National Minimum Dataset (Hospital Inpatient Events)

DATA MART - DATA DICTIONARY

Version 7.8
July 2015

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Publications

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Published by Ministry of Health

Introduction

Objectives

The objectives of the Ministry of Health ('the Ministry') Data Dictionaries are to:

- describe the information available within the National Collections
- promote uniformity, availability and consistency across the National Collections
- support the use of nationally agreed protocols and standards wherever possible
- promote national standard definitions and make them available to users.

It is hoped that the greater level of detail along with clear definitions of the business rules around each element will assist with providing and using the data.

Audiences

The target audiences for Data Dictionaries are data providers, software developers, and data users.

Format

All data element definitions in the Data Dictionaries are presented in a format based on the Australian Institute of Health and Welfare National Health Data Dictionary. This dictionary is based on the ISO/IEC Standard 11179 *Specification and Standardization of Data Elements*—the international standard for defining data elements issued by the International Organization for Standardization and the International Electrotechnical Commission.

The format is described in detail in the appendices of this dictionary.

Changes to dictionary format

A more rigorous approach to recording changes in the data elements has been introduced in these dictionaries along with background material on the features of time-series data for each element.

In summary, the changes to the data dictionaries include:

- standardisation of the element names so that, for instance, a healthcare user's NHI number is referred to as NHI number in all collections
- elements are listed alphabetically within each table, and the tables are organised alphabetically
- each table is described
- verification rules, historical information, and data quality information are included
- alternative names for the elements are listed
- information about how the data is collected is given
- related data, and references to source documents and source organisations are included
- an alphabetical index is included
- code tables are included with the element, or a reference given to the Ministry's web site (for large or dynamic code tables).

Table of Contents

National Minimum Dataset (Hospital Inpatient Events)

Purpose

The NMDS is used for policy formation, performance monitoring, research, and review. It provides statistical information, reports, and analyses about the trends in the delivery of hospital inpatient and day patient health services both nationally and on a provider basis. It is also used for funding purposes.

Content

The NMDS is a national collection of public and private hospital discharge information, including clinical information, for inpatients and day patients. Unit record data is collected and stored. All records must have a valid NHI number.

Data has been submitted electronically in an agreed format by public hospitals since 1993.

The private hospital discharge information for publicly funded events, eg, birth events and geriatric care, has been collected since 1997. Other data is being added as it becomes available electronically.

Start date

The current NMDS was introduced in 1999. The original NMDS was implemented in 1993 and back-loaded with public hospital discharge information from 1988.

Guide for use

The NMDS has undergone many changes over the years. Some data subsets have been removed and are now held in separate collections (Cancer Register and the Mortality Collection). In other cases, additional fields have been included and events are reported in more detail than in the past. For further details refer to the NMDS Data Dictionary.

Private hospital information is also stored in the NMDS. Publicly funded events (primarily maternity and geriatric) and surgical events from some hospitals are up-to-date. Privately funded events may be delayed.

Contact information

For further information about this collection or to request specific datasets or reports, contact the NZHIS Analytical Services team on

- Phone: (04) 816 2893 Fax: (04) 816 2898,
- or e-mail data-enquiries@moh.govt.nz

Collection methods

Data is provided by public and the larger private hospitals in an agreed electronic file format. Paper forms and a cut-down electronic file format are also forwarded by other private hospitals.

Frequency of updates

Publicly funded hospital events are required to be loaded into the NMDS within 21 days after the month of discharge. Electronic files are received and processed almost every day at NZHIS.

NZHIS has a team of staff who manually process private hospital electronic and paper reports.

Security of data

The NMDS is accessed by authorised NZHIS staff for maintenance, data quality, audit and analytical purposes.

Authorised members of the Ministry of Health and DHBs have access to the NMDS for analytical purposes, via the Business Objects reporting tool and the secure Health Information Network. Business Objects contains a subset of the data described in the Data Dictionary.

Privacy issues

The Ministry of Health is required to ensure that the release of information recognises any legislation related to the privacy of health information, in particular the Official Information Act 1982, the Privacy Act 1993 and the Health Information Privacy Code 1994.

Information available to the general public is of a statistical and non-identifiable nature. Researchers requiring identifiable data will usually need approval from an approved Ethics Committee.

National reports and publications	NZHIS publishes an annual report Selected Morbidity Data for Publicly Funded Hospitals in hard copy and on the Ministry web site http://www.health.govt.nz.. This publication contains summary NMDS information for a financial year.
Data provision	Customised datasets or summary reports are available on request, either electronically or on paper. Staff from the NZHIS Analytical Services team can help to define the specifications for a request and are familiar with the strengths and weaknesses of the data. New fields have been added to the collection since 1988, but wherever possible consistent time-series data will be provided. The NZHIS Analytical Services team also offers a peer review service to ensure that NZHIS data is reported appropriately when published by other organisations. There may be charges associated with data extracts.

NMD Admission Source table

Table name	dim_admission_source
Definition	The dim_admission_source dimension holds values for the admission source of the Health Care User.
Primary key	dim_admission_source_key
Business key	admission_source_code
Guide for use	
Relational rules	
Data content	

Admission source code

Definition	A code used to describe the nature of admission (routine or transfer) for a hospital inpatient health event.
Column name	admission_source_code
Table name	dim_admission_source
Data type	char(1)
Other names	
Context	Hospital inpatient or day patient health event.
Layout	A
Data domain	R Routine admission T Transfer from another hospital facility
Guide for use	Patients admitted from rest homes where the rest home is their usual place of residence are routine admissions, not transfers. Patients transferred using DW or DF event end type codes within the same facility should be readmitted with an admission source code of R.
Verification rules	Must be a valid code in the Admission Source code table.
Collection methods	
Related data	Admission Source code.
Source document	
Source organisation	National Data Policy Group

Admission source description

Definition	Description of the admsission source i.e. R = Routine Admission, T = Transferred from another facility.
Column name	admission_source_description
Table name	dim_admission_source
Data type	varchar2(70)
Other names	
Context	
Layout	
Data domain	Free text short description field
Guide for use	See Admission Source code in this table for further information.
Verification rules	
Collection methods	
Related data	admission_source_code
Source document	
Source organisation	

NMD Admission Type table

Table name	dim_admission_type
Definition	This table holds the values associated with the admission type for the health care event.
Primary key	dim_admission_type_key
Business key	admission_type
Guide for use	See admission_type for a list of valid associated values.
Relational rules	
Data content	

Admission type

Definition	A code used to describe the type of admission for a hospital healthcare health event.
Column name	admission_type
Table name	dim_admission_type
Data type	varchar2(2)
Other names	Admission type
Context	Hospital inpatient or day patient health event. Used in the NMDS.
Layout	AA
Data domain	
Guide for use	From 30 June 2004 Admission Types ZA, ZC, ZP and ZW were retired and ACC cases should be identified by use of the Accident Flag. As from July 01 2004, use of the retired codes will generate an error message. CURRENT 'AA' = Arranged admission 'AC' = Acute admission 'AP' = Elective admission of a privately funded patient 'RL' = Psychiatric patient returned from leave of more than 10 days 'WN' = Admitted from DHB booking system (used to be known as 'waiting list') RETIRED 'ZA' = Arranged admission, ACC covered (retired 30 June 2004) 'ZC' = Acute, ACC covered (retired 30 June 2004) 'ZP' = Private, ACC covered (retired 30 June 2004) 'ZW' = Waiting list, ACC covered (retired 30 June 2004) AA - Arranged admission is a planned admission where: - the admission date is less than seven days after the date the decision was made by the specialist that this admission was necessary, or - the admission relates to normal obstetric cases, 36 to 42 weeks' gestation, delivered during the event. In these cases, patients will have been booked into the admitting facility and the health specialty code for records where the date portion of Event End Date is before 1 July 2008 will always be P10 Delivery Services (Mothers). For records where the date portion of Event End Datetime is on or after 1 July 2008 the health specialty code will always be P60 Maternity Services-Mother (no community LMC) or P70 Maternity Services-Mother (with community LMC).

AC - ACUTE ADMISSION (introduced in 1994)

An unplanned admission on the day of presentation at the admitting healthcare facility. Admission may have been from the Emergency or Outpatient Departments of the healthcare facility or a transfer from another facility. Note that the Accident Insurance Act defines Acute as Acute plus Arranged.

AP - ELECTIVE (introduced in 1996)

Elective admission of a privately funded patient in either a public or private hospital.

RL - PSYCHIATRIC PATIENT RETURNED FROM LEAVE (introduced in 1994)

A sectioned mental health patient, returning from more than 14 days leave.

WN - WAITING LIST/BOOKING LIST (introduced in 1994)

A planned admission where the admission date is seven or more days after the date the decision was made by the specialist that this admission was necessary.

Verification rules

Collection methods

Related data

Source document

Source organisation

Admission type description

Definition	Description of the admssion type for the health care user event e.g. AA = Arranged Admission, WN = Admitted from waiting list - Normal,
Column name	admission_type_description
Table name	dim_admission_type
Data type	varchar2(70)
Other names	
Context	
Layout	
Data domain	Free text short description field
Guide for use	See Admission Type code in this table for further information. See Admission Type code table: http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables
Verification rules	
Collection methods	
Related data	Admission Type code
Source document	
Source organisation	

Admission type end date

Definition	The end date of the patients admission for this type.
Column name	admission_type_end_date
Table name	dim_admission_type
Data type	date
Other names	
Context	
Layout	Oracle date/time field
Data domain	
Guide for use	
Verification rules	
Collection methods	
Related data	Admission Type code, Admission Type description.
Source document	
Source organisation	

Admission type start date

Definition	The start date of the patients admission for this type.
Column name	admission_type_start_date
Table name	dim_admission_type
Data type	date
Other names	
Context	
Layout	Oracle date/time field
Data domain	
Guide for use	
Verification rules	
Collection methods	
Related data	Admission Type code, Admission Type description.
Source document	
Source organisation	

NMD Condition Onset Flag Required From Table

Table name	dim_nmd_fac_cond_onset_rqd_dte
Definition	Date when the facility implements the Condition Onset Flag in its Patient Management System (PMS) and reports to the NMDS.
Primary key	
Business key	
Guide for use	Condition Onset Flag (COF) implementation date is 1 July 2012. Facilities are required to notify MOH of the date from which they can supply COF values. Facilities may apply to be exempted from reporting COF in NMDS file version V015.0; however they will need to provide a date when they are likely to implement COF. Some facilities have indicated they are unable to implement COF due to their Patient Management System upgrade cycle. The COF implementation dates will be maintained within the NMDS facility table. This table can be found on the following link under the heading NMDS Facility Code Table. http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables If facilities require further exemption from the date provided apply to Data Management Services, National Collections and Reporting, email compliance@moh.govt.nz
Relational rules	
Data content	

Facility code

Definition	A code that uniquely identifies a healthcare facility.
Column name	facility_code
Table name	dim_nmd_fac_cond_onset_rqd_dte
Data type	varchar(64)
Other names	Health agency facility code, Hospital, HAF code, HAFC
Context	
Layout	
Data domain	See the Facility code table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact Analytical Services.
Guide for use	A healthcare facility is a place, which may be a permanent, temporary, or mobile structure, that healthcare users attend or are resident in for the primary purpose of receiving healthcare or disability support services. This definition excludes supervised hostels, halfway houses, staff residences, and rest homes where the rest home is the patient's usual place of residence. See Appendix: Duplicate and Overlapping Event Checking rules.
Verification rules	Must be a valid code in the Facility code table. The NHI number, Event type code, Event start datetime, Facility code, and Event local identifier form a unique key for checking for duplicates on insert, or checking for existence on delete.
Collection methods	The Ministry of Health allocates codes on request. The code table is continually updated by the Ministry as hospitals open and close. See the Ministry web site for the most recent version.
Related data	Birth location Facility type
Source document	
Source organisation	Ministry of Health

Facility id

Definition

Column name facility_id

Table name dim_nmd_fac_cond_onset_rqd_dte

Data type varchar(64)

Other names

Context

Layout

Data domain

Guide for use

Verification rules

Collection methods

Related data

Source document

Source organisation

NMD condition onset required date from

Definition

Column name	nmd_fac_cond_onset_rqd_frm_dte
Table name	dim_nmd_fac_cond_onset_rqd_dte
Data type	date
Other names	
Context	
Layout	
Data domain	
Guide for use	Condition Onset Flag (COF) implementation date is 1 July 2012. Facilities are required to notify MOH of the date from which they can supply COF values. Facilities may apply to be exempted from reporting COF in NMDS file version V015.0; however they will need to provide a date when they are likely to implement COF. Some facilities have indicated they are unable to implement COF due to their Patient Management System upgrade cycle. The COF implementation dates will be maintained within the NMDS facility table. This table can be found on the following link under the heading NMDS Facility Code Table. http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables If facilities require further exemption from the date provided apply to Data Management Services, National Collections and Reporting, email compliance@moh.govt.nz
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

NMD Fact Diagnosis Procedure Table

Table name fact_nmd_diagnosis_procedure

Definition Details relating to diagnoses and procedures associated with a health event.

Primary key

Business key event_id

Guide for use Contains clinical information about the reason for admission to hospital, procedures carried out while in hospital, and incidental or concurrent diseases that were a factor in the treatment.

Also contains information about accidents that caused health events or occurred during a health event, including adverse reactions.

Diagnoses and procedures are held in multiple versions of the International Classification of Diseases. All events:
- are stored in ICD-9-CM-A
- with an Event end datetime on or after 1 July 1999 are stored in ICD-9-CM-A and ICD-10-AM 1st Edition
- with an Event end datetime on or after 1 July 2001 are stored in ICD-9-CM-A, ICD-10-AM 1st Edition, and ICD-10-AM 2nd Edition
- with an Event end datetime on or after 1 July 2004 are stored in ICD-9-CM-A, ICD-10-AM 1st Edition, ICD-10-AM 2nd Edition- and ICD-10-AM 3rd Edition
- with an Event end datetime on or after 1 July 2008 are stored in ICD-9-CM-A, ICD-10-AM 1st Edition, ICD-10-AM 2nd Edition, ICD-10-AM 3rd Edition and ICD-10-AM 6th Edition
- with an Event end datetime on or after 1 July 2014 are stored in ICD-9-CM-A, ICD-10-AM 1st Edition, ICD-10-AM 2nd Edition, ICD-10-AM 3rd Edition, ICD-10-AM 6th Edition and ICD-10-AM 8th Edition.

See Clinical code type for more information.

The selection of codes are based on the guidelines provided in The Australian Coding Standards (ACS.

The principal diagnosis (refer to ACS 0001 vol 5 p2) is defined as the diagnosis established after study to be chiefly responsible for causing the patient's episode of care in hospital (or attendance at the healthcare facility). The phrase 'after study' in the definition means evaluation of findings to establish the condition that was chiefly responsible for the episode of care. Findings evaluated may include information gained from the history of illness, any mental status evaluation, specialist consultations, physical examination, diagnostic tests or procedures, any surgical procedures, and any pathological or radiological examination.

The condition established after study may or may not confirm the admitting diagnosis.

Additional diagnosis (refer to ACS 0002 vol 5 p5) is defined as a condition or complaint either co-existing with the principal diagnosis or arising during the episode of care or attendance at a healthcare facility.

For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:
- therapeutic treatment
- diagnostic procedures
- increased clinical care and/or monitoring.

Coding procedures carried out in Emergency Department (ED) before admission:
If the patient is admitted as an ED short stay (three hours or more) or is admitted to an inpatient ward, the time spent and the treatment carried

	out in ED are included in the short stay/inpatient event. Procedures carried out in ED meeting the criteria for clinical coding are to be coded on the relevant short stay/inpatient event record. All hours on mechanical ventilation in ED are to be included in the calculation of total hours on mechanical ventilation and have a procedure code assigned, whether the patient is intubated in ED or in the ambulance. If ventilation is commenced in the ambulance, it is counted only from the time of hospitalisation. . The structure of this table has been significantly changed from 1 July 2004. - Prior to this change, the structure held each submitted diagnosis record received from a provider in the same row in the table as any records mapped to other clinical coding classifications. This necessitated the existence of sets of columns specifically for the ICD9, ICD10v1 and ICD10v2 clinical code classifications and the ongoing need to add additional sets of columns each time a new clinical coding classification is to be implemented. - From 1July 2004, only one level of clinical code classification will be held per row in the table. Each new 'submitted' record will be loaded into a new row in the table, then a new row will be created for each record produced by mapping to another clinical coding classification version. These groups of rows are linked by common event id and diagnosis sequence values. The original submitted record is identified by the submitted system id value. - Note: The new database structure
Relational rules	Refer to Guide for Use above
Data content	

Batch id

Definition	A unique identifier for each batch.
Column name	batch_id
Table name	fact_nmd_diagnosis_procedure
Data type	integer
Other names	
Context	
Layout	
Data domain	
Guide for use	Generated by the load process. Used internally for reference to the file in which this record was loaded into the NMDS. The Batch ID is used in place of the batch filename.
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Clinical code

Definition	A code used to classify the clinical description of a condition.
Column name	clinical_code
Table name	fact_nmd_diagnosis_procedure
Data type	varchar2(8)
Other names	Diagnosis/procedure code
Context	Clinical information within a health event. Includes codes for diagnosis, injury, cause of intentional and unintentional injury, and procedure performed.
Layout	
Data domain	Must be a valid code in one of the clinical coding systems mentioned below.
Guide for use	Clinical coding systems: - ICD-9-CM-A 2nd Edition - Australian Version of The International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition - ICD-10-AM 1st Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition - ICD-10-AM 2nd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition - ICD-10-AM 3rd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition - ICD-10-AM 6th Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 6th Edition - ICD-10-AM 8th Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 8th Edition Depending on the context, this is also known as Diagnosis/procedure code (external cause). From 1 July 1995, this field contains the Clinical code as supplied by the provider. ICD-9-CM (TO 30 JUNE 1995) In ICD-9-CM all codes have at least 3 digits and most have 4 or 5. Standard practice was to use a filler 4th digit of '9' for codes with only 3 digits and for codes which have a 5th digit but no 4th digit. ICD-9-CM-A (1 JULY 1995 ONWARDS) In 1995 codes were mapped to ICD-9-CM-A, and the place of occurrence, which had been separate, was mapped onto the 5th digit of the E code. Also, codes that only had 3 digits no longer required a filler digit: the fields for 4th and 5th digits could be left blank. ICD-9-CM-A codes which had a 5th digit but no 4th digit could have a filler 4th digit of '0' (zero) entered. E codes were mandatory for codes between 800 and 999. The location field and code E849 were not used. Instead, the digit to indicate place of occurrence of external cause of injury was recorded as the 5th digit for the following ranges of 4 digit 'E' codes: E810-E829, E846-E848,

E850-E869, E880-E928, E950-E958, E960-E968, E980-E988.

ICD-10-AM 1ST EDITION (1 JULY 1999 ONWARDS)

In ICD-10-AM, codes V01 to Y98 were used to classify environmental events and circumstances as the external cause of injury, poisoning and other adverse effects. (It was intended that the nature of the condition would be indicated separately using the appropriate code, usually codes between S00 and T98.)

1. Place of Occurrence Code

The following 4th-character subdivisions of the external cause code were used with categories W00 to Y34 (except Y06 and Y07) to identify where the external cause occurred:

0 = home

1 = residential institution

2 = school, other institution, and public administrative area

3 = sports and athletics area

4 = street and highway

5 = trade and service area

6 = industrial and construction area

7 = farm

8 = other specified places

9 = unspecified place

2. Activity Code

The following 5th-character subdivision of the external cause code was used with categories V01 to Y34 to indicate the activity of the injured person at the time the event occurred. (This subclassification was used in addition to the 4th-character subdivisions indicating place of occurrence of events classifiable to W00-Y34.)

0 = while engaged in sports activity

1 = while engaged in leisure activity

2 = while working for income

3 = while engaged in other types of work

4 = while resting, sleeping, eating or engaging in other vital activities

8 = while engaged in other specified activities

9 = during unspecified activity

3. Example of the external cause code, place of occurrence and activity code:

Diagnosis type allocated by provider system - Description - ICD-10-AM code

A - # L shaft tibia and fibula, closed - S82.21

B - Laceration L elbow - S51.0

B - Contusion scalp - S00.05

O - Closed reduction of # tibia and fibula - 47564-00

E - Tripped over hose while gardening at home - W01.03*

* The 4th character represents 'home' as place of occurrence; the 5th character represents 'gardening' as activity.

Verification rules Must form part of a valid combination of Clinical code, Clinical code type, and Clinical coding system ID.

Collection methods

Related data Diagnosis/procedure description
Clinical coding system ID
Clinical code type
Diagnosis type

Source document Refer to the Official NCCH Australian Version of ICD-9-CM-A, Second Edition, Volumes 1 to 4, and the International Classification of Diseases for Oncology (ICD-O) Version 2.

For ICD-10-AM, refer to ICD-10-AM, the International Statistical Classification

Source organisation

Clinical code system

Definition A code identifying the clinical coding system used for diagnoses and procedures.

Column name clinical_code_system

Table name fact_nmd_diagnosis_procedure

Data type varchar2(2)

Other names

Context Clinical information.

