cluster describes the following information for an establishment:

Product stream	Total Australian dollars
Admitted acute	N(8)
Admitted subacute	N(8)
Other admitted	N(8)
Emergency care services	N(8)
Non-admitted (in scope for NHRA)	N(8)
Direct teaching, training and research	N(8)
Commonwealth funded aged care	N(8)
Other aged care	N(8)
Non-admitted (out of scope for NHRA)	N(8)
Other (out of scope for NHRA)	N(8)

Source and reference attributes

Submitting organisation: PHE NMDS Working Group

Relational attributes

Implementation in Data Set Specifications: Local Hospital Networks DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Public hospital establishments NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Recurrent expenditure by NHRA product streams	Mandatory	10
-	Total recurrent expenditure in Australian dollars	Mandatory	10

Classification schemes

Impairment type code (AROC 2012)

Identifying and definitional attributes

Metadata item type:	Classification Scheme
METeOR identifier:	498498
Registration status:	Health, Standard 11/04/2014 Independent Hospital Pricing Authority, Standard 11/10/2012
Definition:	The Australasian Rehabilitation Outcomes Centre (AROC) code set describing the primary type of patient impairment in a rehabilitation episode.
Context:	The AROC impairment code set classifies the primary reason for a patient undergoing a rehabilitation episode of care.
Classification structure:	The code set contains the following high level impairment types: • Stroke • Brain dysfunction • Neurological conditions • Spinal cord dysfunction • Amputation of limb • Arthritis • Pain syndromes • Orthopaedic conditions • Cardiac • Pulmonary • Burns • Congenital deformities • Other disabling impairments • Major multiple trauma • Developmental disabilities • Re-conditioning/restorative Underneath each high level impairment type are a subset of codes providing more specific detail on the type of impairment. For example: Stroke • Haemorrhagic Left body involvement Right body involvement Bilateral involvement No paresis Other stroke • Ischaemic Left body involvement Right body involvement

Bilateral involvement
No paresis
Other stroke

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority
Origin:	Australasian Rehabilitation Outcomes Centre (AROC)
Reference documents:	AROC Impairment Codes, March 2012. Australasian Rehabilitation Outcomes Centre (AROC), University of Wollongong, Wollongong. Viewed 15 October 2012, http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@aroc/documents/doc/uow121224.pdf

Relational attributes

Related metadata references:	Supersedes Impairment type code (AROC 2007) Independent Hospital Pricing Authority, Superseded 11/10/2012
Value Domains based on this Classification Scheme:	Impairment type code (AROC 2012) NN.NNNN Health, Standard 11/04/2014 Independent Hospital Pricing Authority, Standard 11/10/2012

International Federation of Gynecology and Obstetrics cancer staging system

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	FIGO cancer staging system
METeOR identifier:	531364
Registration status:	Health, Standard 08/05/2014
Definition:	The International Federation of Gynecology and Obstetrics cancer staging system is an international system for coding gynaecological cancer, including cervical, endometrial, ovarian and vulval cancer. This system was developed by International Federation of Gynecology and Obstetrics (FIGO) in 1958, and most recently updated in 2009. The two purposes of this system are to allow for comparison of patient treatment and outcomes across both treatment centres and population groups, and to divide patients into prognostic groups.

Source and reference attributes

Submitting organisation:	Cancer Australia
Reference documents:	Mutch, D G 2009. The new FIGO staging system for cancers of the vulva, cervix, endometrium and sarcomas. Gynecologic Oncology 115:325–328. Viewed 12 July 2013, http://xa.yimg.com/kq/groups/20406181/1805956361/name/The+new+FIGO+staging+system.pdf

Relational attributes

Value Domains based on this Classification Scheme:	Cervical cancer staging (FIGO) code N[N] Health, Standard 08/05/2014 Endometrial cancer staging (FIGO) code N[N] Health, Standard 08/05/2014 Ovarian cancer staging (FIGO) code N[N] Health, Standard 08/05/2014

Tier 2 Non-Admitted Services classification (version 3.0)

Identifying and definitional attributes

Metadata item type:	Classification Scheme
METeOR identifier:	548185
Registration status:	Health, Standard 07/03/2014 Tasmanian Health, Final 02/07/2014
Definition:	A classification for non-admitted patient service events based on the type and specialty of the health care professional providing the service and the nature of the non-admitted service.
Context:	A list of outpatient clinics was developed in 1997-98 as an outcome of the Developmental Ambulatory Classification Study conducted by the National Hospital Cost Data Collection (NHCDC). During 2011, the list was updated to accommodate the increase in services that were previously provided to inpatients being undertaken as outpatient services. This also included a full review of the classification in response to the 2011 National Health Reform Agreement, which provided for the introduction of a national activity based funding (ABF) system. The aim was to develop a classification system for use with non-admitted services for ABF purposes. The classification was reviewed in 2012 and again in 2013 to ensure the classification's relevance and ability to meet the needs of the users.
Classification structure:	Tier 2 classes provide a consistent framework for counting non-admitted service events. They are based on an assessment of both the type and specialty of the health care professional providing the service and the nature of the service provided. This has resulted in a number of classes that is sufficient to ensure clinical meaningfulness and exclusivity across the spectrum of non-admitted services. The classes are also grouped into a number of categories that reflects the type of service provided and the health care professionals that typically provide the service. The classes are grouped into four categories, as follows: • Procedures • Medical consultation • Stand-alone diagnostic • Allied health/clinical nurse specialist intervention

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority
Origin:	Independent Hospital Pricing Authority, 2014. Tier 2 Outpatient Clinic Definitions (version 3.0). Independent Hospital Pricing Authority, Sydney. Viewed 30 April 2014, http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/non-admitted-care

Relational attributes

Related metadata references:	Supersedes Tier 2 Non-Admitted Services classification (version 2.0) Health, Superseded 07/03/2014, Independent Hospital Pricing Authority, Standard 31/10/2012 Has been superseded by Tier 2 Non-Admitted Services classification (version 4.0) Health, Standardisation pending 23/09/2014
Value Domains based on this Classification Scheme:	Non-admitted service type code (Tier 2 v3.0) NN.NN Health, Standard 07/03/2014 Tasmanian Health, Final 02/07/2014

Glossary items

Asbestos

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	525752
Registration status:	Health, Standard 08/05/2014
Definition:	Asbestos is the commercial product, obtained after mining and processing, of a family of fibrous hydrated silicates divided mineralogically into amphiboles (amosite, anthrophyllite and crocidolite) and serpentines (chrysotile). The inhalation of asbestos particles can cause asbestosis, pleural plaques, pleural fibrosis, pleural effusion, mesothelioma and lung cancer. Asbestos was widely used in Australia between 1945 and 1980. The characteristics that made asbestos popular were its strength, sound absorption, insulating properties and resistance to damage from heat and fire, electricity and chemicals. Asbestos mining ceased in 1983 and its use was phased out in 1989 and banned in 2004. Occupational exposure occurs in workers involved in mining asbestos or the production or use of asbestos products. For example, in occupations related to mining, plumbing, electrical or construction material. Occupational exposure may also extend secondarily to the family members of those in close contact with asbestos in the workplace. Asbestos exposure may occur in the home through, for example, exposure to housing construction material. Examples of products using asbestos: • fibro cement insulation • fireproofing pipes • paint • floor coverings • ceiling tiles • roofing materials • fire-smothering blankets • safety garments

Relational attributes

Metadata items which use this glossary item:	Asbestos exposure indicator Health, Standard 08/05/2014 Asbestos exposure setting Health, Standard 08/05/2014 Lung cancer (clinical) DSS Health, Standard 08/05/2014 Person—asbestos exposure indicator Health, Standard 08/05/2014

Person—asbestos exposure indicator, yes/no/unknown code N Health, Standard 08/05/2014

Person—asbestos exposure setting, code N Health, Standard 08/05/2014

Clinical placement

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	534723
Registration status:	Health, Standard 07/03/2014
Definition:	An activity that contributes to or counts towards clinical/professional education and training requirements for an accredited course. In other words, a clinical placement is an essential requirement that is necessary for successful course completion (and therefore would exclude voluntary extra placements). Clinical placements: • Occur in a clinical setting (i.e. generally outside the university educational setting, although may occur in university clinics). • May include a variety of activities (e.g. rotations, observations, selective placements) across all or some years of a particular course, depending upon the accredited course requirements. • Could potentially, in some cases, include a simulated component which meets the curriculum objectives of a clinical placement.

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority

Relational attributes

Metadata items which use this glossary item:	Establishment—student clinical placement hours Health, Standard 07/03/2014 Establishment—student clinical placement hours, total hours N(7) Health, Standard 07/03/2014 Hospital teaching and training activities DSS 2014-15 Health, Standard 07/03/2014 Hospital teaching, training and research activities DSS 2015-16 Health, Standardisation pending 18/09/2014

Clinical trial

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	522854
Registration status:	Health, Standard 08/05/2014
Definition:	A controlled experiment involving a defined set of subjects and having a clinical event as an outcome measure. It is intended to yield scientifically valid information about the efficacy or safety of a medical intervention such as, for example, a drug, surgical procedure or diagnostic test.

Relational attributes

Metadata items which use this glossary item:	Clinical trial entry status Health, Standard 08/05/2014 Clinical trial entry status code N Health, Standard 08/05/2014 Clinical trial identifier Health, Standard 08/05/2014 Date clinical trial entered Health, Standard 08/05/2014 Lung cancer (clinical) DSS Health, Standard 08/05/2014 Person with cancer—clinical trial entry status, code N Health, Standard 08/05/2014 Person with cancer—clinical trial identifier Health, Standard 08/05/2014 Person with cancer—clinical trial identifier, text X[X(399)] Health, Standard 08/05/2014 Person with cancer—date clinical trial entered Health, Standard 08/05/2014 Person with cancer—date clinical trial entered, DDMMYYYY Health, Standard 08/05/2014

Functional Independence Measure

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	FIM
METeOR identifier:	495857
Registration status:	Health, Standard 11/04/2014 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	An assessment of the severity of patient disability.
Context:	The Functional Independence Measure (FIM™) instrument is a basic indicator of patient disability. FIM™ is used to track the changes in the functional ability of a patient during an episode of hospital rehabilitation care.

Collection and usage attributes

Guide for use:

Patient function is assessed using the FIM™ instrument at the start of a rehabilitation episode of care and at the end of a rehabilitation episode of care. Admission assessment is collected within 72 hours of the start of a rehabilitation episode. Discharge assessment is collected within 72 hours prior to the end of a rehabilitation episode.

Comments:

FIM™ is comprised of 18 items, grouped into 2 subscales - motor and cognition.

The motor subscale includes:

- Eating
- Grooming
- Bathing
- Dressing, upper body
- Dressing, lower body
- Toileting
- Bladder management
- Bowel management
- Transfers - bed/chair/wheelchair
- Transfers - toilet
- Transfers - bath/shower
- Walk/wheelchair
- Stairs

The cognition subscale includes:

- Comprehension
- Expression
- Social interaction
- Problem solving
- Memory

Each item is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task associated with

that item.

1 - Total assistance with helper

2 - Maximal assistance with helper

3 - Moderate assistance with helper

4 - Minimal assistance with helper

5 - Supervision or setup with helper

6 - Modified independence with no helper

7 - Complete independence with no helper

The total score for the FIM motor subscale (the sum of the individual motor subscale items) will be a value between 13 and 91.

The total score for the FIM cognition subscale (the sum of the individual cognition subscale items) will be a value between 5 and 35.

The total score for the FIM instrument (the sum of the motor and cognition subscale scores) will be a value between 18 and 126.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Origin: FIM™ is a trademark of the Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities Incorporated.