Layout NN

Data domain

01 ICD-9
02 ICD-9-CM
03 Read
04 ICPC
05 Old AMR codes
06 ICD-9-CM-A
07 DSM IV (for MHINC only)
10 ICD-10-AM 1st Edition
11 ICD-10-AM 2nd Edition
12 ICD-10-AM 3rd Edition
13 ICD-10-AM 6th Edition
14 ICD -10-AM 8th Edition

Guide for use Previously known as Diagnosis coding system code.

Code '03' (Read) is used for primary care and not reported in the NMDS.

Code '02' (ICD-9-CM) was used between 1988 and 1995. When code '06' (ICD-9-CM-A) was introduced, the database was mapped to this new code. From July 1999 data was submitted in either ICD-9-CM-A or ICD-10-AM 1st Edition, and mapped so that it was held in both systems. Data for code '02' no longer exists in the database.

Between 1 July 2001 and 30 June 2004, data was submitted in '11' (ICD-10-AM 2nd Edition) and mapped to ICD-9-CM-A and '10' (ICD-10-AM 1st Edition). All records in '10' continue to be mapped back to earlier classification versions where mappings exist.

From 1 July 2004 data is submitted in '12' (ICD-10-AM 3rd Edition) and mapped to '11' (ICD-10-AM 2rd Edition). Mappings from '11' to '10' and '10' or earlier classifications continues to be performed, where mappings exist.

From 1 July 2008 data is submitted in '13' (ICD-10-AM 6th Edition) and mapped to '12' (ICD-10-AM 3rd Edition). Mappings from '12' to '10' and '10' or earlier classifications continue to be performed, where mappings exist

From 1 July 2014 data is submitted in '14' (ICD-10-AM 8th Edition) and mapped to '13' (ICD-10-AM 6th Edition). Mappings from '13' to '10' and '10' or earlier classifications continue to be performed, where mappings exist.

Verification rules Must be a valid code in the Clinical Coding System code table.

Must form part of a valid combination of Clinical code, Clinical code type, and Clinical coding system ID.

Collection methods From 1 July 2014 data should be submitted using ICD-10-AM 8th Edition, that is, the Clinical coding system ID should be '14'.

Related data	Diagnosis type Clinical code type Clinical code
Source document	Encoding software
Source organisation	Ministry of Health

Clinical code type

Definition A code denoting which section of the clinical code table the clinical code falls within.

Column name clinical_code_type

Table name fact_nmd_diagnosis_procedure

Data type char(1)

Other names

Context Clinical information.

Layout A

Data domain
'A' = Diagnosis
'B' = Injury
'D' = DSM-IV
'E' = External cause of injury
'M' = Morphology (pathology)
'O' = Operation/procedure
'V' = Supplementary classification/health factors

Guide for use Previously known as Clinical code table type.

This field is required to differentiate between different sections of the clinical code table. In ICD-9-CM-A code values could be repeated in different sections of the table. For example, '0101' is a diagnosis code as well as a procedure code.

Note: M- Morphology (pathology) is historical and originally used for cancer diagnosis which has since been replaced with the introduction of the Cancer Registry data mart.

Verification rules Must be a valid code in the Clinical Code Type code table.

Must form part of a valid combination of Clinical code, Clinical code type, and Clinical coding system ID.

Collection methods

Related data
Clinical coding system ID
Diagnosis type
Clinical code

Source document

Source organisation

Condition onset code

Definition	The condition_onset_code is a means of differentiating between those conditions which arise during an admission from those that were present at the time of admission.
Column name	condition_onset_code
Table name	fact_nmd_diagnosis_procedure
Data type	varchar2(1)
Other names	
Context	
Layout	
Data domain	1 - condition with onset during episode of admitted patient care 2 - condition not noted as arising during the episode of care/unknown 9 - not reported (only for exempt facilities)
Guide for use	Condition Onset Flag will be included on all mappings of clinical code systems, eg 12=ICD-10-AM-10 Ed 3, 13=ICD-AM-10 Ed 6, 14=ICD-10-AM Ed 8 etc. Condition Onset Flag must be reported on diagnosis records (HD) with a clinical code type = A (diagnosis), B (injury), V (supplementary), E (external cause) or M (morphology) . On all other diagnosis records (HD) with clinical code type O (Procedure) the COF field will be null. (note: Clinical Code Type = D (DSM-IV) are not reported to NMDS). Some facilities may be exempt from the July 1 2012 implementation and will need to implement at a later date. A reference table of facilities and their COF implementation dates will be maintained. Each facility will have a Condition Onset Flag implementation date. For an event reported with an event end date less than the Condition Onset Flag implementation date the Condition Onset Flag may be 1, 2 or 9. This will allow events prior to implementation to be sent/resent either coded appropriately or as unreported. For an event with an event end date greater than or equal to the Condition Onset Flag implementation date the Condition Onset Flag may be 1 or 2. Where the event end date is not submitted the event start date will be used for the validation. Principal diagnosis should have a condition onset flag value of 2 (onset before the episode of care)
Verification rules	Condition Onset Flag will be reported in the new file version V015.0
Collection methods	
Related data	
Source document	
Source organisation	

Diagnosis description

Definition	A free-text description of the diagnoses, injuries, external causes, and procedures performed. This should not be the standard description associated with the clinical code.
Column name	diagnosis_description
Table name	fact_nmd_diagnosis_procedure
Data type	varchar2(100)
Other names	Event diagnosis/procedure description
Context	Clinical information.
Layout	Free text
Data domain	
Guide for use	Depending on the context, this is also known as Diagnosis description (external cause), Accident description, Operation description, and Morphology description. It is recommended that free text be used for this field, as this aids the research process and assists with the quality audit of data sent to the NMDS. Free text should always be used with external cause codes. Providers often automate this field using encoding programmes. This greatly detracts from the value of the data. Agencies are encouraged to provide this information, particularly the description of the circumstances surrounding an injury, as it is used extensively in injury-prevention research. The Event supplementary information field may be used to expand the description. The standard descriptions sent to the Ministry of Health by hospitals are only 50 characters long, and often are the expanded description truncated at 50 characters. Many of these abbreviated descriptions are not specific, so their usefulness for research is limited. Your assistance is sought to report fully on the diagnosis, procedure, or circumstances of the injury in the Event supplementary information field.
Verification rules	
Collection methods	
Related data	Diagnosis type Clinical code
Source document	
Source organisation	

Diagnosis sequence

Definition	A sequencing number for clinical codes derived from the diagnosis number as part of the mapping process.
Column name	diagnosis_sequence
Table name	fact_nmd_diagnosis_procedure
Data type	number(5)
Other names	
Context	
Layout	
Data domain	010 - 999
Guide for use	When mapping diagnoses from one clinical coding system to another, the Diagnosis number is mapped to the Diagnosis sequence so that the order can be retained for many to one and one to many mappings. For example, if the original Diagnosis numbers were 1, 2, 3, 4, and diagnosis 2 mapped to 3 separate codes in the new clinical coding system, the Diagnosis sequence numbers would be 10, 20, 21, 22, 30, 40.
Verification rules	
Collection methods	
Related data	Diagnosis number
Source document	
Source organisation	

Diagnosis number

Definition	Sequential number for each clinical code in each event record to assist in unique identification.
Column name	diagnosis_number
Table name	fact_nmd_diagnosis_procedure
Data type	integer
Other names	Event diagnosis/procedure number
Context	
Layout	
Data domain	01 - 99
Guide for use	This is the number hospitals send in for their ordering of diagnoses. When the NMDS began mapping between different classification versions (eg, ICD-9-CM to ICD-10-AM) multiple mappings were sometimes required for single codes. The Diagnosis sequence field was introduced, which is derived from this field but allows multiple mappings to be accommodated.
Verification rules	
Collection methods	Up to 99 clinical codes may be provided with each event.
Related data	Used to calculate Diagnosis sequence
Source document	
Source organisation	

Diagnosis type

Definition A code that groups clinical codes, or indicates the priority of a diagnosis.

Column name diagnosis_type

Table name fact_nmd_diagnosis_procedure

Data type char(1)

Other names Diagnosis type code

Context Clinical information within a health event.

Layout

Data domain

A Principal diagnosis
B Other relevant diagnosis
E External cause of injury
M Pathological nature of growth
O Operation/procedure
P Mental health provisional diagnosis (MHINC only)

Guide for use Only codes 'A', 'B', 'E', 'M', 'O' and 'P' are found in the NMDS database.

It is expected that the codes will be allocated by provider systems at the time of sending data to the national system.
Up to 99 diagnosis/procedure codes may be provided. Every record must have one (and only one) clinical code type \'A' principal diagnosis and may have up to a further 98 diagnosis/procedure/ external cause/morphology codes which accompany the appropriate clinical code type.
The principal diagnosis (refer to ACS 0001 vol 5 p2) is defined as the diagnosis established after study to be chiefly responsible for causing the patient's episode of care in hospital (or attendance at the healthcare facility). The phrase 'after study' in the definition means evaluation of findings to establish the condition that was chiefly responsible for the episode of care. Findings evaluated may include information gained from the history of illness, any mental status evaluation, specialist consultations, physical examination, diagnostic tests or procedures, any surgical procedures, and any pathological or radiological examination. The condition established after study may or may not confirm the admitting diagnosis.
Additional diagnosis (refer to ACS 0002 vol 5 p5) is defined as a condition or complaint either co-existing with the principal diagnosis or arising during the episode of care or attendance at a healthcare facility. For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:
- therapeutic treatment - diagnostic procedures - increased nursing care and/or monitoring.

Validation rules are held in the Event to Diagnosis Type table. Cardinality and optionality have been added. See Appendix : Enhanced Event Type/Event Diagnosis Type Table.

Verification rules Must be a valid code in the Diagnosis Type code table. There must be one and only one type 'A' for each event.

Collection methods

Related data Clinical code
Diagnosis/procedure description
Clinical coding system ID
Clinical code type
External cause date of occurrence

Source document

Diagnosis type sequence

Definition

Column name	diagnosis_type_sequence
Table name	fact_nmd_diagnosis_procedure
Data type	integer
Other names	
Context	
Layout	
Data domain	
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Dim condition onset code key

Definition	The dim_nmd_cndtn_onset_code_scd surrogate key
Column name	dim_condition_onset_code_key
Table name	fact_nmd_diagnosis_procedure
Data type	number(38)
Other names	
Context	
Layout	
Data domain	
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Event end date

Definition	The date and time on which a healthcare user is discharged from a facility (i.e. the date and time the heathcare event ended).
Column name	event_end_date
Table name	fact_nmd_diagnosis_procedure
Data type	date
Other names	
Context	
Layout	Oracle date/time field
Data domain	Valid date and time Hours in the range 00 to 23 Minutes in the range 00 to 59
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Event id

Definition	An internal reference number that uniquely identifies a health event.
Column name	event_id
Table name	fact_nmd_diagnosis_procedure
Data type	integer
Other names	
Context	Any event on the NMDS.
Layout	
Data domain	
Guide for use	Serves as the primary key for all data tables. Event ID is assigned by Ministry of Health on load, so if an event is deleted and then reloaded, a new Event ID will be assigned. Unique link between the main tables in the database.
Verification rules	Add 1 to the previous maximum number.
Collection methods	
Related data	
Source document	
Source organisation	

Event start datetime

Definition	The admission date and time on which a healthcare event began.
Column name	event_start_date
Table name	fact_nmd_diagnosis_procedure
Data type	date
Other names	
Context	
Layout	
Data domain	Valid date and time Hours in the range 00 to 23 Minutes in the range 00 to 59
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Private hospital flag

Definition	Flag to indicate whether the health event was privately funded.
Column name	private_hospital_flag
Table name	fact_nmd_diagnosis_procedure
Data type	char(1)
Other names	
Context	
Layout	A
Data domain	'Y' = Yes 'N' = No Null
Guide for use	
Verification rules	Is 'Y' if: - Principal health service purchaser is '06' or '19', or - Principal health service purchaser is '98' or blank and Facility type is '02'.
Collection methods	
Related data	Principal health service purchaser Facility type
Source document	
Source organisation	

Procedure ACC date

Definition	The date when the accident/injury occurred.
Column name	procedure_acc_date
Table name	fact_nmd_diagnosis_procedure
Data type	date
Other names	Accident date, Injury date
Context	Events resulting from an accident.
Layout	CCYYMMDD
Data domain	Partial dates are permissible. Incomplete dates are stored as 'ccyy0101' or 'ccyymm01' and a partial date flag associated with the date is set to the appropriate value.
Guide for use	External cause date of occurrence and Operation/procedure date are sent in separately but both stored in the same field. If the diagnosis type is 'E' (ie, external cause event), the date is External cause date of occurrence.
Verification rules	Optional.
Collection methods	This field is optional for ICD-10-AM 2nd Edition (and onwards) place of occurrence codes (Y92.x) and activity codes (Y93.x).
Related data	Diagnosis type Accident date flag
Source document	
Source organisation	

Procedure ACC date flag

Definition	Indicates whether the External cause date of occurrence stored is a partial date.
Column name	procedure_acc_date_flag
Table name	fact_nmd_diagnosis_procedure
Data type	char(1)
Other names	
Context	Events resulting from an accident.
Layout	
Data domain	D where the day portion of the date is missing, default to '01' M where both day and month portions of the date are missing, default to '01/01'
Guide for use	A partial date flag, set automatically. As the system allows partial dates to be entered, this identifies what field(s) are missing if a partial date is entered. For example, if a date is entered as '00/00/2005', then the date is stored as '01/01/2005' and the partial indicator would be set to 'M'.
Verification rules	
Collection methods	
Related data	External cause date of occurrence
Source document	
Source organisation	

Submitted system id

Definition	The clinical coding system ID used by the provider when submitting their diagnosis record.
Column name	submitted_system_id
Table name	fact_nmd_diagnosis_procedure
Data type	varchar2(2)
Other names	
Context	
Layout	
Data domain	Refer 'Clinical coding system ID'
Guide for use	This field indentifies the system ID used on a diagnosis record submitted by the health provider. This value is repeated onto each diagnosis record that is mapped to another clinical code classification from the submitted record. This enables the source (submitted) record and system ID level to be identified.
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	Ministry of Health

Transaction id

Definition	A sequential number within the batch. With the Batch ID, this forms a unique identifier for each transaction.
Column name	transaction_id
Table name	fact_nmd_diagnosis_procedure
Data type	integer
Other names	
Context	
Layout	
Data domain	
Guide for use	Generated by the load process. Used internally for reference.
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

NMD Fact Event Legal Status table

Table name	fact_nmd_event_legal_status
Definition	The legal status of a healthcare user. See Guide for Use.
Primary key	
Business key	event_id, legal_status_code
Guide for use	The legal status of a healthcare user under the appropriate section of the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Alcoholism and Drug Addiction Act 1966, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, or the Criminal Procedure (Mentally Impaired Persons) Act 2003. Links to the Fact NMD Health Event table through Event ID. Reported in accordance with the relevant Act. Legal status must be supplied for inpatient mental health events. The reporting timeframe for this information is 21 days post month of admission. The definition of a mental health patient is 'a patient who has a mental illness diagnosis'. Patients with an intellectual disability are no longer regarded as mental health patients. Mental health inpatient and day patient events are to be reported with the relevant health specialty codes. With the introduction of the Mental Health (Compulsory Assessment and Treatment) Act 1992 on 1 November 1992, it became possible for mental health patients, both informal (ie, voluntary) and formal, to be admitted to a general ward of any public hospital or psychiatric hospital. When a mental health patient is admitted to a general ward for treatment of a psychiatric illness, then the event type code of IP can now be used. An event type code of ID can be used for day patients. A legal status code and leave details must also be supplied for these patients if relevant. The default for legal status is 'I' (Voluntary). All changes to legal status made during the course of an inpatient event must be reported to Ministry of Health. Admission information for mental health inpatients is required to be supplied with legal status and provisional diagnoses. It is a requirement to update leave/discharge data, legal status and principal diagnosis as they are obtained. Those facilities with electronic transfer should update legal status changes immediately they occur. This table only contains legal statuses pertaining to inpatient and day patient events. For more complete legal status histories, see the Mental Health Information National Collection.
Relational rules	
Data content	

Batch id

Definition	A unique identifier for each batch.
Column name	batch_id
Table name	fact_nmd_event_legal_status
Data type	integer
Other names	
Context	
Layout	
Data domain	
Guide for use	Generated by the load process. Used internally for reference to the file in which this record was loaded into the NMDS. The Batch ID is used in place of the batch filename.
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Event id

Definition	An internal reference number that uniquely identifies a health event.
Column name	event_id
Table name	fact_nmd_event_legal_status
Data type	integer
Other names	
Context	Any event on the NMDS.
Layout	
Data domain	
Guide for use	Serves as the primary key for all data tables. Event ID is assigned by Ministry of Health on load, so if an event is deleted and then reloaded, a new Event ID will be assigned. Unique link between the main tables in the database.
Verification rules	Add 1 to the previous maximum number.
Collection methods	
Related data	
Source document	
Source organisation	

Legal status code

Definition	Code describing a healthcare user's legal status under the appropriate section of any of a number of Acts (see Guide for Use).
Column name	legal_status_code
Table name	fact_nmd_event_legal_status
Data type	varchar2(2)
Other names	
Context	Used for mental health healthcare users in respect of the current period of institutional care. Defines a healthcare user's standing in terms of the Mental Health (Compulsory Assessment & Treatment) Act 1992, for example, compulsory treatment.
Layout	AA (or A and a space)
Data domain	See the Legal Status code table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact Analytical Services.
Guide for use	- Mental Health (Compulsory Assessment and Treatment) Act 1992 - Alcoholism and Drug Addiction Act 1966 - Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 - Criminal Procedure (Mentally Impaired Persons) Act 2003. Used only in the context of mental health admissions.
Verification rules	At least one required for psychiatric inpatient events.
Collection methods	A Legal status code is required for each Legal status date provided.
Related data	DRG code Legal status date
Source document	
Source organisation	

Legal status date

Definition	The date from which a healthcare user's legal status applies.
Column name	legal_status_date
Table name	fact_nmd_event_legal_status
Data type	date
Other names	Health event legal status date
Context	Defines a healthcare user's standing under the appropriate section of the Mental Health (Compulsory Assessment & Treatment), for example, compulsory treatment.
Layout	CCYYMMDD
Data domain	Valid dates
Guide for use	Only used in the context of mental health admissions. From 1 July 1999 legal status can be reported with ID and IP events as well as IM event types. More than one legal status can be entered for a health event, but the Legal status code and the Legal status date must form a unique combination for that health event. Legal status can be reported outside of the period of an event. If this is done, all Legal status codes for the event will be taken into account when determining the DRG code. Any non-voluntary Legal status code changes the DRG version 4.1, 4.2, 5.0, 6.0 or 6.0x code.
Verification rules	Partial dates not allowed. At least one required for psychiatric inpatient events.
Collection methods	A Legal status date is required for each Legal status code supplied.
Related data	DRG code Legal status code
Source document	
Source organisation	

Private hospital flag

Definition	Flag to indicate whether the health event was privately funded.
Column name	private_hospital_flag
Table name	fact_nmd_event_legal_status
Data type	char(1)
Other names	
Context	
Layout	A
Data domain	'Y' = Yes 'N' = No Null
Guide for use	
Verification rules	Is 'Y' if: - Principal health service purchaser is '06' or '19', or - Principal health service purchaser is '98' or blank and Facility type is '02'.
Collection methods	
Related data	Principal health service purchaser Facility type
Source document	
Source organisation	

Transaction id

Definition

Column name	transaction_id
Table name	fact_nmd_event_legal_status
Data type	integer
Other names	
Context	
Layout	
Data domain	
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

NMD Fact Health Event table

Table name fact_nmd_health_event

Definition Contains data for inpatient and day patient health events - non-diagnostic information about a patient's stay in hospital, such as demographic, administrative, and some summarised/grouped clinical and contracting information.

Primary key

Business key

Guide for use A hospital inpatient event is a contact between a healthcare user and an agency which involves the healthcare user being admitted and discharged.
NMDS contains secondary care events (that is, hospital inpatient and day-patient events), and some ambulatory care events. NMDS also incorporates events from psychiatric hospitals, and some private hospital events since 1996.
Fields have been added to the Health Event table at various times as a result of policy or contracting requirements.