Australasian Rehabilitation Outcomes Centre holds the territory license for the use of the FIM™ instrument in Australia.

Reference documents: Uniform Data System for Medical Rehabilitation. 2009. The FIM System® Clinical Guide, Version 5.2. Buffalo: UDSMR.

What is the FIM™ Instrument? Australasian Rehabilitation Outcomes Centre, University of Wollongong. Viewed 19 September 2012.
http://ahsri.uow.edu.au/aroc/whatisfim/index.html

Relational attributes

Metadata items which use this glossary item: Activity based funding: Admitted sub-acute and non-acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Standard 11/10/2012

Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014

Admitted subacute and non-acute hospital care DSS 2015-16 Health, Standardisation pending 25/09/2014

Episode of admitted patient care—clinical assessment score, code NN Independent Hospital Pricing Authority, Standard 30/10/2012

Gestational diabetes mellitus

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	527427
Registration status:	Health, Standard 07/03/2014
Definition:	Gestational diabetes mellitus (GDM) is a carbohydrate intolerance resulting in hyperglycaemia of variable severity with onset or first recognition during pregnancy. The definition applies irrespective of whether or not insulin is used for treatment or the condition persists after pregnancy.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee
Reference documents:	Nankervis A, McIntyre HD, Moses R, Ross GP, Callaway L, Porter C et al. 2013. Australasian Diabetes In Pregnancy Society (ADIPS) Consensus Guidelines for the Testing and Diagnosis of Gestational Diabetes Mellitus in Australia. Australasian Diabetes In Pregnancy Society (ADIPS).

Relational attributes

Metadata items which use this glossary item:	Female—diabetes mellitus during pregnancy indicator, yes/no/not stated/inadequately described code N Health, Standard 07/03/2014 Perinatal DSS 2014-15 Health, Standard 07/03/2014 Perinatal DSS 2015-16 Health, Standardisation pending 22/09/2014

Health of the Nation Outcome Scale 65+

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	HoNOS65+
METeOR identifier:	495880
Registration status:	Health, Standard 11/04/2014 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	An assessment of psychiatric symptoms and psychosocial functioning in an older patient.
Context:	Health of the Nation Outcome Scale 65+ (HoNOS65+) is a clinical assessment tool used by mental health professionals to evaluate psychiatric symptoms and psychosocial functioning in an older patient.

Collection and usage attributes

Guide for use:

HoNOS65+ is designed to be used by clinicians before and after interventions, so that changes attributable to interventions can be measured.

Comments:

Twelve scales are used to rate older mental health service users. The scales include:

- Behavioural disturbance
- Non-accidental self injury
- Problem drinking or drug use
- Cognitive problems
- Problems related to physical illness or disability
- Problems associated with hallucinations and delusions
- Problems associated with depressive symptoms
- Other mental and behavioural problems
- Problems with social or supportive relationships
- Problems with activities of daily living
- Overall problems with living conditions
- Problems with work and leisure activities and the quality of the day time environment

Together, the scales rate various aspects of mental and social health, each on a scale of 0 to 4.

0 - No problems within the period stated

1 - Minor problem requiring no action

2 - Mild problem but definitely present

3 - Moderately severe problem

4 - Severe to very severe problem

A HoNOS65+ total score (the sum of each individual scale item) will be a value between 0 and 48.

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority

Origin:	Copyright in the Health of the Nation Outcome Scales (HoNOS) is owned by the Royal College of Psychiatrists. Health of the Nation Outcome Scales (HoNOS) © Royal College of Psychiatrists 1996.
Reference documents:	The Royal College of Psychiatrists. 1996. HoNOS65+ (Older Adults). The Royal College of Psychiatrists, London. Viewed 19 September 2012, http://www.rcpsych.ac.uk/training/honos/olderadults.aspx

Relational attributes

Metadata items which use this glossary item:	Activity based funding: Admitted sub-acute and non-acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Standard 11/10/2012 Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014 Admitted subacute and non-acute hospital care DSS 2015-16 Health, Standardisation pending 25/09/2014 Episode of admitted patient care—clinical assessment score, code NN Independent Hospital Pricing Authority, Standard 30/10/2012

Hypertensive disorder during pregnancy

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	523104
Registration status:	Health, Standard 07/03/2014
Definition:	Hypertensive disorder during pregnancy includes pre-existing hypertensive disorders, hypertension arising in pregnancy and associated disorders such as eclampsia and preeclampsia. Hypertension in pregnancy is defined as: 1. Systolic blood pressure greater than or equal to 140 mmHg and/or 2. Diastolic blood pressure greater than or equal to 90 mmHg. Measurements should be confirmed by repeated readings over several hours. Elevations of both systolic and diastolic blood pressures have been associated with adverse fetal outcome and therefore both are important. Disorders associated with hypertension such as eclampsia and preeclampsia are further characterised by symptoms such as proteinuria, oedema or high body temperature. There are several reasons to support the blood pressure readings defined above as diagnostic of hypertension in pregnancy: • Perinatal mortality rises with diastolic blood pressures above 90 mmHg • Readings above this level were beyond two standard deviations of mean blood pressure in a New Zealand cohort of normal pregnant women • The chosen levels are consistent with international guidelines and correspond with the current diagnosis of hypertension outside of pregnancy. This definition of hypertensive disorder in pregnancy from the Society of Obstetric Medicine in Australia and New Zealand (SOMANZ) aligns with the definition of the International Society for the Study of Hypertension in Pregnancy (ISSHP).

Source and reference attributes

Reference documents:	Lowe S, Brown M, Dekker G, Gatt S, McLintock C, McMahon L et al 2008. Guidelines for the Management of Hypertensive Disorders of Pregnancy. Society of Obstetric Medicine of Australia and New Zealand (SOMANZ) Brown M, Lindheimer M, Swiet M, Assche A and Moutquin J-M 2001. The classification and diagnosis of the hypertensive disorders of pregnancy: statement from the International Society for the Study of Hypertension in Pregnancy (ISSHP). Hypertension in pregnancy 20(1), ix-xiv.