RELATIONAL RULES

KEY:	LINKED TO:
Dim admission age key (dim_global_time)	dim_admission_age
Dim admission type key	dim_admission_type
Dim admission source key	dim_admission_source
Dim affiliation key	dim_affiliation
Dim agency facility key	dim_agency_facility
Dim birth date key	dim_birth_date (dim_global_time)
Dim country key	dim_country
Dim discharge age key (dim_age_band)	dim_dischared_age
Dim DRG key	dim_drg
Dim DRG V31 key	dim_drg_v31
Dim event agency key	dim_event_agency
Dim event end date key (dim_global_time)	dim_event_end_date
Dim event end type key	dim_event_type
Dim event facility transfer from key (dim_agency_facility)	dim_facility_transfer_from
Dim event facility transfer to key (dim_agency_facility)	dim_facility_transfer_to
Dim event start date key (dim_global_time)	dim_event_start_date
Dim event type key	dim_event_type
Dim excluded purchase unit key (dim_purchase_unit)	dim_exclu_purchase_unit
Dim first consult date key (dim_global_time)	dim_first_consult_date
Dim geo key	dim_geo
Dim health care user key	dim_health_care_user
Dim health specialty key	dim_health_specialty
Dim last updated date key	dim_last_updated_date
Dim mothers age key	dim_mothers_age
Dim occupation key	dim_occupation
Dim psych lv end date key (dim_global_time)	dim_psych_leave_end_date
Dim purchase unit key	dim_purchase_unit
Dim purchaser code key	dim_purchaser_code
Dim referral date key (dim_global_time)	dim_referral_date
Dim surg decided date key	dim_surgery_decided_date
Event ID	fact_nmd_diagnosis_procedure

	Fields have been added to the Health Event table at various times as a result of policy or contracting requirements.
Relational rules	Refer to Guide for Use above
Data content	

ACC claim number

Definition	This is a separate field to record the M46/45, ACC45 or AITC claim number for the event.
Column name	acc_claim_number
Table name	fact_nmd_health_event
Data type	varchar2(12)
Other names	
Context	Injury resulting from an accident.
Layout	Free text
Data domain	This is a free-text field to allow historical claim numbers, which come in a variety of formats, to be provided.
Guide for use	This field is used to report the Accident Insurance Treatment Certificate (AITC) form number. If the first character of the Principal health service purchaser code is 'A' (eg, 'A0', 'A1', etc) then the Accident flag should be set to 'Y'. If the Accident flag is set to 'Y' (for any Principal health service purchaser code), then the ACC Claim Number field must be populated. If the ACC claim number field is populated and the injury date is before the admission date then the accident flag must be set to Y. If the injury date is between the admission and discharge date (ie the accident happened while the patient was in hospital) then the ACC flag can be N and the ACC45 field populated.
Verification rules	Optional.
Collection methods	
Related data	Accident flag Principal health service purchaser
Source document	
Source organisation	Accident Compensation Corporation

Accident flag

Definition	A flag that denotes whether a person is receiving care or treatment as the result of an accident.
Column name	accident_flag
Table name	fact_nmd_health_event
Data type	char(1)
Other names	ACC flag
Context	Injury resulting from an accident.
Layout	A
Data domain	Y The health event/treatment is assumed to be or is assessed as the result of an accident N The health event/treatment is the result of an illness. U Unknown.
Guide for use	For this accident flag to be 'Y', the healthcare user should be admitted as a result of an accident. This would be either an acute case or someone returning for treatment (in which case an Accident Claim Number would be required). The accident flag can be set to N and an Accident Claim Number reported if a patient has an accident in hospital. In this case the injury date must be between the Event start datetime and Event end datetime. Events where the accident flag is set to 'Y' may or may not have claims that are supported by Accident Compensation Corporation (ACC)
Verification rules	Optional.
Collection methods	
Related data	ACC claim number Clinical code (classifies the injuries and cause of accident)
Source document	
Source organisation	

Admission source code

Definition	A code used to describe the nature of admission (routine or transfer) for a hospital inpatient health event.
Column name	admission_source_code
Table name	fact_nmd_health_event
Data type	char(1)
Other names	
Context	Hospital inpatient or day patient health event.
Layout	A
Data domain	R Routine admission T Transfer from another hospital facility
Guide for use	Patients admitted from rest homes where the rest home is their usual place of residence are routine admissions, not transfers. Patients transferred using DW or DF event end type codes within the same facility should be readmitted with an admission source code of R.
Verification rules	Must be a valid code in the Admission Source code table.
Collection methods	
Related data	Admission Source code.
Source document	
Source organisation	National Data Policy Group

Admission type

Definition	A code used to describe the type of admission for a hospital healthcare health event.
Column name	admission_type
Table name	fact_nmd_health_event
Data type	varchar2(2)
Other names	Admission type
Context	
Layout	AA
Data domain	See the Admission Type code table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information contact Analytical Services.
Guide for use	From July 2004, Admission types 'ZA', 'ZC', ZP' and 'ZW' were retired, and ACC cases should be indentified by the use of the Accident Flag. AA - ARRANGED ADMISSION (introduced in 1995) A planned admission where: - the admission date is less than seven days after the date the decision was made by the specialist that this admission was necessary, or - the admission relates to normal maternity cases, 36 to 42 weeks gestation, delivered during the event. In these cases, patients will have been booked into the admitting facility and the health specialty code for records where the date portion of Event end datetime is before 1 July 2008 will always be P10 Delivery Services (Mothers). For records where the date portion of Event end datetime is on or after 1 July 2008 the health specialty code will always be P60 Maternity Services-Mother (no community LMC) or P70 Maternity Services-Mother (with community LMC). AC - ACUTE ADMISSION (introduced in 1994) An unplanned admission on the day of presentation at the admitting healthcare facility. Admission may have been from the Emergency or Outpatient Departments of the healthcare facility or a transfer from another facility. Note that the Accident Insurance Act defines Acute as Acute plus Arranged. AP - ELECTIVE (introduced in 1996) Elective admission of a privately funded patient in either a public or private hospital. RL - PSYCHIATRIC PATIENT RETURNED FROM LEAVE (introduced in 1994) A sectioned mental health patient, returning from more than 14 days leave. WN - WAITING LIST/BOOKING LIST (introduced in 1994) A planned admission where the admission date is seven or more days after the date the decision was made by the specialist that this admission was necessary. 'WU' (Waiting list - urgent) code not used from 20 August 1993.
Verification rules	Code must be present in the Admission Type code table. The date portion of Event End Datetime must be on or prior to the Admission type end date (if populated). As from 1 July 2004, using a retired code will generate an error message.

Collection methods

Related data Accident Flag,

Source document

Source organisation

Age at admission

Definition	The age of a patient on admission to hospital.
Column name	age_at_admission
Table name	fact_nmd_health_event
Data type	integer
Other names	
Context	Demographic information.
Layout	
Data domain	000 - 120
Guide for use	Event start datetime minus date of birth, expressed in completed years. Age at discharge (not Age at admission) is used in official Ministry of Health publications from the NMDS.
Verification rules	
Collection methods	
Related data	Event start datetime Date of birth
Source document	
Source organisation	

Age at discharge

Definition	The age of a patient on discharge from hospital.
Column name	age_at_discharge
Table name	fact_nmd_health_event
Data type	integer
Other names	
Context	Demographic information.
Layout	
Data domain	000 - 120, XXX
Guide for use	Event end datetime minus date of birth expressed in completed years. If the event end datetime is not entered then this field will contain 'XXX'. Age at discharge (not Age at admission) is the age most often used for analysis.
Verification rules	
Collection methods	
Related data	Date of birth Event end datetime
Source document	
Source organisation	

Age of mother

Definition	Age of mother in years at time of birth of infant.
Column name	age_of_mother
Table name	fact_nmd_health_event
Data type	integer
Other names	
Context	Birth event.
Layout	
Data domain	00 - 99 00 is default value if mother's age is not known.
Guide for use	
Verification rules	If outside 12 to 60 years, will only be accepted on confirmation. Mandatory for birth events. Must not be supplied for other event types.
Collection methods	Only required for babies born in hospital. Found only on the baby's 'BT' (birth) event.
Related data	Event type code
Source document	
Source organisation	

Agency code

Definition	A code that uniquely identifies an agency. An agency is an organisation, institution or group of institutions that contracts directly with the principal health service purchaser to deliver healthcare services to the community.
Column name	agency_code
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	Health agency code, DHB
Context	
Layout	XXXX
Data domain	See the Agency code table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact the Analytical Services.
Guide for use	Historically, also known as CHE (Crown Health Enterprise), HHS (Hospitals and Health Services) and AHB (Area Health Board). Between 1988 and 1993 the Agency code was assigned based on the original 1993 agency groupings. If the facility on an event does not belong to the agency, it means that the agency has contracted a facility belonging to a different agency to treat the patient. Unit record information with Facility codes will not be provided to members of the public without the permission of the agency involved. See the Data Access Policy on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/access-and-use. This is a key field for allocating purchase units. If agencies merge, a new code may be assigned or the new agency can negotiate with the Ministry of Health to maintain the existing codes. The Ministry of Health allocates codes on request. The code table is continually updated by the Ministry as hospitals open and close. See the Ministry of Health web site for the most recent version.
Verification rules	Must be a valid code in the Agency code table.
Collection methods	
Related data	
Source document	
Source organisation	Ministry of Health

Batch id

Definition	A unique identifier for each batch.
Column name	batch_id
Table name	fact_nmd_health_event
Data type	integer
Other names	
Context	
Layout	
Data domain	
Guide for use	Generated by the load process. Used internally for reference to the file in which this record was loaded into the NMDS. The Batch ID is used in place of the batch filename.
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Birth status

Definition	Field which records whether an infant was still or liveborn.
Column name	birth_status
Table name	fact_nmd_health_event
Data type	char(1)
Other names	
Context	Birth event.
Layout	A
Data domain	'L' = Liveborn 'S' = Stillborn
Guide for use	Effectively only livebirths are reported to the NMDS. Information about fetal deaths (still births) is obtained from death registration records, death certificates and autopsy reports, and is entered directly by the Ministry of Health staff. Provider systems will therefore only report information about livebirths that occur in their facilities. Provider systems may default to 'L' (Liveborn). The World Health Organization definition of a livebirth is: 'The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which after such separation, breathes or shows other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered liveborn.' For liveborn infants who die in hospital without ever going home, record the mother's address.
Verification rules	Mandatory for birth events. Must not be supplied for other event types.
Collection methods	
Related data	
Source document	
Source organisation	

Birth weight

Definition	Weight of infant at time of birth, in grams.
Column name	birth_weight
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	Birth weight
Context	Birth event.
Layout	NNNN
Data domain	0001 - 9999
Guide for use	Records reporting 0001 to 0399 grams will be returned with a warning message that birthweight is unusually low. Hospitals will need to confirm this value before the record will be loaded into the NMDS.
Verification rules	Mandatory for birth events.
Collection methods	Record as soon as practicable after the birth event. If not known, the default is '9000'. For birth events, Weight on admission will be identical to the Birthweight.
Related data	Weight on admission
Source document	
Source organisation	

Client system identifier

Definition	A unique identifier for the record stored within the health provider's system
Column name	client_system_identifier
Table name	fact_nmd_health_event
Data type	varchar2(14)
Other names	
Context	
Layout	
Data domain	
Guide for use	Used to store any record level identification that a provider’s system may require in addition to the PMS unique identifier. This field is used as a reference field for checking data quality.
Verification rules	
Collection methods	
Related data	Related to PMS unique identifier.
Source document	
Source organisation	

Complication and comorbidity level (CCL)

Definition CCL - Complication/co-morbidity class level. This comes out of the DRG grouper program and identifies the clinical severity within a DRG code.

Column name ccl

Table name fact_nmd_health_event

Data type char(1)

Other names

Context DRG version 3.1

Layout N

Data domain

1	minor CC or non-CC
2	moderate CC
3	major CC
4	extreme CC

Guide for use Relates only to DRG Grouper versions 3.0 and 3.1.

Serves the same purpose for DRG Grouper clinical versions 3.0 and 3.1 as PCCL does for DRG Grouper clinical versions 4.1, 4.2 and 5.0.

The AR-DRG v4.1 Definitions Manual says CCLs 'are severity weights given to ALL additional diagnoses. They range in value from 0 to 4 for surgical and neonate episodes, and from 0 to 3 for medical episodes, and have been developed through a combination of medical judgement and statistical analysis. CCL values can vary between adjacent DRGs.'

Verification rules

Collection methods

Related data DRG code version 3.1
PCCL

Source document See the AN-DRG manual

Source organisation The logic for the DRG software is specified by the Health Services Division of the Commonwealth Department of Health and Ageing, Australia

Cost weight

Definition	Calculated value designed to weight a base rate payment.
Column name	cost_weight
Table name	fact_nmd_health_event
Data type	number(9,4)
Other names	Cost weight, Case weight
Context	
Layout	
Data domain	
Guide for use	Costweight is calculated using the Weighted Inlier Equivalent Separation (WIES) method, according to different schedules each financial year. The Costweight code indicates the schedule. Costweights in use from 1 July 2008 have been developed from New Zealand costs. Every event is given a Costweight, calculated from: - the DRG code and associated variables - Length of stay - Total hours on mechanical ventilation - some procedure codes and diagnosis codes. For details, see the Technical Documentation page on http://www.health.govt.nz/nz-health-statistics/data-references/weighted-inlier-equivalent-separations/wiesnz11-cost-weights. It is used with the Financial year for calculating payments based on the year of Event end datetime in the patient record.
Verification rules	
Collection methods	
Related data	DRG codes Costweight code Purchase unit DRG grouper type code Health specialty code
Source document	See http://www.health.govt.nz.
Source organisation	National Centre for Classification in Health, University of Sydney, Australia (modified for New Zealand contracting)

Cost weight code

Definition	Indicates the schedule by which the Costweight and Purchase unit are calculated for that financial year.
Column name	cost_weight_code
Table name	fact_nmd_health_event
Data type	varchar2(2)
Other names	
Context	
Layout	
Data domain	
Guide for use	
Verification rules	
Collection methods	
Related data	Costweight DRG codes Purchase unit
Source document	
Source organisation	DHBNZ

Country code

Definition	Coded value for the country of birth as assigned from the Statistics NZ Country Code list (NZSCC86).
Column name	country_code
Table name	fact_nmd_health_event
Data type	varchar2(3)
Other names	
Context	Primarily used for epidemiological studies.
Layout	NNN
Data domain	004 - 999. See the Country of Birth code table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables
Guide for use	Mandatory for cancer patients until 1 July 2001. With the introduction of the Cancer Registry Act, pathologists were given responsibility to ensure that all specified primary cancer cases are reported, and the pathology report became the principal source of information identifying new cases of primary cancer. Because pathology reports do not contain all the information required to complete cancer registrations, Section 6 of the legislation also authorises the Cancer Registry to seek additional information from medical practitioners or hospitals. Information not available from laboratories is: Occupation code, Country of birth code, and Extent of cancer disease code.
Verification rules	Optional.
Collection methods	
Related data	
Source document	
Source organisation	Statistics NZ

Date of birth

Definition	The date on which the person was born.
Column name	date_of_birth
Table name	fact_nmd_health_event
Data type	date
Other names	DOB, HCU date of birth, Birth date
Context	Required to derive age for demographic analyses.
Layout	
Data domain	Valid dates Partial dates are permissible.
Guide for use	In 1993 the option to submit partial dates using the partial date flag was introduced. For events before 1993, there was no partial date option or partial date flag. The default date was 15/6 or 15/month (if the month was known). The 15/6 model of partial dates should only occur in data before 1994/1995. Used, for example, for analysis by age at a point in time and for use to derive a Diagnosis Related Group (for admitted patients). Incomplete dates are stored as 'ccyy0101' or 'ccyymm01' and a partial date flag associated with the date is set to the appropriate value.
Verification rules	Must be on or before the date portion of Event start datetime. Must be consistent with diagnoses and procedure codes for the record to be loaded. Otherwise it will result in a warning.
Collection methods	At a minimum the century and year must be supplied. If day is provided but month is omitted then the day will not be recorded.
Related data	DRG codes Event start datetime Event end datetime Operation/procedure date Age at admission Age at discharge Date of birth flag
Source document	
Source organisation	

Date of birth flag

Definition	Indicates whether the date of birth stored is a partial date.
Column name	date_of_birth_flag
Table name	fact_nmd_health_event
Data type	char(1)
Other names	
Context	
Layout	
Data domain	D where the day portion of the date is missing, default to '01' M where both day and month portions of the date are missing, default to '01/01'
Guide for use	A partial date flag, set automatically. As the system allows partial dates to be entered, this identifies what field(s) are missing if a partial date is entered. For example, if a date is entered as '00/00/2005', then the date is stored as '01/01/2005' and the partial indicator would be set to 'M'.
Verification rules	
Collection methods	
Related data	Date of birth
Source document	
Source organisation	

Date psychiatric leave ends

Definition	The date on which a committed mental health patient's period of leave ended.
Column name	date_psychiatric_leave_ends
Table name	fact_nmd_health_event
Data type	date
Other names	Date psychiatric leave ended
Context	A healthcare user is discharged on leave, then the event ends by discharge or re-admission to hospital. Only for healthcare users committed under the Mental Health (Compulsory Assessment & Treatment) Act 1992.
Layout	
Data domain	Valid dates Partial dates not allowed.
Guide for use	Not reliably reported since 1993. Healthcare users can be on leave for up to 2 years under the Act.
Verification rules	Optional. Must only be present when Event end type is 'DL'.
Collection methods	Only required for committed patients who go on leave for a period of 14 days or more. The data should be provided when leave has ended.
Related data	Psychiatric leave end code
Source document	Mental Health (Compulsory Assessment & Treatment) Act 1992
Source organisation	

Date surgery decided

Definition	The date on which the healthcare user was assessed as requiring surgery.
Column name	date_surgery_decided
Table name	fact_nmd_health_event
Data type	date
Other names	
Context	Elective surgical events.
Layout	
Data domain	Valid dates
Guide for use	No longer reported to NMDS Not reliably reported to the NMDS. From July 2000, this information is also collected in the Date certainty given field in the National Booking Reporting System (NBRS), which has more complete coverage.
Verification rules	
Collection methods	
Related data	Surgical priority
Source document	
Source organisation	

Dim_funding_agency_code_key

Definition	The dim_agency_facility surrogate key.
Column name	dim_funding_agency_code_key
Table name	fact_nmd_health_event
Data type	number(38)
Other names	
Context	
Layout	
Data domain	
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Domicile code

Definition	Statistics NZ Health Domicile Code representing a person's usual residential address. Also used for facility addresses.
Column name	domicile_code
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	
Context	Required for demographic analyses. Domicile codes are key variables for determining the characteristics of the population that are using the health sector.
Layout	
Data domain	See the Domicile code table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact Analytical Services.
Guide for use	Usual residential address is defined as the address of the dwelling where a person considers himself or herself to usually reside. (Statistics NZ definition of 'usually resident'.)If a person usually lives in a rest home or a hospital, that is considered their usual residential address. The Domicile code used for health collections is a four-digit Health Domicile Code specially created by Statistics NZ from their six-digit Census Area Unit Code. This field contains 3 versions of this Domicile code, one for each of the 1991, 1996 and 2001 censuses. The code table contains current and retired codes (see status column: C = current and R = retired). Before July 1993, domicile was coded using the 1986 census Domicile codes. This data has been mapped to the 1991 codes. Care needs to be exercised when analysing pre-1993 data in terms of population, as the 1991 census split a large number of the 1986 codes into two or more new Domicile codes. As it was not possible to accurately attribute particular events to the correct new code, only one of the new multiple codes could be chosen for each old code. This can result in some areas showing no events for one code and an over-representation of events for the other domicile. Since 1996, Domicile code has been automatically assigned on the NHI database using the address provided. This can result in rural addresses being assigned to an urban Domicile code where there is insufficient data to generate the correct code. This is because the automated software relies on generating a post code in order to determine where in a related table it should look to find the code. Most events in the NMDS contain a Domicile code that has been generated in this manner. - The 1991 code was used from 1988 to 30 June 1998. (1986 codes were converted to 1991 codes on migration into NMDS in 1993.) - The 1996 code was used from 1 July 1998 to 30 June 2003. - The 2001 code was used from 1 July 2003 to 30 June 2008. - The 2006 code was used from 1 July 2008 to 30 June 2015. - The 2013 code has been in use since 1 July 2015. The series of Domicile codes used depends on the date portion of Event end datetime. If an event does not have an end date, the date portion of Event start datetime is used. New general codes have been added for DHBs from 1 July 2001. General DHB codes should be a last resort, used only if the correct Domicile code cannot be determined.

Verification rules	Must be a valid code in the Domicile code table.
Collection methods	Care should be taken to record accurate and useful residential addresses, since Domicile codes may be automatically assigned using this information.
Related data	TLA of domicile
Source document	
Source organisation	Statistics NZ

DRG code current

Definition A diagnosis-related group (DRG) code produced by the current DRG grouper program version 6.0x.

Column name drg_code_current

Table name fact_nmd_health_event

Data type varchar2(4)

Other names

Context Clinical demographic and administrative information within a health event.

Layout XXXX

Data domain 801A - 963Z, A01Z - Z65Z

Guide for use A diagnosis-related group (DRG) code of clinical version 4.1, 4.2, 5.0, 6.0 or 6.0x produced by the current DRG grouper program version 6.0 which takes up to 30 diagnoses and 30 procedure codes in a health event and assigns a DRG code based on a complex algorithm.

The version 4 groupers used 20 codes. This provides another way of analysing event information based on classifying episodes of inpatient care into clinically meaningful groups with similar resource consumption.

Introduced on 1 July 2001 for DRG clinical version 4.1.

If the date portion of Event end datetime is between 1 July 2001 and 30 June 2002, this field contains a DRG code of clinical version 4.1.

If the date portion of Event end datetime is between 1 July 2002 and 30 June 2004, this field contains a DRG code of clinical version 4.2.