Relational attributes

Metadata items which use this glossary item:	Female—hypertensive disorder during pregnancy indicator Health, Standard 07/03/2014

Female—hypertensive disorder during pregnancy indicator, yes/no/not stated/inadequately described code N Health, Standard 07/03/2014

Female—type of hypertensive disorder during pregnancy Health, Standard 07/03/2014

Female—type of hypertensive disorder during pregnancy, code N Health, Standard 07/03/2014

Hypertensive disorder during pregnancy indicator Health, Standard 07/03/2014

Perinatal DSS 2014-15 Health, Standard 07/03/2014

Perinatal DSS 2015-16 Health, Standardisation pending 22/09/2014

Type of hypertensive disorder during pregnancy Health, Standard 07/03/2014

Type of hypertensive disorder during pregnancy code N Health, Standard 07/03/2014

Immunohistochemistry

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	523027
Registration status:	Health, Standard 08/05/2014
Definition:	Immunohistochemistry is a technique used in the evaluation of pathology specimens to analyse and identify cell types based on the binding of antibodies to specific components (antigens) of the cell. The antigens are demonstrated in tissues by the use of markers that are either fluorescent dyes or enzymes such as horseradish peroxide. Immunohistochemistry may be useful, for example, to distinguish between primary and metastatic tumours, identify where the tumour originated if the primary is unknown, and help reach a diagnosis when there is limited biopsy material available for morphological assessment.

Relational attributes

Metadata items which use this glossary item:	Immunohistochemistry type Health, Standard 08/05/2014 Lung cancer (clinical) DSS Health, Standard 08/05/2014 Person with cancer—immunohistochemistry type Health, Standard 08/05/2014 Person with cancer—immunohistochemistry type, text X[X(49)] Health, Standard 08/05/2014 Person with cancer—lung cancer immunohistochemistry type, code N[N] Health, Standard 08/05/2014

Macroscopic

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	545389
Registration status:	Health, Standard 08/05/2014
Definition:	Large enough to be seen with the naked eye. For example, a macroscopic tumour is able to be seen without the aid of a microscope.

Source and reference attributes

Submitting organisation:	Cancer Australia
Origin:	Oxford 2012. Concise Medical Dictionary 8th Edition. Oxford: Oxford University Press.

Relational attributes

Metadata items which use this glossary item:	Person with cancer—tumour outside primary site indicator Health, Standard 08/05/2014 Person with cancer—tumour size outside primary site Health, Standard 08/05/2014 Person with cancer—tumour size outside primary site, code N Health, Standard 08/05/2014 Tumour outside primary site indicator Health, Standard 08/05/2014

Medical imaging

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	525782
Registration status:	Health, Standard 08/05/2014
Definition:	The production of visual representations of body parts, tissues, or organs, for use in clinical diagnosis. Computed tomography (CT), magnetic resonance imaging (MRI) and ultrasounds are examples of medical imaging techniques.

Relational attributes

Metadata items which use this glossary item:	Diagnostic imaging type Health, Standard 08/05/2014 Lung cancer (clinical) DSS Health, Standard 08/05/2014 Person—diagnostic imaging type, lung cancer code N[N] Health, Standard 08/05/2014

Mental health carer

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	515278
Registration status:	Health, Standard 07/03/2014
Definition:	A person who has a caring role for a person with a mental health problem or mental illness. They could be family, friends or staff and be paid or unpaid. The role of the carer is not necessarily static or permanent, and may vary over time according to the needs of the consumer and carer.

Source and reference attributes

Origin:	Australian Health Ministers 2009. Fourth national mental health plan: an agenda for collaborative government action in mental health 2009–2014. Commonwealth of Australia, 84.

Relational attributes

Metadata items which use this glossary item:	Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014 Mental health establishments NMDS 2015-16 Health, Standardisation pending 23/09/2014 Specialised mental health service organisation—carer representation arrangements indicator Health, Standard 07/03/2014 Specialised mental health service organisation—carer representation arrangements indicator, code N Health, Standard 07/03/2014 Specialised mental health service organisation—use of formal complaints mechanism for carer participation arrangements indicator Health, Standard 07/03/2014 Specialised mental health service organisation—use of formal complaints mechanism for carer participation arrangements indicator Health, Standardisation pending 23/09/2014 Specialised mental health service organisation—use of formal complaints mechanism for carer participation arrangements indicator, code N Health, Standard 07/03/2014 Specialised mental health service organisation—use of formal complaints mechanism for carer participation arrangements indicator, code N Health, Standardisation pending 23/09/2014 Specialised mental health service organisation—use of formal participation policy for carer participation arrangements indicator Health, Standard 07/03/2014 Specialised mental health service organisation—use of formal participation policy for carer participation arrangements indicator, code N Health, Standard 07/03/2014 Specialised mental health service organisation—use of regular carer experience surveys for carer participation arrangements indicator Health, Standard 07/03/2014

Specialised mental health service organisation—use of regular carer experience surveys for carer participation arrangements indicator, code N Health, Standard 07/03/2014

Specialised mental health service organisation—use of regular discussion groups for carer participation arrangements indicator Health, Standard 07/03/2014

Specialised mental health service organisation—use of regular discussion groups for carer participation arrangements indicator, code N Health, Standard 07/03/2014

Mental health consumer

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	515275
Registration status:	Health, Standard 07/03/2014
Definition:	A person who uses or has used a mental health service.
Context:	Mental health care.

Source and reference attributes

Origin:	Australian Health Ministers 2009. Fourth national mental health plan: an agenda for collaborative government action in mental health 2009–2014. Commonwealth of Australia, 84.

Relational attributes

Metadata items which use this glossary item:	Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014 Mental health establishments NMDS 2015-16 Health, Standardisation pending 23/09/2014 Mental health restraint events cluster Health, Standardisation pending 22/09/2014 Mental health seclusion and restraint DSS 2015- Health, Standardisation pending 22/09/2014 Specialised mental health service organisation—consumer representation arrangements indicator Health, Standard 07/03/2014 Specialised mental health service organisation—consumer representation arrangements indicator, code N Health, Standard 07/03/2014 Specialised mental health service organisation—use of formal complaints mechanism for consumer participation arrangements indicator Health, Standardisation pending 23/09/2014 Specialised mental health service organisation—use of formal complaints mechanism for consumer participation arrangements indicator Health, Standard 07/03/2014 Specialised mental health service organisation—use of formal complaints mechanism for consumer participation arrangements indicator, code N Health, Standard 07/03/2014 Specialised mental health service organisation—use of formal complaints mechanism for consumer participation arrangements indicator, code N Health, Standardisation pending 23/09/2014 Specialised mental health service organisation—use of formal participation policy for consumer participation arrangements indicator Health, Standard 07/03/2014 Specialised mental health service organisation—use of formal participation policy for consumer participation arrangements indicator, code N Health, Standard 07/03/2014 Specialised mental health service organisation—use of regular

consumer experience surveys for consumer participation arrangements indicator Health, Standard 07/03/2014

Specialised mental health service organisation—use of regular consumer experience surveys for consumer participation arrangements indicator, code N Health, Standard 07/03/2014

Specialised mental health service organisation—use of regular discussion groups for consumer participation arrangements indicator Health, Standard 07/03/2014

Specialised mental health service organisation—use of regular discussion groups for consumer participation arrangements indicator, code N Health, Standard 07/03/2014

Specialised mental health service—seclusion duration Health, Standardisation pending 22/09/2014

Specialised mental health service—seclusion duration, total hours NNNNN Health, Standardisation pending 22/09/2014

Specialised mental health service—type of restraint event Health, Standardisation pending 22/09/2014

Specialised mental health service—type of restraint event, code N Health, Standardisation pending 22/09/2014

Molecular pathology

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	523059
Registration status:	Health, Standard 08/05/2014
Definition:	Molecular pathology is the study and diagnosis of disease through the examination of genetic and molecular abnormalities. It endeavours to explain why a given genetic change results in particular clinical phenotype. Molecular pathology testing is performed on a patient's tissue sample and includes techniques such as, for example, oligonucleotide array sequence analysis of gene expression patterns in disease states and the detection of mutations with polymerase chain reaction.

Relational attributes

Metadata items which use this glossary item:	Lung cancer (clinical) DSS Health, Standard 08/05/2014 Lung cancer molecular pathology test results code N[N] Health, Standard 08/05/2014 Molecular pathology indicator Health, Standard 08/05/2014 Molecular pathology test date Health, Standard 08/05/2014 Molecular pathology test results Health, Standard 08/05/2014 Person with cancer—lung cancer molecular pathology test results, code N[N] Health, Standard 08/05/2014 Person with cancer—molecular pathology indicator Health, Standard 08/05/2014 Person with cancer—molecular pathology indicator, yes/no/unknown code N Health, Standard 08/05/2014 Person with cancer—molecular pathology test date, DDMMYYYY Health, Standard 08/05/2014 Person with cancer—molecular pathology test results, (other) code X[X(19)] Health, Standard 08/05/2014

National Partnership Agreement on Improving Public Hospital Services: National Elective Surgery Target (NEST) - Calculating overdue patients with the longest waits

Identifying and definitional attributes

Metadata item type: Glossary Item

Synonymous names: National Elective Surgery Target (NEST) tail

METeOR identifier: 481100

Registration status: Health, Standard 21/11/2013

Definition: Calculating the 'tail' (the 10% of overdue patients who have waited the longest)

The 'tail' is the list of patients who meet the criteria at National Health Reform Agreement—National Partnership Agreement on Improving Public Hospital Services (NPA IPHS), Clause A26(c).

As per the NPA IPHS, the baseline for calculating the 'tail' will be 10% of overdue patients who have waited the longest as at 31 December prior to the reporting year. The 'tail' is 10% plus ties, meaning all patients due on that day get included, not necessarily just 10% of patients. The Commonwealth and jurisdictions should agree on the list of patients in the 'tail' by 28 February of the reporting year. As per the NPA IPHS, the 'tail' will be calculated from unit level data provided by the jurisdictions, enabling the Commonwealth to uniquely identify patients and verify performance in the subsequent year.

The 10% of overdue patients who have waited the longest are the 10% of 'ready for care' patients in each jurisdiction, in each category who have been waiting more than: Category 1 = 30 days; Category 2 = 90 days; Category 3 = 365 days.

For each category:

1. Identify all patients overdue as at 31 December, then calculate the 10% of these numbers rounded up to a whole number.
2. List all overdue patients by number of days past overdue date.
3. Working from the longest 'overdue' case, work back up the list to the 10th percentile case.
4. Include all the cases up to this point in the 'tail', including all patients equal to or more overdue than the 10th percentile case.

For further explanation, see the example below:

Explanation of 10% 'tail' calculation across categories

Overdue patients are those who have waited more than Category 1: 30 days, Category 2: 90 days, or Category 3: 365 days for surgery. For example, the spread across categories may be:

	Category 1	Category 2	Category 3
Number overdue	0	154	300
Number of overdue in bottom 10%	0	15.4	30

How to calculate 'ties':

The 'tail' needs to be calculated separately for each category. Where 10% does not equate to a whole number, the total should always be rounded up.

In the example above, Category 2 includes 15.4 patients, which is rounded to 16. To calculate ties, the jurisdiction must determine how long the 16th patient has been waiting, and then include all other patients who have been waiting the same number of days.