If the date portion of Event end datetime is between 1 July 2004 and 30 June 2011, this field contains a DRG code of clinical version 5.0.

If the date portion of Event end datetime is between 1 July 2011 and 30 June 2013, this field contains a DRG code of clinical version 6.0.

If the date portion of Event end datetime is on or after 1 July 2013, this field contains a DRG code of clinical version 6.0x.

Calculated from:
- personal information (eg, Sex, Date of birth), and
- event information (eg, Admission date, Event end type), and
- diagnosis and procedure information in the appropriate ICD code for the DRG Grouper (ICD-10-AM 3rd Edition).
- Between 1 July 2004 and 30 June 2005, most hospitals supplied diagnosis and procedure information using ICD-10-AM 3rd Edition codes. As AR-DRG version 5.2 requires ICD-10-AM 2nd Edition codes, NMDS will map the 3rd edition codes supplied by hospitals to 2nd edition codes and use these to assign an AR-DRG 4.2 code.
- Between 1 July 2004 and 30 June 2008, most hospitals supplied diagnosis and procedure information using ICD-10-AM 3rd Edition codes. AR-DRG version 5.0 required no additional mapping.
- Between 1 July 2008 and 30 June 2011, the field contains a DRG from AR-DRG version 5.0 derived, if necessary, by mapping ICD-10-AM 6th Edition codes back to ICD-10-AM 3rd Edition Codes
- Between 1 July 2011 and 30 June 2013, the field contains a DRG from AR-DRG version 6.0, the derivation for which uses ICD-10-AM 6th Edition codes.
- Between 1 July 2013 and 30 June 2014, the field contains a DRG from

AR-DRG version 6.0x, the derivation for which uses ICD-10-AM 6th Edition codes.
- From 1 July 2014, the field contains a DRG from AR-DRG version 6.0x derived, if necessary, by mapping ICD-10-AM 8th Edition codes back to ICD-10-AM 6th Edition codes.

Verification rules

Collection methods External cause codes are not used by the grouper. It is recommended that hospitals prioritise diagnoses and procedure codes in order to present the grouper with the most severe diagnoses and operations.

Related data
Costweight code
Costweight
Purchase unit
PCCL
MDC code
MDC type
DRG grouper type code

Source document

Source organisation The logic for the DRG software is specified by the Health Services Division of the Commonwealth Department of Health and Ageing, Australia.

DRG code v30

Definition	Diagnosis-related group code produced by version 3.0 of AN-DRG.
Column name	drg_code_v30
Table name	fact_nmd_health_event
Data type	varchar2(3)
Other names	
Context	
Layout	XXX
Data domain	
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

DRG code v31

Definition Diagnosis-related group code produced by clinical version 3.1 of AN-DRG Grouper.

Column name drg_code_v31

Table name fact_nmd_health_event

Data type varchar2(3)

Other names

Context Clinical demographic and administrative information within a health event.

Layout

Data domain 001 - 956

Guide for use A diagnosis-related group (DRG) produced by invoking a DRG program that compares all diagnostic codes in a health event and assigns a DRG code based on a complex series of decision trees.

This classifies the episodes of inpatient care into clinically meaningful groups with similar resource consumption.

Until 1 July 2001 the clinical version of AN-DRG 3.1 was produced by running 3M version 3.1 AN-DRG Grouper Program over ICD-9-CM-A version II diagnosis and procedure codes. Since July 2001, 3M AR-DRG version 4.2 of the Grouper Program has been used to generate clinical version 3.1 codes in this field. The current version (4.2) uses up to 20 diagnoses and 20 procedure codes. The previous version (3.1) used up to 15 diagnoses and 15 procedures.

Before 1 July 1995 for DRG v3.1 data providers mostly reported only 4 diagnosis and 3 procedure codes, so that was all that was available for DRG assignment.

DRG codes of clinical version 3.1 are stored for all events, as this field is often used for analysis.

Verification rules

Collection methods

Related data CCL
Costweight code
Costweight
Purchase unit
MDC code
MDC type
DRG grouper type code

Source document

Source organisation

DRG grouper type

Definition A code to describe the clinical version of the DRG calculation used.

Column name drg_grouper_type

Table name fact_nmd_health_event

Data type varchar2(2)

Other names

Context

Layout

Data domain A code to describe the clinical version of the DRG calculation used.

01	Medicare version 4.0 Secondary Care (retired)
02	AN-DRG version 3.1
03	AR-DRG version 4.1
04	AR-DRG version 4.2
05	AR-DRG version 5.0
06	AR-DRG version 6.0
07	AR-DRG version 6.0x

Guide for use DRG grouper type code should be the same as the MDC type.

'02' was used until 30 June 2000.
'03' was used between 1 July 2000 and 30 June 2002.
'04' was used between 1 July 2002 and 30 June 2005
'05' was used between 1 July 2005 and 30 June 2012.
‘06’ was used between 1 July 2012 and 30 June 2013
‘07’ will be used from 1 July 2013

The grouper software version produce a number of clinical versions. Ministry of Health is currently using software version 6.0x to produce DRG codes of clinical versions 3.1, 4.1, 4.2, 5.0, 6.0 and 6.0x. This field describes the clinical version.

Verification rules

Collection methods

Related data DRG codes
MDC type
MDC code

Source document

Source organisation

Encrypted hcu id

Definition	The NHI number in encrypted form.
Column name	encrypted_hcu_id
Table name	fact_nmd_health_event
Data type	varchar2(11)
Other names	Encrypted HCU identifier, Encrypted NHI, etc. See other names for the NHI number under 'Guide for use' below.
Context	A unique 7-character identification number assigned to a healthcare user by the National Health Index (NHI) database. It is encrypted in the NMDS to ensure privacy of individual records.
Layout	
Data domain	System-generated
Guide for use	The NHI number is the cornerstone of the Ministry of Health's data collections. The NHI number uniquely identifies healthcare users, and allows linking between different data collections. The NHI number is also known as National Health Index, HCU identifier, NHI, HCU, HCU Number, Healthcare User identifier, HCU identification number, NMPI number, Hospital Number, Patient Number. New numbers can be allocated by health providers who have direct access to the NHI Register. New NHI numbers are also allocated by Sector Services for GPs and other primary care providers When duplicate records for a healthcare user are merged, one of their NHI numbers will be deemed to be the master (or primary), and the others become event (or secondary) NHI numbers. This does not affect which NHI numbers are used in local systems. In the NMDS, the NHI number that is sent in by the data provider is encrypted during the loading process. Only this encrypted NHI number is stored. For the analysis of healthcare information relating to a unique individual, the master NHI number should be used. Please contact Analytical Services for further information on how to obtain the master encrypted NHI number if you are performing your own data extraction. The Privacy Commissioner considers the NHI number to be personally identifying information (like name and address) so, if it is linked to clinical information, it must be held securely and the healthcare user's privacy protected. The Encrypted NHI number is not considered personally identifying. The Ministry of Health will return data containing unencrypted NHI numbers to providers who have sent it in. Information with unencrypted NHI numbers may be disclosed to researchers on a case-by-case basis. VALIDATION The first three characters of an NHI number must be alpha (but not 'I' or 'O'). The 4th to 6th characters must be numeric. The 7th character is a check digit modulus 11. The NHI number, Event type code, Event start datetime, Facility code, and Event local identifier form a unique key for checking for duplicates on insert, or checking for existence on delete. See Appendix : Duplicate and overlapping event checking rules.

ENCRYPTION
The NHI number is encrypted using a one-way encryption algorithm. The aim is to provide an encrypted number that can be sent across public (unsecured) networks.

Verification rules	Must be registered on the NHI database before the NHI number can be used in the NMDS. There is a verification algorithm which ensures that the NHI number is in the correct format and is valid.
Collection methods	NHI numbers are often included on patient notes and other patient documentation.
Related data	
Source document	http://www.health.govt.nz/our-work/health-identity/national-health-index
Source organisation	Ministry of Health

Ethnic code

Definition	Ethnic affiliation
Column name	ethnic_code
Table name	fact_nmd_health_event
Data type	varchar2(2)
Other names	Ethnicity
Context	
Layout	NN
Data domain	See the Ethnic Group code table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact Analytical Services.
Guide for use	Information on ethnicity is collected for planning and service delivery purposes and for monitoring health status across different ethnic groups. Ethnic group codes are key variables for determining the characteristics of the population that are using the health sector. See Appendix: Guide for use of Ethnic Codes. From 1 July 1996 up to 3 Ethnic group codes can be collected for each healthcare user and each event. Where more than 3 Ethnic group codes are reported, the Statistics NZ prioritisation algorithm is used to report only 3 values. Because ethnicity is self-identified, it can change over time. This is why Ministry of Health collects ethnicity information for each health event, rather than relying on the data in the National Health Index (which does not include historical data). Each ethnic group as maintained by Statistics NZ has a 5-digit code. Ministry of Health collections use only the first 2 digits. Use of the code '54' (Other) is limited to only about 5 ethnic groups. It must not be used as a generic 'other' code. If a person chooses not to answer the ethnicity question, record their ethnicity as 'not stated'. See Appendix : Collection of Ethnicity Data. Each ethnic group as maintained by Statistics NZ has a 5-digit code. Ministry of Health collections use only the first 2 digits.
Verification rules	Ethnicity 1 is mandatory. Ethnicity 2 and Ethnicity 3 are optional. Ethnicity 2 cannot be the same as Ethnicity 1 or 3. Ethnicity 3 cannot be the same as Ethnicity 2 or 1. Must be a valid code in the Ethnic code table.
Collection methods	Ethnicity should be self-identified wherever possible. If the Ethnic group code changes for this event, please update the NHI.
Related data	Prioritised ethnicity
Source document	Smith, Anthony. 1981. The Ethnic Revival. Cambridge University Press.
Source organisation	Statistics NZ

Event elapsed time in minutes

Definition

Column name	event_elapsed_time_in_minutes
Table name	fact_nmd_health_event
Data type	integer
Other names	
Context	
Layout	
Data domain	
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Event end datetime

Definition	The date and time on which a healthcare user is discharged from a facility (ie, the date and time the heathcare event ended) or the date and time on which a sectioned mental health patient is discharged to leave.
Column name	event_end_date
Table name	fact_nmd_health_event
Data type	date
Other names	Discharge date, Event end/leave date
Context	
Layout	
Data domain	Valid date and time
Guide for use	
Verification rules	Partial dates not allowed. Optional for psychiatric inpatient events. Mandatory for births, intended day cases and non-psychiatric inpatient events.
Collection methods	
Related data	Event end type code Date of birth Event start datetime Operation/procedure date Event leave days Age at discharge Length of stay Year of data Month of data Financial year
Source document	
Source organisation	

Event end type

Definition	A code identifying how a healthcare event ended.
Column name	event_end_type
Table name	fact_nmd_health_event
Data type	varchar2(2)
Other names	Discharge type
Context	
Layout	
Data domain	See the Event End Type code table on the MoH web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact Analytical Services.
Guide for use	'RO' was superseded on 1 July 1994. 'DA' and 'DW' were introduced in 1995. 'DO' was introduced in 1997. 'DF' was introduced in 2000. EA, ED, EI, ER, ES and ET were introduced in 1 July 2007 See Appendix for the allocation Guide for Use of NMDS Emergency Department (ED) Event End Type Codes, Emergency Department scenarios and Event End Type Code mappings for 3M CodefinderTM.
Verification rules	Must be a valid code in the Event End Type code table. Optional for psychiatric inpatient events. Mandatory for all other event types.
Collection methods	Refer to notes in the National Minimum Dataset (Hospital Events) Data Dictionary on the Ministry of Health web site at http://www.health.govt.nz/publication/national-minimum-dataset-hospital-events-data-dictionary
Related data	event_end_date, event_end_description
Source document	
Source organisation	National Data Policy Group

Event extra information

Definition	Enables extra information concerning an event to be recorded in a free-text format.
Column name	event_extra_information
Table name	fact_nmd_health_event
Data type	varchar2(90)
Other names	Comment field, Free text field
Context	
Layout	Free text
Data domain	
Guide for use	The field is currently used primarily for cancer events, as a place to record extra information about primary tumours. It may also be used to supply extra information for external cause of injury where the diagnosis description field is not long enough.
Verification rules	Optional.
Collection methods	
Related data	
Source document	
Source organisation	

Event id

Definition	An internal reference number that uniquely identifies a health event.
Column name	event_id
Table name	fact_nmd_health_event
Data type	integer
Other names	
Context	Any event on the NMDS.
Layout	
Data domain	
Guide for use	Serves as the primary key for all data tables. Event ID is assigned by the Ministry of Health on load, so if an event is deleted and then reloaded, a new Event ID will be assigned. Unique link between the main tables in the database.
Verification rules	Add 1 to the previous maximum number.
Collection methods	
Related data	
Source document	
Source organisation	

Event leave days

Definition	The number of days an inpatient on leave is absent from the hospital at midnight, up to a maximum of three days (midnights) for non-psychiatric hospital inpatients for any one leave episode.
Column name	event_leave_days
Table name	fact_nmd_health_event
Data type	varchar2(3)
Other names	Leave days
Context	
Layout	NNN
Data domain	000 - 999
Guide for use	Where there is more than one period of leave during an episode, accumulated leave days should be reported. This is not how leave is calculated for sectioned mental health patients, and their leave days should not be accumulated under this field. If after three days for non-psychiatric hospital inpatients or 14 days for informal mental health inpatients the patient has not returned to care, discharge is effective on the date of leaving hospital. These days should not be recorded as Event leave days in this case.
Verification rules	Optional. Event leave days must be null or greater than zero. Event leave days must not be greater than the difference in days between Event start datetime and Event end datetime.
Collection methods	
Related data	Event start datetime Event end datetime Length of stay
Source document	
Source organisation	

Event local id

Definition	Local system-generated number to distinguish two or more events of the same type occurring on the same day at the same facility.
Column name	event_local_id
Table name	fact_nmd_health_event
Data type	char(1)
Other names	Local ID
Context	
Layout	N
Data domain	1-Sep
Guide for use	
Verification rules	The NHI number, Event type code, Event start datetime, Facility code, and Event local identifier form a unique key for checking for duplicates on insert, or checking for existence on delete. See Appendix : Duplicate and overlapping event checking rules.
Collection methods	Use 9 first then ' 8,7, ...,1'.
Related data	
Source document	
Source organisation	

Event start datetime

Definition	The admission date on which a healthcare event began.
Column name	event_start_date
Table name	fact_nmd_health_event
Data type	date
Other names	Admission date
Context	Admitted patients.
Layout	CCYYMMDDhhmm
Data domain	Valid date and time Hours is in the range 00 to 23 Minutes is in the range 00 to 59 Midnight is the beginning of the calendar day i.e. 201101280000 (which equates to 24:00 of 27/01/2011).
Guide for use	The time portion of Event start datetime has only been collected since 1 July 2011. Event start time (Admission time): - For acute events meeting the three hour admission rule the event start time is when the patient is first seen by a clinician, nurse or other healthcare professional in the Emergency Department, Acute Assessment Unit, Admission Planning unit or the like. When determining the event start time exclude waiting time in a waiting room and triage time. - For acute patients admitted directly to a ward/unit eg direct admission to intensive care unit (ICU), admission via delivery suite then the admission time is the time the patient arrives in the ward/unit care setting. - For non acute events - (i.e. elective/arranged patients, same day or inpatient), the event start time will be when the patient physically arrives in the ward/unit or day stay clinical area. This will not include the time they spend in a waiting area before any nursing/clinical care starts. - For birth events (BT events) - the event start time will be the time of birth for in hospital births only. Babies born before mother's admission to hospital or transferred from the hospital of birth are recorded as IP (inpatient event) and the event start time will be the time the patient arrives in the ward/neonatal intensive care unit (NICU). - For internal and external transfers the event start time is the time the patient physically arrives in the new health care setting. The event end time for a discharge to another service within the same facility (DW) or discharge to another facility (DT, DA) will be when the patient leaves the health care setting. There will be a gap between these events which is the time taken to transfer. We would not expect these events to be contiguous. This will also apply to patient retrievals where a retrieval team is sent to another hospital to retrieve and transport a patient back to their hospital.
Verification rules	Must be on or before the Date of load and the Event end datetime. Must be the same as the Date of birth for Birth Events.
Collection methods	
Related data	Date of birth Event end datetime Operation/procedure date Event leave days Age at admission Length of stay
Source document	
Source organisation	

Event type

Definition	Code identifying the type of health event.
Column name	event_type
Table name	fact_nmd_health_event
Data type	varchar2(2)
Other names	
Context	
Layout	
Data domain	See the Event Type code table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact Analytical Services.
Guide for use	The presence of some fields depends on the Event type code. See Appendix : Enhanced Event Type/Event Diagnosis Type Table. Only one birth event is allowed for each NHI number. Babies born before mother's admission to hospital or transferred from the hospital of birth are recorded as IP. The NHI number, Event type code, Event start datetime, Facility code, and Event local identifier form a unique key for checking for duplicates on insert, or checking for existence on delete. See Appendix : Duplicate and overlapping event checking rules. 'ID' was used where the intention at admission was that the event will be a day-case event. This Event type was retired in 2013. 'IP': The definition of a mental health patient is 'a patient who has a mental illness diagnosis'. Patients with an intellectual disability are no longer regarded as mental health patients. With the introduction of the Mental Health (Compulsory Assessment and Treatment) Act 1992 on 1 November 1992, it became possible for mental health patients, both informal (ie, voluntary) and formal, to be admitted to a general ward of any public hospital or psychiatric hospital. When a mental health patient is admitted to a general ward for treatment of a psychiatric illness, then the event type code of 'IP' can now be used. This also includes day patients. A legal status code and leave details must also be supplied for these patients if relevant. The default for legal status is 'I' (voluntary patient).
Verification rules	Must be a valid code in the Event Type code table.
Collection methods	
Related data	
Source document	
Source organisation	

Excluded Purchase Unit

Definition	For events that have a Purchase Unit of 'EXCLU', the Purchase Unit allocated by mapping the Health Specialty Code to a Purchase Unit from the National Service Framework Data Dictionary.
Column name	exclu_purchase_unit
Table name	fact_nmd_health_event
Data type	varchar2(10)
Other names	
Context	
Layout	
Data domain	Purchase Units in the National Service Framework Data Dictionary.
Guide for use	Derived using a mapping table of Health Specialty Codes to Purchase Units.
Verification rules	
Collection methods	
Related data	Purchase Unit, Health Specialty Code
Source document	
Source organisation	Ministry of Health

Facility Transfer From

Definition	For transfers, the facility that the healthcare user was transferred from.
Column name	facility_transfer_from
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	
Context	
Layout	
Data domain	See the Facility code table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables For further information or a printed copy of the code table, contact Analytical Services.
Guide for use	Unit record information with Facility codes will not be provided to members of the public without the permission of the agency involved. See the Current Data Access Policy on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/access-and-use.
Verification rules	Mandatory for Admission Source Code = 'T' (Transfers) for the events ending on or after 1 July 2008. Must be a valid code in the Facility code table.
Collection methods	
Related data	Facility Code, Admission Source Code
Source document	
Source organisation	Ministry of Health

Facility Transfer To

Definition	For transfers, the facility that the healthcare user was transferred to.
Column name	facility_transfer_to
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	
Context	
Layout	
Data domain	See the Facility code table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact Analytical Services.
Guide for use	Unit record information with Facility codes will not be provided to members of the public without the permission of the agency involved. See the Current Data Access Policy on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/access-and-use
Verification rules	Mandatory for Event End Type Code = 'DA', 'DP', 'DT', 'EA' or 'ET' (Transfers) for the events ending on or after 1 July 2008. Must be a valid code in the Facility code table.
Collection methods	
Related data	Facility Code, Event End Type Code
Source document	
Source organisation	Ministry of Health

Facility code

Definition	A code that uniquely identifies a healthcare facility.
Column name	facility_code
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	Health agency facility code, Hospital, HAF code, HAFC
Context	
Layout	
Data domain	See the Facility code table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact Analytical Services.
Guide for use	A healthcare facility is a place, which may be a permanent, temporary, or mobile structure, that healthcare users attend or are resident in for the primary purpose of receiving healthcare or disability support services. This definition excludes supervised hostels, halfway houses, staff residences, and rest homes where the rest home is the patient's usual place of residence. See Appendix: Duplicate and Overlapping Event Checking rules.
Verification rules	Must be a valid code in the Facility code table. The NHI number, Event type code, Event start datetime, Facility code, and Event local identifier form a unique key for checking for duplicates on insert, or checking for existence on delete.
Collection methods	The Ministry of Health allocates codes on request. The code table is continually updated by the Ministry as hospitals open and close. See the Ministry web site for the most recent version.
Related data	Birth location Facility type
Source document	
Source organisation	Ministry of Health

Facility type

Definition	A code that categorises facilities into particular types.
Column name	facility_type
Table name	fact_nmd_health_event
Data type	varchar2(2)
Other names	
Context	
Layout	NN
Data domain	See the Facility Type code table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or printed copy of the code table, contact Analytical Services.
Guide for use	Used with Principal health service purchaser in determining whether an event is publicly funded.
Verification rules	
Collection methods	
Related data	Facility code Birth location Private flag
Source document	Create using the Facility type from the Facility table
Source organisation	

Financial year

Definition	Field identifying which financial year data belongs to.
Column name	financial_year
Table name	fact_nmd_health_event
Data type	varchar2(8)
Other names	
Context	
Layout	
Data domain	Range from '19221923', XXXXXXXX.
Guide for use	Runs from 1 July to 30 June. For example, 1 July 1998 to 30 June 1999 would be entered as '19981999'. Almost all data requests are based on a time period, the main ones of which are calendar and fiscal years. XXXXXXXX is used for those events where there is no Event end datetime. Event end datetime is not mandatory for mental health events.
Verification rules	Derived from the year in Event end datetime where present. If Event end datetime is missing then set to 'XXXXXXXX'.
Collection methods	
Related data	Event end datetime
Source document	
Source organisation	

First consult date

Definition	The date of the first specialist consultation which led to this event (including consultation with specialist in private practice). It may be the same date as the date of referral, eg, emergency admissions.
Column name	first_consult_date
Table name	fact_nmd_health_event
Data type	date
Other names	
Context	Elective surgical events.
Layout	
Data domain	Valid dates. Partial dates permissible. At a minimum the century and year must be supplied.
Guide for use	No longer reported to the NMDS. From July 2000, this information is collected in the Date of first specialist assessment field in the National Booking Reporting System (NBRS), which has more complete coverage. If day is provided but month is omitted then the day will not be recorded. Incomplete dates are stored as 'ccyy0101' or 'ccyymm01' and a partial date flag associated with the date is set to the appropriate value.
Verification rules	Optional. Must be on or after the Date of birth.
Collection methods	Required for total hip replacement, total knee replacement and coronary artery bypass graft events.
Related data	
Source document	
Source organisation	

Funding_agency_code

Definition The funding DHB code

Column name funding_agency_code

Table name fact_nmd_health_event

Data type varchar2(64)

Other names

Context

Layout

Data domain See the Agency code table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact the Analytical Services.

Guide for use The Funding Agency has been introduced from 1 July 2012. This field can be reported as a valid agency code or a given value or null based on the rules given for the validation.
Funding Agency must be reported in all the events reported in the v0r15.0 files regardless of the event end date.
Funding Agency will be available for reporting in the warehouse and BO universes.
Funding Agency will be used to determine if a health event is included in casemix funding.
An IDF will occur when the DHB of domicile is not the same as the Funding Agency.
Electives volumes will be calculated using the Funding Agency.
Mandatory for Principal health service purchaser = ('34','35','20','55','A0') for the events reported in v015.0 files. This is regardless of the event end date reported in the Ver15.0 files..
Must be a valid code in the agency code table if the Principal health service purchaser = '20','35','55'
Must be reported as 1236 if Principal health service purchaser = '35'
Must be reported as 1237 if Principal health service purchaser = 'A0'
For more details see Section 14.2 of the NMDS File Specification v015.2

Verification rules

Collection methods

Related data

Source document

Source organisation

Gender code

Definition	The person's biological sex.
Column name	gender_code
Table name	fact_nmd_health_event
Data type	char(1)
Other names	Sex type code
Context	Required for demographic analyses.
Layout	A
Data domain	M = Male F = Female U = Unknown I = Indeterminate
Guide for use	Stored as Gender code. Because it is possible for a person's sex to change over time, the Ministry of Health collects sex information for each health event, rather than relying on the data in the National Health Index (which does not include historical data). '"U' codes must be updated as soon as possible after admission. 'I' codes are for use in cases, usually newborns, where it is not possible to determine the sex of the healthcare user. The term sex refers to the biological differences between males and females, while the term gender refers to a person's social role (masculine or feminine). Information collected for transsexuals and transgender people should be treated in the same manner, ie, their biological sex reported. To avoid problems with edits, transsexuals undergoing a sex change operation should have their sex at time of hospital admission reported."
Verification rules	Must be a valid code in the Gender code table. The value in this field must be consistent with the diagnosis and procedures reported. If it is not, the record will be rejected from the NMDS with a warning. Generate warning if Gender code is 'U'.
Collection methods	
Related data	
Source document	
Source organisation	

Gestation period

Definition	Time measured from the date of mother's last menstrual period to the date of birth and expressed in completed weeks.
Column name	gestation_period
Table name	fact_nmd_health_event
Data type	varchar2(2)
Other names	Gestation
Context	Birth event.
Layout	XX
Data domain	XX = not stated 10 - 50 completed weeks
Guide for use	
Verification rules	Mandatory for birth events. Must not be supplied for other event types. If outside 17 to 45 completed weeks, will only be accepted on confirmation.
Collection methods	
Related data	
Source document	
Source organisation	

Health specialty code

Definition	A classification describing the specialty or service to which a healthcare user has been assigned, which reflects the nature of the services being provided.
Column name	health_specialty_code
Table name	fact_nmd_health_event
Data type	varchar2(3)
Other names	HSC, Service code, Department code
Context	Healthcare user on discharge.
Layout	
Data domain	See the Health Specialty code table at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact Analytical Services.
Guide for use	Generalist and specialist subspecialty medical and surgical health specialty codes were retired from 1 July 2001. On 1 July 2007 the following changes took place: M20: Endocrinology and Diabetology ..was discontinued and replaced with.. M95: Endocrinology M96: Diabetology M24: Paediatric Endocrinology and Diabetology ..was discontinued and replaced with.. M97: Specialist Paediatric Endocrinology M98: Specialist Paediatric Diabetology The need to separate diabetes out from other endocrinology events is because diabetes is the strategic area that the government has targeted and there is no other way to differentiate outpatient activity. On 1 July 2008 the following changes took place: P00 Antenatal services P10 Delivery services [mother] P11 Primary delivery services [midwife] P20 Postnatal services [mother] P30 Postnatal services [well newborn] P35 Primary postnatal services [specialist] Were retired and replaced with: P60 Maternity services - mother [no community LMC] P61 Maternity services - well newborn [no community LMC] P70 Maternity services - mother [with community LMC] P71 Maternity services - well newborn [with community LMC] 'With a Community LMC' should be defined as: At the time of the event, the woman and her baby(s) are registered with and under the care of a Lead Maternity Carer (LMC) under Section 88 Notice for primary Maternity Services (see subpart DA). Registered being as defined in the notice (clause DA2). For clarity, this should not include women or babies who have been transferred over to secondary maternity, tertiary maternity or specialist neonatal services (clause DA8). Note: - That this is the specialty on admission

- Community means not employed by the DHB - ie, a section 88 claim will be made for this birth or postnatal care.

For 'Section 88 Notice for Primary Maternity Services' refer to the Ministry of Health website: http://www.health.govt.nz/our-work/life-stages/maternity-and-breastfeeding/maternity-services/primary-maternity-services-notice-section-88

New health specialty code for events with a discharge date on or after 1 July 2008:

D55 Non-weight bearing and other related convalescence

This Health Specialty Code is intended for use where a patient undergoes a period of convalescence at a step-down facility other than the facility where their main rehabilitation program will occur.

Verification rules

Collection methods The specialty reported to the NMDS should be the specialty for the patient at the time of discharge.

Related data Purchase unit
Costweight

Source document

Source organisation

Length of stay

Definition	Length of stay in a facility in days.
Column name	length_of_stay
Table name	fact_nmd_health_event
Data type	varchar2(5)
Other names	LOS
Context	
Layout	NNNNN
Data domain	00001 - 99999
Guide for use	Calculated for events with Event end datetime. Date portion of Event end datetime minus date portion of Event start datetime minus Event leave days. Equates to midnights spent in hospital.
Verification rules	
Collection methods	
Related data	Event start datetime Event end datetime Event leave days
Source document	
Source organisation	

Location code

Definition	Birth location
Column name	location_code
Table name	fact_nmd_health_event
Data type	integer
Other names	Birth location code, Birth/death location code
Context	Birth event.
Layout	
Data domain	
Guide for use	
Verification rules	Mandatory for birth events. Must not be supplied for other event types. Must be a valid code in the Location code table. Must match the Facility type code on the Facility table.
Collection methods	
Related data	Facility code Facility type
Source document	
Source organisation	Ministry of Health

Major diagnostic category (MDC) code

Definition	The Major Diagnostic Category (MDC) is a category generally based on a medical classification that is associated with a particular medical speciality. MDCs are assigned by the DRG grouper program.
Column name	mdc_code
Table name	fact_nmd_health_event
Data type	varchar2(2)
Other names	
Context	
Layout	NN
Data domain	See the MDC code table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact Analytical Services.
Guide for use	
Verification rules	
Collection methods	
Related data	MDC type DRG codes DRG grouper type
Source document	AR_DRG Definitions Manual
Source organisation	

Major diagnostic category (MDC) type

Definition A code denoting which version of a grouper a Major Diagnostic Category (MDC) code belongs to.

Column name mdc_type

Table name fact_nmd_health_event

Data type char(1)

Other names

Context

Layout A

Data domain

A	AN-DRG version 3.1
B	AR-DRG version 4.1
C	AR-DRG version 4.2
D	AR-DRG version 5.0
E	AR-DRG version 6.0
F	AR-DRG version 6.0x

Guide for use Derived from the version of the grouper used to create the DRG code.

Verification rules

Collection methods

Related data MDC code
DRG codes
DRG grouper type code

Source document

Source organisation

Month of data

Definition	Field identifying which month the dta belongs to
Column name	month_of_data
Table name	fact_nmd_health_event
Data type	varchar2(2)
Other names	
Context	Field to assist in compiling fiscal year datasets.
Layout	XX
Data domain	01 - 12, XX
Guide for use	
Verification rules	Derived from the month of discharge. If Event end datetime is missing then set to 'XX'.
Collection methods	
Related data	Event end datetime Financial year
Source document	
Source organisation	

Mother's Encrypted NHI

Definition	For birth events, the Mother's NHI in encrypted form.
Column name	mothers_encrypted_hcu_id
Table name	fact_nmd_health_event
Data type	varchar2(11)
Other names	Mother's NHI
Context	
Layout	
Data domain	System-generated
Guide for use	Only reported for Birth events The NHI number is the cornerstone of the Ministry of Health's data collections. It is a unique 7-character identification number assigned to a healthcare user by the National Health Index (NHI) database. The NHI number uniquely identifies healthcare users, and allows linking between different data collections. It is encrypted in the NMDS to ensure privacy of individual records. VALIDATION The first three characters of an NHI number must be alpha (but not 'I' or 'O'). The 4th to 6th characters must be numeric. The 7th character is a check digit modulus 11. ENCRYPTION The NHI number is encrypted using a one-way encryption algorithm. The aim is to provide an encrypted number that can be sent across public (unsecured) networks. New numbers can be allocated by health providers who have direct access to the NHI Register. New NHI numbers are also allocated by Sector Services for GPs and other primary care providers.
Verification rules	Must be registered on the NHI database before the NHI number can be used in the NMDS.
Collection methods	NHI numbers are often included on patient notes and other patient documentation.
Related data	Encrypted NHI Number
Source document	http://www.health.govt.nz/our-work/health-identity/national-health-index
Source organisation	Ministry of Health

NZ drg code

Definition A diagnosis-related group (DRG) code produced by the current DRG grouper program version 6.0.

Column name nz_drg_code

Table name fact_nmd_health_event

Data type varchar2(4)

Other names

Context Clinical demographic and administrative information within a health event.

Layout

Data domain 801A - 963Z, A01Z - Z65Z

Guide for use A diagnosis-related group (DRG) code of clinical version 4.1, 4.2, 5.0, 6.0 or 6.0x produced by the current DRG grouper program version 6.0x which takes up to 30 diagnoses and 30 procedure codes in a health event and assigns a DRG code based on a complex algorithm.

The version 4 groupers used 20 codes. This provides another way of analysing event information based on classifying episodes of inpatient care into clinically meaningful groups with similar resource consumption.

Introduced on 1 July 2001 for DRG clinical version 4.1.

If the Event end datetime is between 1 July 2001 and 30 June 2002, this field contains a DRG code of clinical version 4.1.

If the Event end datetime is between 1 July 2002 and 30 June 2004, this field contains a DRG code of clinical version 4.2.

If the Event end datetime is between 1 July 2005 and 30 June 2011 this field contains a DRG code of clinical version 5
If the Event end datetime is between 1 July 2011 and 30 June 2013 this field contains a DRG code of clinical version 6
If the Event end datetime is on or after 1 July 2013, this field contains a DRG code of clinical version 6.0x
Calculated from:
- personal information (eg, Sex, Date of birth), and
- event information (eg, Admission date, Event end type), and
- diagnosis and procedure information in the appropriate ICD code for the DRG Grouper (ICD-10-AM 3rd Edition).
- Between 1 July 2004 and 30 June 2005, most hospitals supplied diagnosis and procedure information using ICD-10-AM 3rd Edition codes. As AR-DRG version 5.2 requires ICD-10-AM 2nd Edition codes, NMDS will map the 3rd edition codes supplied by hospitals to 2nd edition codes and use these to assign an AR-DRG 4.2 code.
- Between 1 July 2004 and 30 June 2008, most hospitals supplied diagnosis and procedure information using ICD-10-AM 3rd Edition codes. AR-DRG version 5.0 required no additional mapping.
- Between 1 July 2008 and 30 June 2011, the field contains a DRG from AR-DRG version 5.0 derived, if necessary, by mapping ICD-10-AM 6th Edition codes back to ICD-10-AM 3rd Edition Codes
- Between 1 July 2011 and 30 June 2013, the field contains a DRG from AR-DRG version 6.0, the derivation for which uses ICD-10-AM 6th Edition codes.
- Between 1 July 2013 and 30 June 2014, the field contains a DRG from AR-DRG version 6.0x, the derivation for which uses ICD-10-AM 6th Edition codes.
- From 1 July 2014, the field contains a DRG from AR-DRG versions 6.0x derived, if necessary, by mapping ICD-10-AM 8th Edition codes

back to ICD-10-Am 6th Edition codes.

External cause codes are not used by the grouper. It is recommended that hospitals prioritise diagnoses and procedure codes in order to present the grouper with the most severe diagnoses and operations.

Verification rules

Collection methods

Related data

Costweight code
Costweight
Purchase unit
PCCL
MDC code
MDC type
DRG grouper type code

Source document

Source organisation

The logic for the DRG software is specified by the Health Services Division of the Commonwealth Department of Health and Ageing, Australia.

NZ resident flag

Definition	A code identifying resident status at the time of this event.
Column name	nz_resident_flag
Table name	fact_nmd_health_event
Data type	char(1)
Other names	HCU resident status, Residency, Resident status, HCU NZ resident status
Context	Used to identify overseas residents treated in New Zealand. Tied to public funding of events.
Layout	A
Data domain	'Y' = Permanent resident (New Zealand citizen or classified as 'ordinarily resident in New Zealand') 'N' = Temporary (not a New Zealand citizen, does not have New Zealand 'ordinarily resident' status)
Guide for use	A permanent resident is defined as a person who: - resides in New Zealand and - is not a person to whom Section 7 of the Immigration Act 1987 applies or a person obliged by or pursuant to that Act to leave New Zealand immediately or within a specified time or deemed for the purposes of that Act to be in New Zealand unlawfully.
Verification rules	
Collection methods	
Related data	
Source document	Immigration Act 1987
Source organisation	

Occupation code

Definition	A code for an occupation of the healthcare user, classified according to the Australian and New Zealand Standard Classification of Occupations, 2013, Version 1.2 with effect from 1 July 2015, and the Statistics NZ Standard Classification of Occupations (NZSCO90) up until 30 June 2015.
Column name	occupation_code
Table name	fact_nmd_health_event
Data type	varchar2(6)
Other names	
Context	
Layout	
Data domain	0111 - 999999. See the Occupation code table at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact Analytical Services.
Guide for use	
Verification rules	Optional.
Collection methods	Occupation free-text is preferred.
Related data	Occupation description
Source document	Australian and New Zealand Standard Classification of Occupations, 2013, Version 1.2 NZSCO90 - Statistics NZ Standard Classification of Occupations
Source organisation	Australian Bureau of Statistics and Statistics NZ

Occupation free text

Definition	A free-text description of the healthcare user's occupation.
Column name	occupation_free_text
Table name	fact_nmd_health_event
Data type	varchar2(70)
Other names	Occupation free-text, Occupation text
Context	
Layout	
Data domain	
Guide for use	Introduced in November 2001. Since September 2008, Cancer Registry staff have not been able to populate or update this field. Note that the NMDS is a better source of information about the occupation of healthcare users than is the Cancer Registry. This is because the Cancer Registry obtains this data while automatically creating cancer events from hospital discharge events, but most of these cancer events are subsequently rejected rather than registered.
Verification rules	Optional
Collection methods	Should be reported for cancer patients
Related data	Occupation code
Source document	
Source organisation	

Patient clinical complexity level (PCCL)

Definition	Patient Clinical Complexity Level (PCCL) data identifies the clinical severity of the patients symptoms, within the patient record.
Column name	pccl
Table name	fact_nmd_health_event
Data type	char(1)
Other names	
Context	
Layout	
Data domain	
Guide for use	Relates only to DRG Grouper versions 4.1, 4.2, 5.0, 6.0 and 6.0x. Serves the same purpose for DRG Grouper clinical versions 4.1, 4.2, 5.0, 6.0 and 6.0x as CCL does for DRG Grouper clinical versions 3.1 and 3.2. In the AR-DRG Definitions Manual it says 'PCCL is a measure of the cumulative effect of a patient's complications and comorbidities, and is calculated for each episode. The calculation is complex and has been designed to prevent similar conditions from being counted more than once'.
Verification rules	
Collection methods	
Related data	DRG code current CCL
Source document	AR-DRG Definitions Manual
Source organisation	The logic for the DRG software is specified by the Health Services Division of the Commonwealth Department of Health and Ageing, Australia

Pms unique identifier

Definition	A unique local PMS identifier for a particular health event.
Column name	pms_unique_identifier
Table name	fact_nmd_health_event
Data type	varchar2(14)
Other names	
Context	
Layout	Free text
Data domain	
Guide for use	This field is intended to be used to link NMDS events with the relevant booking system entry. With the Client system identifier, this field replaced the Local system health event identifier field in 2000. The Local system health event identifier field was introduced in 1999.
Verification rules	
Collection methods	This should be a unique event identifier in your patient management system. For security reasons, do not use the NHI number.
Related data	Replaces the field previously known as Local system health event identifier
Source document	
Source organisation	

Principal diag 06 clin code

Definition	A code used to classify the principal diagnosis/clinical description of a condition.
Column name	principal_diag_06_clin_code
Table name	fact_nmd_health_event
Data type	varchar2(8)
Other names	
Context	
Layout	
Data domain	Must be a valid code in the ICD-9-CM-A 2nd Edition – Australian Version of The International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition.
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Principal diag 10 clin code

Definition	A code used to classify the clinical description of a condition.
Column name	principal_diag_10_clin_code
Table name	fact_nmd_health_event
Data type	varchar2(8)
Other names	
Context	
Layout	See Collection method.
Data domain	Must be a valid code in one of the ICD-10-AM 1st Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition.
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Principal diag 11 clin code

Definition	A code used to classify the clinical description of a condition.
Column name	principal_diag_11_clin_code
Table name	fact_nmd_health_event
Data type	varchar2(8)
Other names	
Context	
Layout	See Collection method.
Data domain	Must be a valid code in one of the ICD-10-AM 2nd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Principal diag 12 clin code

Definition	A code used to classify the clinical description of a condition.
Column name	principal_diag_12_clin_code
Table name	fact_nmd_health_event
Data type	varchar2(8)
Other names	
Context	
Layout	
Data domain	Must be a valid code in one of the ICD-10-AM 3rd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition.
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Principal diag 13 clin code

Definition	A code used to classify the clinical description of a condition.
Column name	principal_diag_13_clin_code
Table name	fact_nmd_health_event
Data type	varchar2(8)
Other names	
Context	
Layout	
Data domain	Must be a valid code in ICD-10-AM 6th Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 6th Edition.
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Principal diag 14 clin code

Definition	A code used to classify the clinical description of a condition.
Column name	principal_diag_14_clin_code
Table name	fact_nmd_health_event
Data type	varchar2(8)
Other names	
Context	
Layout	
Data domain	Must be a valid code in ICD-10-AM 8th Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 8th Edition.
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Prioritised ethnic code

Definition	The most highly prioritised ethnicity of the three ethnic groups recorded for the healthcare user, determined according to a Statistics NZ algorithm.
Column name	prioritised_ethnic_code
Table name	fact_nmd_health_event
Data type	varchar2(2)
Other names	
Context	Demographic information.
Layout	NN
Data domain	See the Ethnic code table table on the Ministry of Health web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact Analytical Services.
Guide for use	Ethnic codes are ranked on the Ethnic code table from '1' (highest priority) to '21' (lowest priority), with '99' for not stated. Prioritised ethnicity is the healthcare user's ethnic code with the highest priority. Prioritising ethnic codes simplifies analysis. See Appendix: Guide for Use of Ethnic Codes.
Verification rules	
Collection methods	
Related data	Ethnic group Ethnic group 2 Ethnic group 3
Source document	
Source organisation	Statistics NZ

Private hospital flag

Definition	Flag to indicate whether the health event was privately funded.
Column name	private_hospital_flag
Table name	fact_nmd_health_event
Data type	char(1)
Other names	
Context	
Layout	A
Data domain	'Y' = Yes 'N' = No Null
Guide for use	
Verification rules	Is 'Y' if: - Principal health service purchaser is '06' or '19', or - Principal health service purchaser is '98' or blank and Facility type is '02'.
Collection methods	
Related data	Principal health service purchaser Facility type
Source document	
Source organisation	

Psychiatric leave end type

Definition	A code describing how a period of leave ended for a committed mental health patient.
Column name	psychiatric_leave_end_type
Table name	fact_nmd_health_event
Data type	char(1)
Other names	
Context	A healthcare user is discharged on leave, then the event ends by discharge or re-admission to hospital. Only for healthcare users committed under the Mental Health (Compulsory Assessment & Treatment) Act 1992.
Layout	A
Data domain	D Discharged E Died R Returned to the same psychiatric institution T Transferred to another psychiatric institution
Guide for use	Not reliably reported since 1993. Healthcare users can be on leave for up to 2 years under the Act.
Verification rules	Optional. Must only be present if Event end type is 'DL'.
Collection methods	
Related data	Psychiatric leave end date
Source document	
Source organisation	

Public birth

Definition	A flag to indicate whether a birth is publicly funded.
Column name	public_birth
Table name	fact_nmd_health_event
Data type	char(1)
Other names	
Context	Birth event.
Layout	
Data domain	
Guide for use	Not used.
Verification rules	Is 'Y' if Principal health service purchaser is not '06' or '19' and Event type code is 'BT'. Only one Public birth flag must be 'Y' for any primary NHI number.
Collection methods	
Related data	Principal health service purchaser
Source document	
Source organisation	

Purchase unit

Definition	Purchase unit indicates which contract the event is funded under.
Column name	purchase_unit
Table name	fact_nmd_health_event
Data type	varchar2(10)
Other names	
Context	
Layout	
Data domain	
Guide for use	It is derived directly from Health specialty. Some events have a purchase unit of 'EXCLU' (ie, not eligible). See the New Zealand Casemix Framework for Publicly Funded Hospitals including WIES methodology and Casemix Purchase Unit Allocation document for the criteria. http://www.health.govt.nz/nz-health-statistics/data-references/weighted-inlier-equivalent-separations.
Verification rules	
Collection methods	
Related data	DRG codes Costweight Costweight code Health specialty code
Source document	New Zealand Casemix Framework for Publicly Funded Hospitals including WIES methodology and Casemix Purchase Unit Allocation
Source organisation	Cost Weights Working Group

Purchaser code

Definition Principal health service purchaser - The organisation or body that purchased the healthcare service provided. In the case of more than one purchaser, the one who paid the most.