	Days overdue	Patient number	
	159	1 *	Longest overdue patient
	158	2	
	:	:	
10% of longest -waiting overdue patients	133	14	
	131	15	
	129	16	
Cut-off for the 'tail' = 10% plus ties	129	17 **	These three patients all have the same wait time as patient number 16. Therefore they are the 'ties' and they will also be included in the 'tail', to receive treatment in the following year.
	129	18 **	
	129	19 **	
	122	20	
	120	21	
	:	:	

Notes:

* Indicates the longest overdue patient

** These three patients all have the same wait time as patient number 16. Therefore they are the 'ties' and they will also be included in the 'tail', to receive treatment in the following year.

As this example demonstrates, including the 'ties' will increase the number of category 2 patients in the 'tail'. In this case, the 'tail' will be extended to include 19 patients.

This process should be followed for each category, to determine the number of 'ties' in each category that need to be added to the 'tail'.

Scope

All hospitals reporting to the Elective Surgery Waiting List Reduction Plan. Subject to agreement between the jurisdiction and the Commonwealth, hospitals can come into the scheme that have existing waiting lists that have not previously been reported. If facilities are to be added, they should be added to reporting figures only from 31 December. To be eligible to be in scope, a jurisdiction must submit both removals and census data for each hospital.

Patient on more than one waiting list

This is an issue only in cases where a particular patient is in the 'tail' for more than one waiting list for the same procedure. The jurisdictions have agreed that patients should not appear on more than one waiting list; if this occurs, jurisdictions will identify any such instances.

Changing urgency categories

For the purposes of the NPA IPHS NEST tail: once identified in the 'tail', subsequent changes to urgency category are not relevant and the patient must be treated in the relevant year.

'Not ready for care' patients

'Not ready for care' patients are not counted in the 'tail' calculations, as patients not ready for care will not be on the waiting list when the 'tail' is calculated. If a patient is classified as 'not ready for care' subsequent to inclusion in the 'tail', jurisdictions are advised to manage early.

Palliative care

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	522938
Registration status:	Health, Standard 08/05/2014
Definition:	Palliative care is defined as the active total care of patients whose disease is not responsive to curative treatment. The control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. The point of transition to palliative care is when treatment goals become focussed on improving quality of life. However, the transition does not imply a discontinuation of active care or abandonment from the treating cancer team. Palliative care may be administered in a community setting, for example, the patient's home or a nursing home, in the palliative care unit of an acute hospital, or a hospice.

Relational attributes

Metadata items which use this glossary item:	Lung cancer (clinical) DSS Health, Standard 08/05/2014 Person with cancer—date of referral to palliative care services, DDMMYYYY Health, Standard 08/05/2014 Person with cancer—referral to palliative care services indicator Health, Standard 08/05/2014 Person with cancer—referral to palliative care services indicator, yes/no/unknown code N Health, Standard 08/05/2014 Referral to palliative care services indicator Health, Standard 08/05/2014

Palliative care phase

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	497358
Registration status:	Health, Standard 11/04/2014 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	The stage of a patient's illness. The palliative care phase refers to a distinct clinical period which reflects the stage of the patient's illness. Palliative care phase provides a good indication of the type of care required by a palliative care patient. An episode of admitted patient palliative care may comprise of a single phase or multiple phases, depending on changes in the patient's condition. Phases are not sequential and a patient may move back and forth between phases within the one episode of admitted patient palliative care. The palliative care phases are stable, unstable, deteriorating, terminal and bereavement.
Context:	Palliative care phase is a common assessment measure recorded for episodes of admitted patient palliative care. Palliative care is care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family.

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority
Reference documents:	Palliative Care Outcomes Collaboration Assessment Toolkit. Palliative Care Outcomes Collaboration, University of Wollongong, Wollongong. Viewed 19 September 2012, http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow129133.pdf

Relational attributes

Metadata items which use this glossary item:	Activity based funding: Admitted sub-acute and non-acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Standard 11/10/2012 Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014 Admitted subacute and non-acute hospital care DSS 2015-16 Health, Standardisation pending 25/09/2014 Episode of admitted patient care—palliative care phase Health, Standard 11/04/2014 Independent Hospital Pricing Authority, Standard 30/10/2012 Episode of admitted patient care—palliative care phase, code N Health, Standard 11/04/2014 Independent Hospital Pricing Authority, Standard 31/10/2012

Episode of admitted patient care—palliative phase of care end date, DDMMYYYY Health, Standard 11/04/2014
Independent Hospital Pricing Authority, Standard 31/10/2012

Episode of admitted patient care—palliative phase of care start date Health, Standard 11/04/2014
Independent Hospital Pricing Authority, Standard 31/10/2012

Episode of admitted patient care—palliative phase of care start date, DDMMYYYY Health, Standard 11/04/2014
Independent Hospital Pricing Authority, Standard 31/10/2012

Primary postpartum haemorrhage

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	524114
Registration status:	Health, Standard 07/03/2014
Definition:	Primary postpartum haemorrhage, a form of obstetric haemorrhage, is excessive bleeding from the genital tract after childbirth, occurring within 24 hours of birth. A blood loss of 500mls is the usual minimum amount for identification of postpartum haemorrhage however a woman's haemodynamic instability is also taken into account, meaning that a smaller blood loss may be significant in a severely compromised woman. A loss of 1,000mls or more is considered major or severe although definitions of severity vary. Secondary postpartum haemorrhage is excessive bleeding from the genital tract after childbirth occurring between 24 hours and 6 weeks postpartum.

Source and reference attributes

Reference documents:	Medforth J, Battersby S & Evans M 2011. Oxford Handbook of Midwifery. Oxford: Oxford University Press. Queensland Maternity and Neonatal Clinical Guidelines Program 2009. Queensland maternity and neonatal clinical guideline: primary postpartum haemorrhage. Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) 2011. Management of postpartum haemorrhage (PPH): College statement C-Obs 43 Royal College of Obstetricians and Gynaecologists (RCOG) 2009. Prevention and management of postpartum haemorrhage: Green-top guideline no. 52.

Relational attributes

Metadata items which use this glossary item:	Female—blood transfusion due to primary postpartum haemorrhage indicator Health, Standard 07/03/2014 Female—blood transfusion due to primary postpartum haemorrhage indicator, yes/no/not stated/inadequately described code N Health, Standard 07/03/2014 Female—estimated blood loss indicating primary postpartum haemorrhage Health, Standard 07/03/2014 Female—estimated blood loss indicating primary postpartum haemorrhage, estimated blood loss volume category, code N Health, Standard 07/03/2014 Female—primary postpartum haemorrhage indicator Health, Standard 07/03/2014 Female—primary postpartum haemorrhage indicator, yes/no/not stated/inadequately described code N Health, Standard 07/03/2014 Perinatal DSS 2014-15 Health, Standard 07/03/2014

Perinatal DSS 2015-16 Health, Standardisation pending 22/09/2014

Primary postpartum haemorrhage indicator Health, Standard 07/03/2014

Psychosocial services

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	522999
Registration status:	Health, Standard 08/05/2014
Definition:	Psychosocial services are those services which aim to address the ongoing psychological and social needs of individuals. Within the health system services are generally provided to individuals with a disease or disorder, and/or their partners, families or caregivers. Examples of psychosocial services include: • Individual or group based education relating to psychological and social needs • The provision of individual or group based counselling • Individual peer support or involvement in support groups • Spiritual support (such as pastoral care) • Other community services (such as domiciliary care)

Relational attributes

Metadata items which use this glossary item:	Date of referral to psychosocial services Health, Standard 08/05/2014 Lung cancer (clinical) DSS Health, Standard 08/05/2014 Person with cancer—date of referral to psychosocial services, DDMMYYYY Health, Standard 08/05/2014 Person with cancer—referral to psychosocial services indicator, yes/no/unknown code N Health, Standard 08/05/2014

Resident

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	524972
Registration status:	Health, Standard 07/03/2014 Indigenous, Endorsed 16/09/2014
Definition:	A person who receives residential care intended to be for a minimum of one night.
Context:	Specialised mental health services (Residential mental health care).

Collection and usage attributes

Comments:	A resident in one residential mental health service can be concurrently a resident in a second residential mental health service if there is an intention to return to the original service and the absent period is recorded as *leave days*. A resident in a residential mental health service can be concurrently a patient admitted to a hospital.

Relational attributes

Related metadata references:	Supersedes Resident Health, Superseded 07/03/2014
Metadata items which use this glossary item:	Activity based funding: Mental health care DSS 2015-16 Health, Standardisation pending 30/09/2014 Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014 Admitted patient care NMDS 2015-16 Health, Standardisation pending 24/09/2014 Admitted patient mental health care NMDS 2014-15 Health, Standardisation pending 18/07/2014 Community mental health care NMDS 2014-15 Health, Standard 07/03/2014 Community mental health care NMDS 2015-16 Health, Standardisation pending 22/09/2014 Episode of care—mental health legal status, code N Health, Standard 07/03/2014 Episode of care—number of psychiatric care days Health, Standard 11/04/2014 Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 11/04/2014 Episode of residential care Health, Standard 07/03/2014 Indigenous, Endorsed 16/09/2014 Episode of residential care—episode end date Health, Standard 07/03/2014 Episode of residential care—episode end date, DDMMYYYY Health, Standard 07/03/2014 Episode of residential care—episode start date Health, Standard 07/03/2014

Episode of residential care—episode start date, DDMMYYYY Health, Standard 07/03/2014

Episode of residential care—mental health care referral destination Health, Standard 07/03/2014

Episode of residential care—mental health care referral destination, code N Health, Standardisation pending 22/09/2014

Episode of residential care—mental health care referral destination, code N Health, Standard 07/03/2014

Episode of residential care—number of leave days, total N[NN] Health, Standard 07/03/2014

Government health expenditure NMDS 2014- Health, Standardisation pending 18/07/2014

Health or health related-function code NNN Health, Standardisation pending 18/07/2014

Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Mental health establishments NMDS 2015-16 Health, Standardisation pending 23/09/2014

Mental health non-government organisation establishments DSS 2015- Health, Standardisation pending 19/09/2014

Residential mental health care NMDS 2014-15 Health, Standard 07/03/2014

Residential mental health care NMDS 2015-16 Health, Standardisation pending 22/09/2014

Residential stay—episode start date Health, Standard 07/03/2014

Residential stay—episode start date, DDMMYYYY Health, Standard 07/03/2014

Resource Utilisation Groups - Activities of Daily Living

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	RUG-ADL
METeOR identifier:	495909
Registration status:	Health, Standard 04/04/2014 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	An assessment of patient motor function.
Context:	The Resource Utilisation Groups - Activities of Daily Living (RUG-ADL) scale measures the motor function of a patient for four activities of daily living.

Collection and usage attributes

Comments:

RUG-ADL is a four-item scale measuring patient motor function for activities of daily living including:

- Bed mobility
- Toileting
- Transfers
- Eating

The scoring scale for bed mobility, toileting and transfers is:

1 - Independent or supervision only

3 - Limited physical assistance

4 - Other than two person physical assist

5 - Two or more person physical assist

Note: A score of 2 is not valid for bed mobility, toileting and transfer items.

The scoring scale for eating is:

1 - Independent or supervision only

2 - Limited assistance

3 - Extensive assistance/total dependence/tube fed

The total RUG-ADL score (the sum of the individual scale items) will be a value between 4 and 18.

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority
Origin:	Fries BE, Schneider DP et al (1994). Refining a casemix measure for nursing homes. Resource Utilisation Groups (RUG-III). Medical Care, 32, 668-685.
Reference documents:	Palliative Care Outcomes Collaboration Assessment Toolkit. Palliative Care Outcomes Collaboration, University of Wollongong, Wollongong. Viewed 19 September 2012, http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow129133.pdf

Relational attributes

Metadata items which use this glossary item:

Activity based funding: Admitted sub-acute and non-acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Standard 11/10/2012

Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014

Admitted subacute and non-acute hospital care DSS 2015-16 Health, Standardisation pending 25/09/2014

Episode of admitted patient care—clinical assessment score, code NN Independent Hospital Pricing Authority, Standard 30/10/2012

Second-line treatment

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	525478
Registration status:	Health, Standard 08/05/2014
Definition:	Treatment which is given when the initial treatment (also known as first-line therapy or primary therapy) for a disease, disorder or symptom is not effective (does not work, stops working or causes too many negative side effects). This includes treatment for recurring diseases or disorders even many years after initial diagnosis and treatment.