Column name purchaser_code

Table name fact_nmd_health_event

Data type varchar2(2)

Other names Principal purchaser, Health purchaser, Purchaser code, PHP, PHS, Purchase code

Context

Layout XN

Data domain See the Principal health service purchaser code table at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables. For further information or a printed copy of the code table, contact Analytical Services.

Guide for use Introduced on 1 July 1995.
From 1 July 1999, codes '01', '02', '03', and '04' were replaced by the code for base purchases ('13'), that is, the four Regional Health Authorities were integrated into one Health Funding Authority.
From 1 July 2004, codes '07', '08', '09', '10', '11', '12' and '14' were retired as they have been rolled into base funding and therefore are no longer required.
'A1' to 'A7' codes are only for health events resulting from workplace accidents that occurred in the one year for which the Accident Insurance Act 1998 applied.
See Appendix: Guide for use of NMDS Health Service Purchaser Codes.
If the Principal Health Service Purchaser Code is between 'A0' and 'A7', the Accident Flag should be set to 'Y' and the ACC Claim Number field should not be blank.
As from 1 July 2007 events with an end date outside the Principal health service purchaser code's start and end date range will be rejected. Events with an end date before 1 July 2007 and having a Purchaser Code with a start date before 1 July 2007 will not be rejected. For event type IM where there is no end date, the event start datetime is used when validating against the Purchaser Code's start and end dates.
Prior to 1 July 2007 acute, arranged and booking list cases would normally be assigned the base funding code ('13').
On or after 1 July 2007 acute or arranged cases should be reported with purchaser code 35- DHB Funded.
The Additional Electives funding (Orthopeadics Initiative, Cataract Initiative and Additional Elective Services Initiative) should be reported as 35- DHB Funded. This is because the Ministry now pays the money to the DHB funder arm, who then contracts with the DHB provider arm, or makes IDF payments for the work.
Purchaser code 33 was introduced in 2013 for MoH funded screening programmes
All Accredited Employer acute treatment/visits should be reported with 35-DHB Funded purchaser code with the Accident Flag and ACC45 claim number. These are then included in the Acute Levy calculations the same as ACC patients.
Purchaser 17 (just like purchaser A0) is used for all post acute/elective treatments or visits and should be invoiced directly to the Accredited Employer. Purchaser 17 activity is excluded from the Levy calculations because it is not acute and has been invoiced directly.
Privately funded cases would normally be assigned '06'.

If a specified purchaser for the health event has been identified, use that code.
For elective cases, use the appropriate insurer code.
Where the employer has a risk-sharing arrangement with their insurer, the insurer must still be recorded as the principal purchaser.
Refer to the booklet 'Accident Services - Who Pays?' available from http://www.moh.govt.nz/notebook/nbbooks.nsf/0/9fecff85d44b17c8cc25709300001caa/$FILE/AccidentServices.pdf for guidelines on coding acute accident patients.
OVERSEAS VISITORS
If the healthcare user is an overseas resident who:
- does not meet the eligibility criteria for publicly-funded health services, including overseas residents from non-reciprocal countries and patients with pre-existing conditions from reciprocal agreement countries, use code '19' (Overseas chargeable)
- meets the eligibility criteria for publicly-funded health services, including students from any country with a valid visa and patients from countries with reciprocal health agreements, use code '20' (Overseas eligible).
Note: Codes '19' and '20' will be excluded from funding if the date portion of Event end datetime is before 1 July 2003.
For further information, see the Guide to Eligibility for Publicly-Funded Personal Health and Disability Services in

	New Zealand on the Ministry of Health web site http://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services
Verification rules	Code must be present in the Purchaser code table. The date portion of Event end datetime must be on or prior to the Purchaser code end date (if populated).
Collection methods	
Related data	ACC claim number Private Flag
Source document	
Source organisation	

Referral date

Definition	The date of the doctor's referral letter, or date presented for self-referral, or date of transfer which resulted in this event, whichever date is earlier. This date is required for select surgical procedures.
Column name	referral_date
Table name	fact_nmd_health_event
Data type	date
Other names	
Context	Elective surgical events.
Layout	
Data domain	Valid dates Partial dates are permissible. At a minimum the century and year must be supplied.
Guide for use	Not used. Not reliably reported to the NMDS. From July 2000, this information is also collected in the Date of referral for first specialist assessment field in the National Booking Reporting System (NBRS), which has more complete coverage. If day is provided but month is omitted then the day will not be recorded. Incomplete dates are stored as 'ccyy0101' or 'ccyymm01' and a partial date flag associated with the date is set to the appropriate value.
Verification rules	Optional.
Collection methods	Required for total hip replacement, total knee replacement and coronary artery bypass graft events.
Related data	
Source document	
Source organisation	

Suppression flag

Definition	A flag signifying that the healthcare user has requested that details of this event not be passed to the event summary extract for display in the MWS system.
Column name	suppression_flag
Table name	fact_nmd_health_event
Data type	char(1)
Other names	
Context	
Layout	A
Data domain	Y suppress this event summary N allow this event summary to be displayed
Guide for use	Providers should inform patients that their data will be sent to the Ministry of Health for inclusion in the NMDS, and advise them that the event may also be viewed via the Medical Warning System. The patient must be given the option of suppressing the event from display on the NMDS, but the patient does not have the right to object to the information being stored on the NMDS.
Verification rules	
Collection methods	See Guide for Use
Related data	
Source document	
Source organisation	

Surgical priority

Definition	A code defining the severity of a healthcare user's condition at the date surgery was decided.
Column name	surgical_priority
Table name	fact_nmd_health_event
Data type	char(1)
Other names	
Context	Elective surgical events.
Layout	A
Data domain	R Routine S Semi-urgent U Urgent
Guide for use	Not used. Previously known as Severity code. Not reliably reported to the NMDS. From July 2000, this information is also collected in the CPAC score field in the National Booking Reporting System (NBRS), which has more complete coverage.
Verification rules	Optional.
Collection methods	
Related data	Date surgery decided
Source document	
Source organisation	

TLA of domicile

Definition	Territorial local authority of domicile.
Column name	tla
Table name	fact_nmd_health_event
Data type	varchar2(3)
Other names	
Context	Geographical aggregation.
Layout	NNN
Data domain	See TLA code table in Appendix.
Guide for use	The TLA of domicile roughly equates to local council boundaries. Populated from 1988. Derived from the Ministry of Health mapping of Domicile code to TLA. No code table exists. Domicile code 3402 Oceanic - Chatham Islands is included in TLA 'other' as it is not a Land Authority and is classified as subregion 15 'Hawke's Bay' which is not shown in this table.
Verification rules	
Collection methods	
Related data	Domicile code
Source document	
Source organisation	

Total hours on continunous positive airway pressure

Definition Total hours on continuous positive airway pressure - The total number of hours a neonate (less than 29 days, or more than 29 days and less than 2500 g) is on CPAP during a perinatal episode of care.

Column name hours_on_cpap

Table name fact_nmd_health_event

Data type varchar2(5)

Other names CPAP hours

Context

Layout NNNNN

Data domain 00000 - 99999

Guide for use Hours on continuous positive airway pressure has been used in determining the DRG code since 1 July 2001.

A CPAP CPAP procedure is:
- an ICD-10-AM 6th Edition Clinical codes of 9220900,9220901,9220902 (Clinical code type = 'O') or
- an ICD-10-AM 1st, 2nd, 3rd Edition Clinical code of 9203800 (Clinical code type = 'O'), or
- an ICD-9-CM or ICD-9-CM-A Clinical code of 93.90 (Clinical code type = 'O').

There is no specific procedure code for CPAP in ICD-10-AM 6th edition or ICD-10-AM 8th edition; it is included in the non invasive ventilation (NIV) codes:

9220900 [570] Management of noninvasive ventilatory support, <= 24 hours
9220901 [570] Management of noninvasive ventilatory support, > 24 and < 96 hours
9220902 [570] Management of noninvasive ventilatory support, >= 96 hours

Note:
The logical back mapping tables (from 6th edition to 3rd edition) convert the three NIV procedure codes (above) to the CPAP procedure code 9203800. Therefore, any data extract based on the CPAP procedure code 9203800 for events where the date portion of Event end datetime is on or after 1 July 2008 will include bilevel positive airway pressure [BiPAP] and intermittent positive pressure breathing [IPPB] and continuous positive airway pressure [CPAP].

Generate warning if infant is:
- more than 364 days old at Event end datetime, or
- between 28 and 364 days old and Weight on admission is more than 2500 g at Event end datetime.

Generate warning if:
- more than 100, or
- more than calculated number of hours from Event start datetime to Event end datetime inclusive.

For records with the date portion of Event end datetime before 1 July 2008
Generate warning if present and a CPAP procedure (as defined in Guide for use above) is not present.

Generate warning if not present when a CPAP procedure (as defined in Guide for use above) is present, unless:
- Total hours on mechanical ventilation is present, or
- age at Event end datetime is more than 364 days, or

- age is between 28 days and 364 days and Weight on admission is more than 2500 g.

Generate warning if present and Health specialty code not in the P30 and P40 ranges.
For records where the date portion of Event end datetime is on or after 1 July 2008
Generate error if present and a NIV procedure (as defined in Guide for use above) is not present.

Records can be reported with an NIV procedure and no hours present if IPPB or BiPAP has been administered.
Generate warning if present and Health specialty code is not P61, P71 or in the P40 range.

Total hours on continuous positive airway pressure (CPAP) is used to capture the number of hours a patient is on CPAP during an episode of care. As in the Total hours on mechanical ventilation variable, part hours are rounded up. CPAP hours should not be collected when CPAP is used as a method of weaning from continuous ventilatory support or performed by endotracheal tube [ETT] or tracheostomy.

CPAP hours may be reported within the same event as mechanical ventilation hours. If CPAP is used to wean a patient from mechanical ventilation, the time on CPAP will be added to the hours on mechanical ventilation. Where CPAP is being used as a separate valid treatment modality in the same episode of care as mechanical ventilation, a CPAP (NIV) procedure must be coded and CPAP hours recorded.

CLINICAL CODING GUIDELINES
When coding in ICD-10-AM 6th edition NIV procedure codes should be assigned for all cases and calculation of hours are to be in accordance with the coding standard (ACS 1006 page 176).

NIV should not be assigned when it is used as a method of weaning from continuous ventilatory support (CVS) or performed by endotracheal tube [ETT] or tracheostomy.

NIV should not be coded when the patient brings in their own ventilatory support devices (eg, CPAP machine) into hospital.
The CPAP 92038-00 [568] 1st, 2nd and 3rd procedure code should be assigned for any duration when required for infants.

Verification rules Optional.

Collection methods

Related data Total hours on mechanical ventilation

Source document

Source organisation

Total Hours on mechanical ventilation

Definition	The total number of hours on mechanical ventilation.
Column name	hours_on_ventilation
Table name	fact_nmd_health_event
Data type	varchar2(5)
Other names	Hours on mechanical ventilation, HMV
Context	Total hours for the health event irrespective of the specialty team treating the patient
Layout	NNNNN
Data domain	00000 - 99999
Guide for use	Hours on mechanical ventilation has been used in determining the DRG code since 1 July 1999. It may also trigger the mechanical ventilation co-payment for eligible DRGs
Verification rules	Optional. Generate warnings if: —not present when a Mechanical Ventilation procedure is present (i.e., ICD-10-AM, 1st, 2nd, 3rd, 6th or 8th Edition Clinical Code = 1388200, 1388201 or 1388202 (Clinical Code Type = 'O'); or ICD-9 or ICD-9-CM-A Clinical Code = 96.70 or 96.71 or 96.72 (Clinical Code Type = 'O'), and/or —greater than the difference (calculated in hours) between the date portions of Event start datetime and Event end datetime. The ICD-10-AM 8th-edition procedure code 9221100 must be assigned to a health event record if and only if: —the health specialty code in in P41, P42, P43, P61, or P71 and —the submitted system ID is 14 and —one of 1388200, 1388201, 1388202 has been assigned and —one of 9220900, 9220901, 9220902 has been assigned and —the sum of NIV and CVS hours is greater than or equal to 96.
Collection methods	When calculating the total hours on mechanical ventilation include all ventilated hours (excluding surgery). This includes all ventilation administered irrespective of the health specialty or team treating the patient. Calculation of the total hours on mechanical ventilation will commence from the time the patient is ventilated. If the patient has commenced ventilation prior to arriving to the hospital (e.g., on route in the ambulance), it will be calculated from the time of arrival. Exclude time spent being ventilated while undergoing surgery (being ventilated while undergoing surgery is not an indicator of severity). Hours where the patient is in radiology or emergency care should be included in the total mechanical ventilation hours for reporting purposes. Time spent weaning (regardless of the physical location in which the patient is treated) with other types of ventilation such as continuous positive airways pressure (CPAP) or intermittent mechanical ventilation (IMV) is included if the patient is still intubated. Apart from weaning as described, other forms of ventilation should not be included (e.g., non-intubated CPAP, IPPB, BiPAP). When reporting the total hours on mechanical ventilation an incomplete hour is rounded up to the next hour; e.g., if the time ventilated is 98 hours 10 minutes, then the total hours on mechanical ventilation

reported will be '00099'. The minimum number of ‘total hours on mechanical ventilation’ reported is 1.

CLINICAL CODING
All hours on mechanical ventilation in the Emergency Department (ED) should be coded, whether the patient is intubated in ED or in the ambulance. If ventilation is commenced in the ambulance, it will be counted only from the time of hospitalisation.

Hours on continuous ventilatory support (CVS) (mechanical ventilation) should be interpreted as completed cumulative hours.

1. If more than one period of CVS (mechanical ventilation) occurs during the same hospitalisation when used for treatment (not weaning) should be added together. For example, if a patient is on CVS for the first day of their admission, then on CVS again on the fourth day of their admission, the CVS hours should be added together to arrive at the correct CVS procedure code.

2. ICD procedure coding includes all time spent ventilated from time of arrival to hospital (or time of intubation).

3. For ICD procedure coding the minimum number of completed hours is 1.

4. Partially completed hours are not counted when allocating a procedure code, ie, they are roundeddown for ICD procedure coding.

WORKED EXAMPLE
Patient brought in by ambulance at 10.32am. Patient goes into acute respiratory failure and was intubated and commenced ventilation in ED at 10.50am. Once the patient was stabilised he was admitted to ICUat 11.43am (day one). The next day (day two) the patient was transferred to theatre for surgery. Total time in theatre was 4 hours. The patient returned to ICU and remained ventilated until the next day (day three) when mechanical ventilation ceased and the patient was extubated at 12.32pm.

On day one patient commenced ventilation in ED at 10.50am and was extubated 12.32pm on day three. Total mechanical ventilation hours:
(Day 1) 13hrs 10mins + (Day 2) 24hrs + (Day 3) 12.32hrs
Total hours on mechanical ventilation = 49 hours 42 minutes

Reporting total hours on mechanical ventilation:
49.42 hours minus 4 hours in theatre = 45.42 hours (rounded up) = 46 hours. 46 hours is to be reported in the total hours on mechanical ventilation field.

Procedure code assignment:
13882-01 [569] *Management of continuous ventilatory support, > 24 and < 96 hours* As per the coding guidelines the total hours used in order to assign the correct procedure code would be 49 hours.

Related data Total hours on continuous positive airway pressure
Total noninvasive ventilation hours

Source document See the AR-DRG manual

Source organisation

Total ICU Hours

Definition	Total duration of stay (hours) in an Intensive Care Unit (ICU) during this episode of care.
Column name	total_icu_hours
Table name	fact_nmd_health_event
Data type	number(5)
Other names	
Context	Total hours for the health event.
Layout	NNNNN
Data domain	00001-99999 or NULL
Guide for use	An intensive care unit (ICU) is a specially staffed and equipped, separate and self-contained section of a hospital for the management of patients with life-threatening or potentially life-threatening conditions. Such conditions should be compatible with recovery and have the potential for an acceptable future quality of life. An ICU provides special expertise and facilities for the support of vital functions, and utilises the skills of medical nursing and other staff experienced in the management of these problems. Smaller hospitals may have an ICU combined with an HDU and/or a CCU. Not all admissions to such a unit will be an Intensive Care. Events with the date portion of Event end datetime before 1 July 2008 and a value in the Total ICU hours will not be loaded in to the NMDS. Events with the date portion of Event end datetime on or after 1 July 2008 must have a null value or positive for the field Total ICU hours. A warning is generated if the total ICU hours reported in an NMDS event (with the date portion of Event end datetime on or after 1 July 2008) is greater than the length of stay. If ICU treatment started in the ED before admission then it is possible that the hours are greater than the length of stay but this is unusual. If the patient has more than one period in ICU during this hospital episode, the total duration of all such periods is reported. Hours in a High Dependency Unit (HDU) and in a Neonatal Intensive Care Unit (NICU) are not to be included. An incomplete hour is rounded up to the next hour; eg, if the total time in the care of the ICU team during the event is 98 hours 10 minutes, then the reported time will be '99'.
Verification rules	Optional. If reported, must be positive
Collection methods	
Related data	
Source document	
Source organisation	

Total NIV hours

Definition The total number of hours on noninvasive ventilation during an episode of care.

Column name total_niv_hours

Table name fact_nmd_health_event

Data type number(5)

Other names

Context

Layout

Data domain 00001-99999 or NULL

Guide for use Noninvasive ventilation (NIV) refers to all modalities that assist ventilation without the use of an ETT or tracheostomy. Noninvasive devices include: face mask, mouthpiece, nasal mask, nasal pillows, nasal prongs, nasal tubes and nasopharyngeal tubes.

Types/modes of noninvasive ventilatory support are:

- Bi-level positive airway pressure [BiPAP]
- Continuous positive airway pressure [CPAP]
- Intermittent mask [CPAP]
- Intermittent positive pressure breathing [IPPB]
- Intermittent positive pressure ventilation [IPPV]
- Noninvasive mask ventilation [NIMV]
- Noninvasive pressure ventilation [NIPV]

Total hours on noninvasive ventilation (NIV) is used to capture the number of hours a patient is on NIV during an episode of care. As in the total hours on mechanical ventilation variable, part hours are rounded up.
NIV hours should not be collected when NIV is used as a method of weaning from continuous ventilatory support (CVS) or performed by endotracheal tube (ETT) or tracheostomy. If NIV is used to wean a patient from CVS, the time on NIV will be added to the hours on CVS.

NIV hours may be reported within the same event as mechanical ventilation hours. Where NIV is being used as a separate valid treatment modality in the same episode of care as CVS, a NIV procedure must be coded and NIV hours recorded.

Subsequent periods of NIV when used for treatment (not weaning) should be added together.

CLINICAL CODING AND REPORTING GUIDELINES

When coding in ICD-10-AM 6th edition and ICD-10-AM 8th Edition NIV procedure codes 92209-00, 92209-01 and 92209-02 [570] should be assigned for all cases and calculation of hours are to be in accordance with Australian Coding Standard (ACS 1006 page 176).

Hours on noninvasive ventilation (NIV) should be interpreted as completed cumulative hours.

For ICD coding the minimum number of completed hours is 1.
The minimum number reported for the field 'Total hours on noninvasive ventilation' is 1.

If more than one period of NIV occurs during the same episode of care when used for treatment (not

weaning) should be added together. For example, if a patient is on NIV for the first day of their
admission, then on NIV again on the fourth day of their admission, the NIV hours should be added
together to arrive at the correct NIV procedure code.

Partially completed hours are not counted when allocating a procedure code, eg, they are rounded down
for ICD procedure coding but rounded up for calculating the total NIV hours field.

NIV should not be assigned when it is used as a method of weaning from continuous ventilatory support
(CVS) or performed by endotracheal tube (ETT) or tracheostomy.

NIV should not be coded when the patient brings in their own ventilatory support devices (eg, CPAP
machine) into hospital.

Verification rules Optional. If reported, must be positive integer or null.

The ICD-10-AM 8th-edition procedure code 9221100 must be assigned to a health event record if and only if:
—the health specialty code in in P41, P42, P43, P61, or P71 and
—the submitted system ID is 14 and
—one of 1388200, 1388201, 1388202 has been assigned and
—one of 9220900, 9220901, 9220902 has been assigned and
—the sum of NIV and CVS hours is greater than or equal to 96.

Collection methods

Related data Total hours on mechanical ventilation

Source document

Source organisation

Transaction id

Definition	A sequential number within the batch. With the Batch ID, this forms a unique identifier for each transaction.
Column name	transaction_id
Table name	fact_nmd_health_event
Data type	integer
Other names	
Context	
Layout	
Data domain	
Guide for use	Generated by the load process. Used internally for reference.
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Weight on admission

Definition The weight in grams at time of admission for infants less than 29 days old.

Column name weight_on_admission

Table name fact_nmd_health_event

Data type integer

Other names HCU weight on admission, Admission weight

Context Used in DRG calculations.

Layout NNNN

Data domain 0001 - 9999 grams

Guide for use A reported admission weight of less than 2500 grams for infants older than 28 days means these infants are allocated to the low-weight neonatal DRGs. Failure to supply Weight on admission data will result in inappropriate DRG code assignment.

Records reporting 0001 to 0399 grams are returned with a warning message that weight on admission is unusually low. Hospitals will need to confirm this value before the record will be loaded into the NMDS.

This is not the same field as Birthweight. In some instances the weight on admission of previously discharged neonates may be the same as the recorded birthweight, but this will not generally be the case. There will be instances when the weight on admission is lower than that recorded at birth.

The Ministry of Health started collecting this information on 1 July 1995.

With the introduction of ICD-10-AM 2nd Edition, this field should be reported for all infants:
- aged less than 29 days, or
- aged between 29 and 365 days (inclusive) who weigh less than 2500 g.

It may be optionally sent for any infant less than one year old. For newborn infants, weight on admission will be identical to the birth weight. Newborn infants discharged and readmitted to the same or another healthcare facility after birth will need to have their weight on admission for the subsequent event recorded and reported.

If not known, the default is '9000'.

Verification rules Mandatory if age at admission is less than 29 days.

Optional for all babies between 29 and 365 days old (inclusive) who weigh less than 2500 g.

Collection methods

Related data Birthweight
DRG code (used as key input for the AR-DRG grouper, so many of these rules are derived from the grouper logic)

Source document

Source organisation

Year of data

Definition	Field identifying which calendar year data belongs to.
Column name	year_of_data
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	Calendar year
Context	
Layout	CCYY
Data domain	Range from 1960, XXXX.
Guide for use	Almost all data requests are based on a time period, the main ones being calendar year and fiscal year. The earliest year on the database in 1923.
Verification rules	Derived from year of discharge where present. If Event end datetime is missing then set to 'XXXX'.
Collection methods	
Related data	Event end datetime
Source document	
Source organisation	

NMD Psych leave end type table

Table name	dim_psych_lv_end_type
Definition	This table holds values associated with how a period of psychiatric leave ended for a committed mental patient.
Primary key	dim_psych_lv_end_type_key
Business key	psychiatric_leave_end_type
Guide for use	
Relational rules	
Data content	

Psychiatric leave description

Definition	Description for how a period of leave ended for a committed mental health patient.
Column name	psychiatric_leave_description
Table name	dim_psych_lv_end_type
Data type	varchar2(70)
Other names	
Context	
Layout	
Data domain	Free text short description field
Guide for use	See psychiatric_leave_end_type in this document.
Verification rules	
Collection methods	
Related data	psychiatric_leave_end_type
Source document	
Source organisation	

Psychiatric leave end type

Definition	A code describing how a period of leave ended for a committed mental health patient.
Column name	psychiatric_leave_end_type
Table name	dim_psych_lv_end_type
Data type	char(1)
Other names	
Context	A healthcare user is discharged on leave, then the event ends by discharge or re-admission to hospital. Only for healthcare users committed under the Mental Health (Compulsory Assessment & Treatment) Act 1992.
Layout	A
Data domain	D Discharged E Died R Returned to the same psychiatric institution T Transferred to another psychiatric institution
Guide for use	Not reliably reported since 1993. Healthcare users can be on leave for up to 2 years under the Act.
Verification rules	Optional. Must only be present if Event end type is 'DL'.
Collection methods	
Related data	Psychiatric leave end date
Source document	
Source organisation	

Appendix A: Logical to Physical Table Mapping

The following list shows the mapping of the logical, or business, table name to the actual physical table name.

Logical (Business) Table Name	***Physical Table Name***
NMD Admission Source table	dim_admission_source
NMD Admission Type table	dim_admission_type
NMD Condition Onset Flag Required From Table	dim_nmd_fac_cond_onset_rqd_dte
NMD Psych leave end type table	dim_psych_lv_end_type
NMD Fact Diagnosis Procedure Table	fact_nmd_diagnosis_procedure
NMD Fact Event Legal Status table	fact_nmd_event_legal_status
NMD Fact Health Event table	fact_nmd_health_event

Appendix B: List of Shared Dimensions

Dimension tables are the descriptive or lookup-type tables that link to fact tables. This data mart has a number of shared Dimension tables. The definitions for these dimensions are held in a separate data dictionary called "SHARED Dimensions". The table below lists the shared dimensions within this data mart.

Dimension Table	*Description*
Affiliation table (dim_affiliation)	This table is a matrix of gender and ethnicity code combination. Each row denotes the gender and ethnicity combination applicable to a person at the time of a transaction, i.e. it does not change over time.
Clinical Code table (dim_clinical_code)	A validation table and a repository of all codes contained in: - ICD-9-CM-A 2nd Edition - Australian Version of The International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition - ICD-10-AM 1st Edition - The International Stati
Country table (dim_country)	This table holds a list of all countries. Used to provide details of the health care user's country of birth.
Diagnosis Type table (dim_diagnosis_type)	This dimension table hold the details of the diagnosis type and the associated diagnosis type description.
DRG table (dim_drg)	Dimension table of Diagnostic Related Groups (DRG).
Event End Type table (dim_event_end_type)	This table holds values that describe the end type to the HCU event.
Event Type table (dim_event_type)	This table holds values that describe the event type for the HCU event.
Geo table (dim_geo)	This reference table contains a geographical breakdown of New Zealand at the level of Domicile Code . Each row of the table describes a single Domicile Code, and locates it within broader geographical definitions eg DHB.
Health Care User table (dim_health_care_user)	This reference table contains information about all people who have received healthcare directly from healthcare providers.
Health Specialty table (dim_health_specialty)	A classification describing the specialty or service to which a healthcare user has been assigned, which reflects the nature of the services being provided.
Legal Status table (dim_legal_status)	The legal status of a healthcare user under the appropriate section of the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Alcoholism and Drug Addiction Act 1966, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003,
Occupation table (dim_occupation)	This dimension table holds values for the occupation of the health care user.
Purchase Unit table (dim_purchase_unit)	The purchase unit (PU) indicates what contract the event is funded under. PUs are in fact a classification system. PUs are a means of quantifying (volume) and valuing (price) a service.
Purchaser Code table (dim_purchaser_code)	This table holds values that defines the organisation or body that purchased the healthcare service provided.
dim_submitted_coding_system (dim_submitted_coding_system)	

Appendix C: List of Views

The table views used in this datamart are shown below.

View Name	*Description*
Admission Age view (dim_admission_age)	A view of the shared Age Band dimension table.
Birth Date view (dim_birth_date)	A view of the shared Global Time dimension table.
Birth Location view (dim_birth_location)	A view of the Location table.
Discharge Age view (dim_discharge_age)	A view of the shared Age Band dimension table.
DRG v31 view (dim_drg_v31)	
Event Agency view (dim_event_agency)	A view of the shared Agency Facility dimension table.
dim_event_end_date (dim_event_end_date)	
dim_event_facility (dim_event_facility)	
Event Facility Type view (dim_event_facility_type)	
dim_event_start_date (dim_event_start_date)	
Excluded purchase unit dimension (dim_exclu_purchase_unit)	
Facility transfer from dimension (dim_facility_transfer_from)	
Facility transfer to dimension (dim_facility_transfer_to)	
dim_first_consult_date (dim_first_consult_date)	
dim_last_updated_date (dim_last_updated_date)	
Mothers Age view (dim_mothers_age)	A view of the shared Age Band dimension table.
dim_pd_06_clinical_code (dim_pd_06_clinical_code)	
dim_pd_10_clinical_code (dim_pd_10_clinical_code)	
dim_pd_11_clinical_code (dim_pd_11_clinical_code)	
dim_pd_12_clinical_code (dim_pd_12_clinical_code)	

dim_procedure_acc_date (dim_procedure_acc_date)	
Psych leave end date view (dim_psych_lv_end_date)	A view of the shared Global Time dimension table.
dim_referral_date (dim_referral_date)	
dim_surg_decided_date (dim_surg_decided_date)	

Appendix D: Data Dictionary Template

Introduction

This appendix explains how data element attributes are organised in the data dictionary template.

Order of elements

Within the dictionary, elements are organised by table, and then alphabetically. An alphabetical index at the back of the data dictionary (Appendix I) and the graphical data model are intended to assist the user in finding specific elements.

Template

This table explains the template.

Administrative status

The operational status (eg, CURRENT, SUPERSEDED) of the data element. No SUPERSEDED data elements will be included in the Dictionaries.

Reference ID

A code that uniquely identifies the data element. If the data element is used in more than one collection, it should retain its Reference ID wherever it appears.

Version number

A version number for each data element. A new version number is allocated to a data element/concept when changes have been made to one or more of the following attributes of the definition:

– name
– definition
– data domain, eg, adding a new value to the field.

Elements with frequently updated code tables, such as the Facility code table, will not be assigned a new version for changes to data domain.

Version date

The date the new version number was assigned.

Identifying and defining attributes

Name

A single or multi-word designation assigned to a data element. This appears in the heading for each unique data definition in the Dictionaries. Previous names for the data element are included in the Guide for Use section.

Data element type

DATA ELEMENT—a unit of data for which the definition, identification, representation and permissible values are specified by means of a set of attributes.

DERIVED DATA ELEMENT—a data element whose values are derived by calculation from the values of other data elements.

COMPOSITE DATA ELEMENT—a data element whose values represent a grouping of the values of other data elements in a specified order.

Definition

A statement that expresses the essential nature of a data element and its differentiation from all other data elements.

Context (optional)

A designation or description of the application environment or discipline in which a name is applied or from which it originates. This attribute may also include the justification for collecting the items and uses of the information.

Relational and representational attributes

Data type

The type of field in which a data element is held. For example, character, integer, or numeric.

Field size

The maximum number of storage units (of the corresponding data type) to represent the data element value. Field size does not generally include characters used to mark logical separations of values, eg, commas, hyphens

or slashes.

Layout	The representational layout of characters in data element values expressed by a character string representation. For example: - 'CCYYMMDD' for calendar date - 'N' for a one-digit numeric field - 'A' for a one-character field - 'X' for a field that can hold either a character or a digit, and - '$$$,$$$,$$$' for data elements about expenditure.
Data domain	The permissible values for the data element. The set of values can be listed or specified by referring to a code table or code tables, for example, ICD-10-AM 2nd Edition.
Guide for use (optional)	Additional comments or advice on the interpretation or application of the data element (this attribute has no direct counterpart in the ISO/IEC Standard 11179 but has been included to assist in clarification of issues relating to the classification of data elements). Includes historical information, advice regarding data quality, and alternative names for this data element.
Verification rules (optional)	The rules and/or instructions applied for validating and/or verifying elements, in addition to the formal edits.
Collection methods – Guide for providers (optional)	Comments and advice concerning the capture of data for the particular data element, including guidelines on the design of questions for use in collecting information, and treatment of 'not stated' or non-response (this attribute is not specified in the ISO/IEC Standard 11179 but has been added to cover important issues about the actual collection of data).
Related data (optional)	A reference between the data element and any related data element in the Dictionary, including the type of this relationship. Examples include: 'has been superseded by the data element…', 'is calculated using the data element…', and 'supplements the data element…'.

Administrative attributes

Source document (optional)	The document from which definitional or representational attributes originate.
Source organisation (if available)	The organisation responsible for the source document and/or the development of the data definition (this attribute is not specified in the ISO/IEC Standard 11179 but has been added for completeness). The source organisation is not necessarily the organisation responsible for the ongoing development/maintenance of the data element definition. An example of a source organisation is the National Data Policy Group (NDPG).

Appendix E: Code Table Index

Code table	Location
Admission Source code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/admission-source-code-table
Admission Type code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/admission-type-code-table
Agency code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/agency-code-table
Agency Type code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/agency-type-code-table
Birth/Death Location code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/birth-death-location-code-table
Clinical code table	See *Clinical code* on page 39
Clinical Code Table Type code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/clinical-code-type
Clinical Coding System code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/clinical-coding-system-code-table
Country of Birth code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/country-birth-code-table
Domicile code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/domicile-code-table
DRG code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/drg-code-table
DRG Grouper Type code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/drg-grouper-code-table
Ethnicity code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/ethnicity-code-tables
Event Clinical Code Type code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/event-clinical-code-type-code-table
Event Type code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/event-type-code-table
Facility code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/facility-code-table
Facility Type code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/facility-type-code-table
Health Specialty code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/health-specialty-code-table
Legal Status code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/legal-status-code-table
MDC code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/mdc-code-

	table
MDC Type code table	See *MDC type* on page 141
Occupation code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/occupation-code-table
Principal Health Service Purchaser code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/principal-health-service-purchaser-code-table
Psychiatric Leave End code table	http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/psychiatric-leave-end-code-table

Code tables on web site

For code tables on the Ministry of Health web site go to http://www.health.govt.nz/nz-health-statistics/data-references/code-tables
For further information contact Analytical Services. Contact details are given at the front of this dictionary.

Appendix F: Logical Groups of Elements

Health Event (Administrative)
Admission source code
Admission type code
Client system identifier
Event end date
Event end type code
Event ID
Event leave days
Event local identifier
Event start date
Event summary suppress flag
Event supplementary information
Event type code
Health specialty code
Length of stay
Mother's Encrypted NHI
Principal health service purchaser
Private flag
PMS unique identifier

Healthcare User
Age at admission
Age at discharge
Country of birth code
Date of birth
Date of Birth flag
Domicile code
Encrypted NHI number
Ethnic group codes
NHI number
NZ Resident Status
Occupation code
Occupation free-text
Prioritised ethnicity
Sex

DRG
AN-DRG grouper code version 3.1
CCL
Cost Weight Code
Cost Weights
DRG code
DRG grouper type code
Excluded Purchase Unit
MDC code
MDC type
NZ DRG code current
PCCL
Purchase unit

Birth Event
Age of mother
Birth location
Birth status
Birthweight
Gestation period

Mental Health Events
Legal status code
Legal status date
Psychiatric leave end code
Psychiatric leave end date

Clinical
Clinical code
Clinical code type
Clinical coding system ID
Diagnosis number
Diagnosis sequence
Diagnosis type
Diagnosis/procedure description
Operation/procedure date
Total hours on mechanical ventilation
Total hours on CPAP
Total ICU Hours
Weight on Admission

External Cause Events
ACC claim number
Accident flag
External cause date of occurrence

Common Groupings
Area unit code
Domicile code description
Domicile code status
Financial year
Month of data
Region of agency of treatment
Region of treatment
TLA of domicile
Year of census
Year of data

Agencies and Facilities
Agency address
Agency closing date
Agency code
Agency name
Agency opening date
Agency type code
Facility address
Facility closing date
Facility code
Facility name
Facility opening date
Facility Transfer From
Facility Transfer To
Facility type
WIES Agency Code
WIES Agency From Date
WIES Agency To Date
WIES Facility Code
WIES Facility From Date
WIES Facility To Date

File and Record Administration
Batch ID
Date updated
Transaction ID

Appendix G: Collection of Ethnicity Data

Introduction

This appendix contains information about collecting and coding ethnic group code data. To help with correct allocations of ethnicities, it includes a detailed list of ethnicities and their corresponding codes.

Points to remember

- Ethnicity is self-identified and can change over time.
- The Ministry of Health (MOH) can record up to three ethnic group codes for a healthcare user.
- An algorithm is used to automatically prioritise ethnic group codes if more than one is reported.
- If a person chooses not to specify their ethnicity, it should be recorded using a residual code such as '94' (Don't Know), '95' (Refused to Answer) or '99' (Not specified), not as '61' (Other).
- The NHI database should be updated if a healthcare user provides a more specific or different specific ethnicity than that already held for that person.

About ethnicity

The term 'ethnic group' is defined as 'a group of people who have culture, language, history or traditions in common.' Ethnicity is not the same as race, ancestry, or country of birth.

Because ethnicity is self-identified, it can change over time. This is why MOH collects ethnicity data whenever information is collected for different datasets, rather than relying on the National Health Index (which does not include historical data).

Collecting ethnicity data has always been problematic because of the reluctance of some data providers to collect the information, the unwillingness of some healthcare users to label themselves, and the confusion between ethnicity, nationality, citizenship, and race.

Purpose

Information about ethnicity is used extensively in planning and resourcing health services, developing and monitoring health policies, and measuring health outcomes.

Collection of data

It is very important that the ethnicity data from the health sector is collected in the same way as the data in the Census because rates of hospitalisation are calculated by comparing the two datasets (to determine proportions of the population). The 2001 Census question is provided below as a guide.

Important: For MOH collections, up to three ethnic group codes can be collected for a healthcare user. Providers should make sure that healthcare users are aware of this. MOH stores all reported ethnic group codes, and also prioritises them based on a Statistics NZ algorithm.

Coding data

Use the Classification of Ethnicity table below to code the healthcare user's ethnic group.

If they have ticked one or more specific ethnicities, or if they have ticked 'other' and written in an ethnicity, look on the table to find the code.

If they have written an invalid ethnicity, such as 'Kiwi' or 'Mainlander', which does not map to any item on the code table, or if they have ticked 'other' but not stated an ethnicity, you can:

- discuss this with them and encourage them to choose a valid ethnic group
- ignore it if one or more other ethnicities are provided, or
- code as '99' (Not specified).

If they write 'New Zealander', this can be coded as '11' (New Zealand European)

If they have written 'pakeha', this can be coded as '11' (New Zealand European).

'Not Specified' and 'Other'

If a person chooses not to answer the ethnicity question, record their ethnicity response with an appropriate residual code such as '95' (Refused to Answer) or '99' (Not specified).

Important: The code '61' (Other) applied to only 0.037% of the New Zealand population in the 2006 census. It is limited to about 5 ethnic groups (such as Inuit/Eskimos, North, Central or South American Indians, Seychelles Islanders, and Mauritians). It must not be used as a generic 'other' code.

Recording ethnicity as 'Other' or 'Not specified' skews statistics on rates of hospitalisation and this affects health policy. Where possible, encourage healthcare users to choose a valid ethnic group.

Prioritisation of ethnicity

Many National Data Collections include Prioritised ethnicity. This is the most highly prioritised ethnicity where multiple ethnicity responses have been recorded for the healthcare user (either submitted with the health event/service or extracted from the NHI as part of the data load process). Priorisation is determined according to a Statistics NZ
Algorithm and prioritising ethnic codes simplifies analysis.

Each of the ethnic group codes is prioritised using the mappings in the table below.