Relational attributes

Metadata items which use this glossary item:	Lung cancer (clinical) DSS Health, Standard 08/05/2014 Person with cancer—reason(s) second-line treatment administered Health, Standard 08/05/2014 Person with cancer—reason(s) second-line treatment administered, code N Health, Standard 08/05/2014 Person with cancer—second-line treatment intention, code N Health, Standard 08/05/2014 Person with cancer—second-line treatment type Health, Standard 08/05/2014 Person with cancer—second-line treatment type, code N[N] Health, Standard 08/05/2014 Reason(s) second-line treatment administered Health, Standard 08/05/2014 Reason(s) second-line treatment administered code N Health, Standard 08/05/2014 Second-line treatment intention Health, Standard 08/05/2014 Second-line treatment type Health, Standard 08/05/2014

Stillbirth (fetal death)

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	482008
Registration status:	Health, Standard 07/03/2014
Definition:	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 grams 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.
Context:	Perinatal statistics.

Collection and usage attributes

Comments:	Terminations of pregnancy performed at gestational ages of 20 or more weeks should be included in perinatal collections and should be recorded either as stillbirths or, in the unlikely event of showing evidence of life, as live births. Fetus papyraceous and fetus compressus are products of conception recognisable as a deceased fetus. These fetal deaths are likely to have occurred before 20 weeks gestation but should be included as stillbirths in perinatal collections if they are recognisable as a fetus and have been expelled or extracted with other products of conception at 20 or more weeks gestational age.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Stillbirth (fetal death) Health, Standard 01/03/2005
Metadata items which use this glossary item:	Female—parity Health, Standard 07/03/2014 Female—parity, total pregnancies N[N] Health, Standard 07/03/2014 Perinatal DSS 2014-15 Health, Standard 07/03/2014 Perinatal DSS 2015-16 Health, Standardisation pending 22/09/2014 Perinatal NMDS 2014- Health, Standard 07/03/2014

Synchronous tumours

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	545438
Registration status:	Health, Standard 08/05/2014
Definition:	Histologically distinct cancers in the same organ or tumours in both sides of a paired organ which are histologically similar, diagnosed within two months of each other. If they are not diagnosed within 2 months of each other they are metachronous and classified separately from each other preceding tumour.

Source and reference attributes

Reference documents:	The Surveillance, Epidemiologic, and End Results (SEER), National Cancer Institute, US National Institutes of Health, USA.

Treatment complication

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	546483
Registration status:	Health, Standard 08/05/2014
Definition:	A short or long term side effect or critical event arising from a medical treatment generally within 30 days of treatment. This includes complications from surgical treatment, such as an unplanned return to theatre, infection or haemorrhage, or complication from drug treatment, such as hypertension or toxicity.

Source and reference attributes

Submitting organisation:	Cancer Australia

Relational attributes

Metadata items which use this glossary item:	Cancer treatment—gynaecological cancer post-radiotherapy complication indicator Health, Standard 08/05/2014
	Cancer treatment—gynaecological cancer post-radiotherapy complication indicator, yes/no/unknown code N Health, Standard 08/05/2014
	Cancer treatment—primary surgical treatment complication indicator Health, Standard 08/05/2014
	Cancer treatment—primary surgical treatment complication indicator, yes/no/unknown code N Health, Standard 08/05/2014
	Cancer treatment—treatment complication type Health, Standard 08/05/2014
	Cancer treatment—treatment complication type, cancer-related primary surgery complication type code N[N] Health, Standard 08/05/2014
	Cancer treatment—treatment complication type, gynaecological cancer-related radiotherapy code N Health, Standard 08/05/2014
	Cancer treatment—treatment complication type, text X[X(149)] Health, Standard 08/05/2014
	Cancer-related primary surgery complication type code N[N] Health, Standard 08/05/2014
	Gynaecological cancer post-radiotherapy complication indicator Health, Standard 08/05/2014
	Primary surgical treatment complication indicator Health, Standard 08/05/2014
	Treatment complication type Health, Standard 08/05/2014

4 Data elements listed by technical name

List of tables

Related publications

This publication, *National Health Data Dictionary: version 16.2*, is the last of a regular series. Earlier versions can be downloaded for free from the AIHW via the METeOR website <http://meteor.aihw.gov.au/content/index.phtml/itemId/274816>.

The following AIHW publications relating to data development, health information and other national data dictionaries might also be of interest:

- Australian Institute of Health and Welfare (AIHW) 2014. Creating nationally-consistent health information: engaging with the national health information committees. Cat. no. CSI 18. Canberra: AIHW.
- AIHW 2014. National Community Services Data Dictionary: version 8. Cat. no. HWI 126. Canberra: AIHW.
- AIHW 2013. National Housing and Homelessness Data Dictionary: version 1. Cat. no. HOU 269. Canberra: AIHW.
- AIHW 2007. A guide to data development. Cat. no. HWI 94. Canberra: AIHW.

The National Health Data Dictionary (NHDD) provides national data standards for the health sector. This version (Version 16.2) reflects changes to data standards between July 2013 and June 2014. Eight national minimum data sets, 12 data set specifications, 16 data element clusters, 174 data elements, 13 classification schemes and 13 glossary items have been added to the NHDD. Nine national minimum data sets, 4 data set specifications, 7 data element clusters, 64 data elements, 1 classification schemes and 1 glossary item have been superseded and 12 data elements have been retired since the previous version of the NHDD (Version 16.1) was published.