Ethnic code	Ethnic code description	Priority
10	European not further defined	21
11	New Zealand European / Pakeha	22
12	Other European	20
21	Maori	1
30	Pacific Peoples not further defined	9
31	Samoan	7
32	Cook Island Maori	6
33	Tongan	5
34	Niuean	4
35	Tokelauan	2
36	Fijian	3
37	Other Pacific Peoples	8
40	Asian not further defined	14
41	Southeast Asian	10
42	Chinese	12
43	Indian	11
44	Other Asian	13
51	Middle Eastern	17
52	Latin American / Hispanic	15
53	African (or cultural group of African origin)	16
54	Other (retired on 01/07/2009)	19
61	Other Ethnicity	18
94	Don’t Know	94
95	Refused to Answer	95
97	Response Unidentifiable	97
99	Not stated	99

Detailed code table

The codes used to report ethnicity to MOH are taken from the Statistics NZ Statistical Standard for Ethnicity 2005. This classification is a very detailed 5-digit code: only the first two digits (shown in the table below) are reported to MOH.

Use this table to code healthcare user's self-identified ethnicities.

MOH Ethnicity code	Country of Ethnicity Affiliation
37	Admiralty Islander
44	Afghani
53	African American
53	African nec
53	African nfd
12	Afrikaner
32	Aitutaki Islander
12	Albanian
51	Algerian
12	American (US)
51	Arab
52	Argentinian
12	Armenian
44	Asian nec
40	Asian nfd
51	Assyrian
32	Atiu Islander
37	Austral Islander
12	Australian
37	Australian Aboriginal
12	Austrian
37	Banaban
44	Bangladeshi
37	Belau/Palau Islander
12	Belgian
12	Belorussian
43	Bengali
37	Bismark Archipelagoan
52	Bolivian
12	Bosnian
37	Bougainvillean
52	Brazilian
12	British nec
12	British nfd
12	Bulgarian
12	Burgher
41	Burmese
12	Byelorussian
41	Cambodian
42	Cambodian Chinese
12	Canadian
37	Caroline Islander
12	Celtic nfd
61	Central American Indian
37	Chamorro
12	Channel Islander

MOH Ethnicity code	Country of Ethnicity Affiliation
52	Chilean
42	Chinese nec
42	Chinese nfd
52	Colombian
32	Cook Island Maori nfd
12	Cornish
12	Corsican
52	Costa Rican
52	Creole (Latin America)
53	Creole (US)
12	Croat/Croatian
12	Cypriot nfd
12	Czech
12	Dalmatian
12	Danish
12	Dutch/Netherlands
37	Easter Islander
52	Ecuadorian
51	Egyptian
12	English
53	Eritrean
12	Estonian
53	Ethiopian
44	Eurasian
10	European nfd
12	Falkland Islander/Kelper
36	Fijian (except Fiji Indian/ Indo-Fijian)
43	Fijian Indian/Indo-Fijian
41	Filipino
12	Finnish
12	Flemish
12	French
12	Gaelic
37	Gambier Islander
12	German
53	Ghanian
12	Greek (incl Greek Cypriot)
12	Greenlander
37	Guadalcanalian
37	Guam Islander/Chamorro
52	Guatemalan
43	Gujarati
52	Guyanese
37	Hawaiian
52	Honduran

MOH Ethnicity code	Country of Ethnicity Affiliation
42	Hong Kong Chinese
12	Hungarian
12	Icelander
37	I-Kiribati/Gilbertese
43	Indian nec
43	Indian nfd
41	Indonesian (incl Javanese/ Sundanese/Sumatran)
61	Inuit/Eskimo
51	Iranian/Persian
51	Iraqi
12	Irish
51	Israeli/Jewish/Hebrew
12	Italian
53	Jamaican
44	Japanese
51	Jordanian
42	Kampuchean Chinese
37	Kanaka/Kanak
53	Kenyan
41	Khmer/Kampuchean/ Cambodian
44	Korean
51	Kurd
41	Lao/Laotian
52	Latin American/Hispanic nec
52	Latin American/Hispanic nfd
12	Latvian
51	Lebanese
51	Libyan
12	Lithuanian
12	Macedonian
37	Malaitian
41	Malay/Malayan
42	Malaysian Chinese
12	Maltese
52	Malvinian (Spanish-speaking Falkland Islander)
32	Mangaia Islander
32	Manihiki Islander
37	Manus Islander
12	Manx
37	Marianas Islander
37	Marquesas Islander
37	Marshall Islander
32	Mauke Islander
61	Mauritian
52	Mexican
51	Middle Eastern nec
51	Middle Eastern nfd
32	Mitiaro Islander
51	Moroccan

MOH Ethnicity code	Country of Ethnicity Affiliation
37	Nauru Islander
44	Nepalese
37	New Britain Islander
12	New Caledonian
37	New Georgian
37	New Irelander
11	New Zealander
11	New Zealand European
21	New Zealand Maori
52	Nicaraguan
53	Nigerian
34	Niuean
61	North American Indian
12	Norwegian
99	Not Specified
37	Ocean Islander/Banaban
51	Omani
12	Orkney Islander
53	Other African nec
44	Other Asian nec
12	Other European
61	Other nec
61	Other nfd
41	Other Southeast Asian nec
37	Pacific Peoples nec
30	Pacific Peoples nfd
44	Pakistani
51	Palestinian
32	Palmerston Islander
52	Panamanian
37	Papuan/New Guinean/Irian Jayan
52	Paraguayan
32	Penrhyn Islander
52	Peruvian
37	Phoenix Islander
37	Pitcairn Islander
12	Polish
12	Portuguese
52	Puerto Rican
32	Pukapuka Islander
43	Punjabi
32	Rakahanga Islander
32	Rarotongan
12	Romanian/Rumanian
12	Romany/Gypsy
37	Rotuman/Rotuman Islander
12	Russian
31	Samoan
37	Santa Cruz Islander
12	Sardinian
12	Scottish (Scots)

MOH Ethnicity code	Country of Ethnicity Affiliation
12	Serb/Serbian
61	Seychelles Islander
12	Shetland Islander
43	Sikh
42	Singaporean Chinese
44	Sinhalese
12	Slavic/Slav
12	Slovak
12	Slovene/Slovenian
37	Society Islander (including Tahitian)
37	Solomon Islander
53	Somali
61	South African coloured
12	South African nec
61	South American Indian
12	South Slav (formerly Yugoslav groups) nfd
12	South Slav (formerly Yugoslav) nec
41	Southeast Asian nfd
12	Spanish
44	Sri Lankan nec
44	Sri Lankan nfd
44	Sri Lankan Tamil
12	Swedish
12	Swiss
51	Syrian
42	Taiwanese Chinese
37	Tahitian (including Society Islander)
43	Tamil
41	Thai/Tai/Siamese
44	Tibetan
35	Tokelauan
33	Tongan
37	Torres Strait Islander/Thursday Islander
37	Tuamotu Islander
51	Tunisian
51	Turkish (incl Turkish Cypriot)
37	Tuvalu Islander/Ellice Islander
53	Ugandan
12	Ukrainian
52	Uruguayan
37	Vanuatu Islander/New Hebridean
52	Venezuelan
41	Vietnamese
42	Vietnamese Chinese
37	Wake Islander
37	Wallis Islander
12	Welsh
53	West Indian/Caribbean
37	Yap Islander
51	Yemeni
12	Zimbabwean

nfd = Not further defined
nec = Not elsewhere classified

Appendix H: DRG Process

Introduction

This appendix describes the process by which the Diagnostic Related Grouping (DRG) and related fields are calculated.

Schedules not stored

For version 3, the Grouper Program stored schedules of:
- average cost weights (of a Cost Weight Code), and
- average length of stay for each of its DRG codes.

However, for versions 4.1, 4.2, 5.0, 6.0 and 6.0x no historical data is available, so no average values are stored.

Current software

The current DRG Grouper Program (software) is version 6.0x. This can produce DRG codes in clinical versions 3.1, 4.1, 4.2, 5.0, 6.0 and 6.0x

Which DRG versions are stored

DRG codes of clinical version 3.1 are stored for all events.
For events with end dates between 1 July 2001 and 30 June 2002, DRG codes are also calculated and stored in clinical version 4.1.

For events with end dates between 1 July 2002 and 30 June 2005, DRG codes are calculated and stored in clinical version 4.2.

For events with end dates between 1 July 2005 and 30 June 2011, DRG codes are calculated and stored in clinical version 5.0

For events with end dates between 1 July 20011 and 30 June 2013, DRG codes are calculated and stored in clinical version 6.0

For events with an end date on or after 1 July 2013, DRG codes are calculated and stored in clinical version 6.0x

Note: The 4.1, 4.2, 5.0, 6.0 and 6.0x codes are both stored in the same field, health_event_tab: drg_code_current.

DRG Process

This table shows the DRG process for the NMDS.

Stage	Description
1	The diagnosis and procedure information are mapped to different ICD codes, so that codes are held in: • ICD-9-CM-A, and • ICD-10-AM 1st Edition, and • ICD-10-AM 2nd Edition, and • ICD-10-AM 3rd Edition, and • ICD-10-AM 6th Edition and • ICD-10-AM 8th Edition **Note:** 1. The diagnosis_procedure_tab.submitted_system_id indicates which version of the ICD the clinical code was reported in. 2. For the 2004-2005 financial year, NMDS will continue to apply ICD-10-AM 2nd Edition code to the Grouper 3. For the 2005 to 2010 financial years, NMDS will apply ICD-10-AM 3rd Edition codes to the Grouper. 4. For the 2011 financial years, NMDS will apply ICD-10-AM 6th Edition codes to the Grouper.

2	The DRG Grouper Program version 6.0 processes information about an event for each grouper clinical version, including: • personal information (eg, Sex, Date of birth), and • event information (eg, Admission date, Event end type), and • diagnosis and procedure information in the appropriate ICD code for the DRG Grouper.
3	For each clinical version of the Grouper (3.1, 4.1, 4.2, 5.0, 6.0 and 6.0x), the DRG Grouper Program version 6.0x calculates (for that event): • a DRG code (of the DRG grouper type) • an MDC code (of an MDC type that is the same as the DRG grouper type) • CCL or PCCL (as appropriate for that clinical version of the Grouper)
4	NMDS processing calculates the Cost weight (using the WIES methodology) and Purchase unit from: • the DRG and associated variables • Length of stay • Total hours on mechanical ventilation • some diagnosis and procedure codes • Health specialty code For details, see http://www.health.govt.nz/nz-health-statistics/data-references/weighted-inlier-equivalent-separations

Appendix I: Enhanced Event Type/Event Diagnosis Type Table

Event type	Event Type Description (not stored in table)	Diagnosis type	Diagnosis type description (not stored in table)	Cardinality	Optionality
BT	Birth event	A	Principal diagnosis	1	M
BT	Birth event	B	Other relevant diagnosis	N	O
BT	Birth event	E	E-code (External cause of injury)	N	O
BT	Birth event	O	Operation / Procedure	N	O
ID**	Intended day case	A	Principal diagnosis	1	M
ID*	Intended day case	B	Other relevant diagnosis	N	O
ID*	Intended day case	E	E-code (External cause of injury)	N	O
ID*	Intended day case	O	Operation / Procedure	N	O
ID*	Intended day case*	M	Morphology	N	O
IM	Psychiatric inpatient event	A	Principal diagnosis	1	M
IM	Psychiatric inpatient event	B	Other relevant diagnosis	N	O
IM	Psychiatric inpatient event	E	E-code (External cause of injury)	N	O
IM	Psychiatric inpatient event	O	Operation / Procedure	N	O
IM	Psychiatric inpatient event	P	Mental health provisional diagnosis	N	O
IM	Psychiatric inpatient event	M	Morphology	N	O
IP	Non-psychiatric inpatient event	A	Principal diagnosis	1	M
IP	Non-psychiatric inpatient event	B	Other relevant diagnosis	N	O
IP	Non-psychiatric inpatient event	E	E-code (External cause of injury)	N	O
IP	Non-psychiatric inpatient event	O	Operation / Procedure	N	O
IP	Non-psychiatric inpatient event	M	Morphology	N	O

* Retired 30 June 2013

Appendix J: Duplicate and overlapping event checking rules

Fatal duplicate events

Reject if:
- the same key fields exist.
- master_hcu_id, Event type, and Event start and end dates are all the same, facility is different, and Length of stay is greater than zero days.
- master_hcu_id, Facility, and the Event start and end dates are all the same, Event types are different, and Length of stay is greater than zero days.

Warnings

Generate warning if:
- master_hcu_id, Facility, Event start and end dates, and Event type are all the same, and Length of stay of both events is zero.

Fatal overlapping events

Reject if:
- master_hcu_id, Facility, Event start date, and Event type are all the same; and Length of stay of both events is greater than zero.
- master_hcu_id, Facility, and Event type (not “IM”) are all the same; Event start date of one event is between the Event start and end dates of the other event; and Length of stay of both events is greater than zero.
- master_hcu_id, Facility, and Event start date are all the same; Event types are different (not “IM”); and Length of stay of each event is greater than zero.
- master_hcu_id, Event start date, and Event type (not “IM”) are the same; Facilities are different; and Length of stay of each event is greater than zero.
- master_hcu_id is the same; Facilities and Event types are different (Event types not “IM”); Event start date of one event is between Event start and end dates of the other event; and Length of stay of each event is greater than zero.

In general (in plain English)

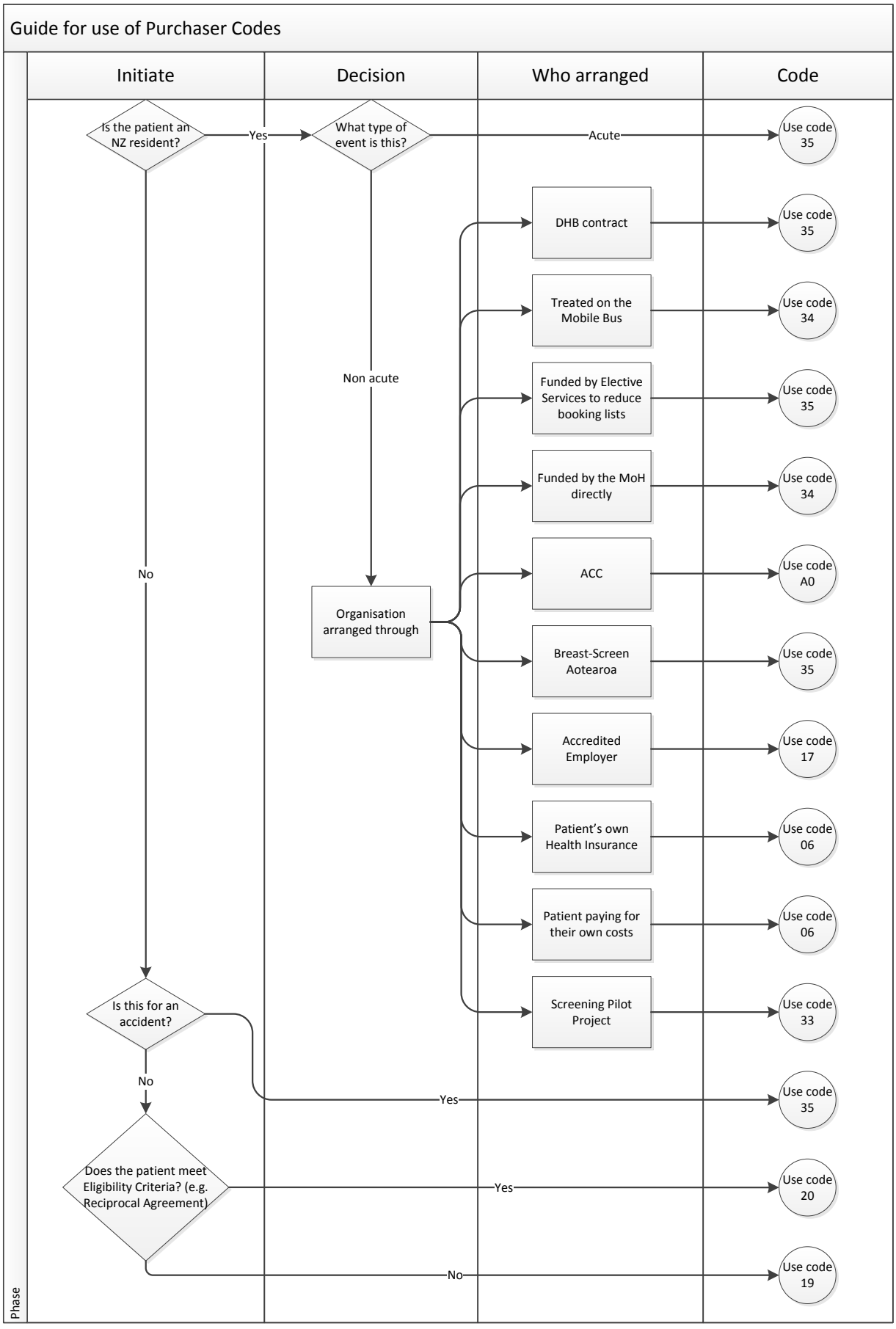
A day case (Event type either ID or IP and Length of stay 0 days) may occur within an IP or IM event for the same master_hcu_id where the Length of stay is not zero.

Two day cases (Event type = IP and Length of stay = 0, or Event type = ID and Event start date is the same as an IP or IM event) may exist on one day for the same master_hcu_id.

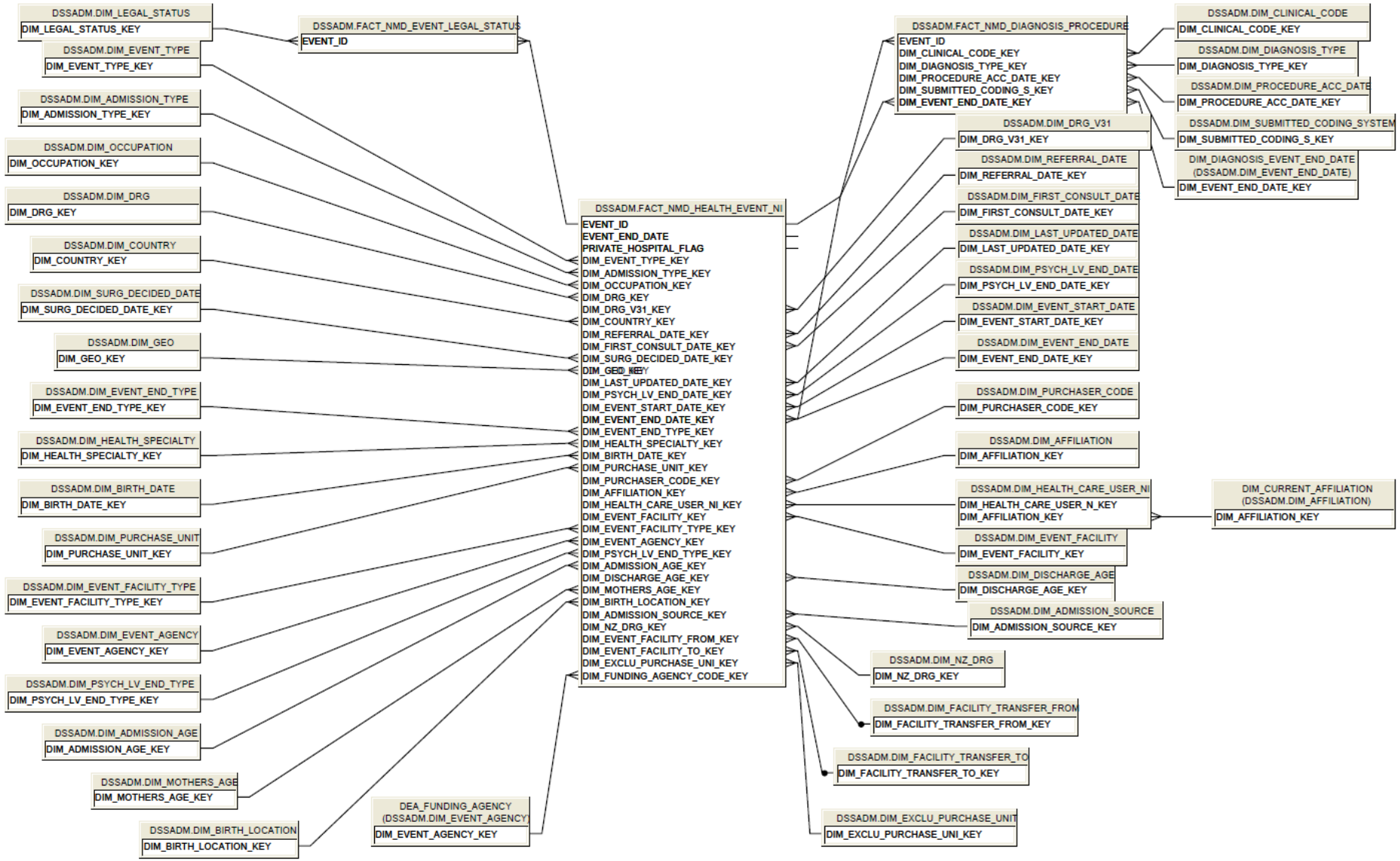
An IP or IM event where Length of stay is greater than zero may exist within an IM event for the same master_hcu_id.

If Length of stay is greater than zero for both events and the Length of stay for both events for the same master_hcu_id is the same then reject.

Appendix K: Guide for Use of NMDS Purchaser Code

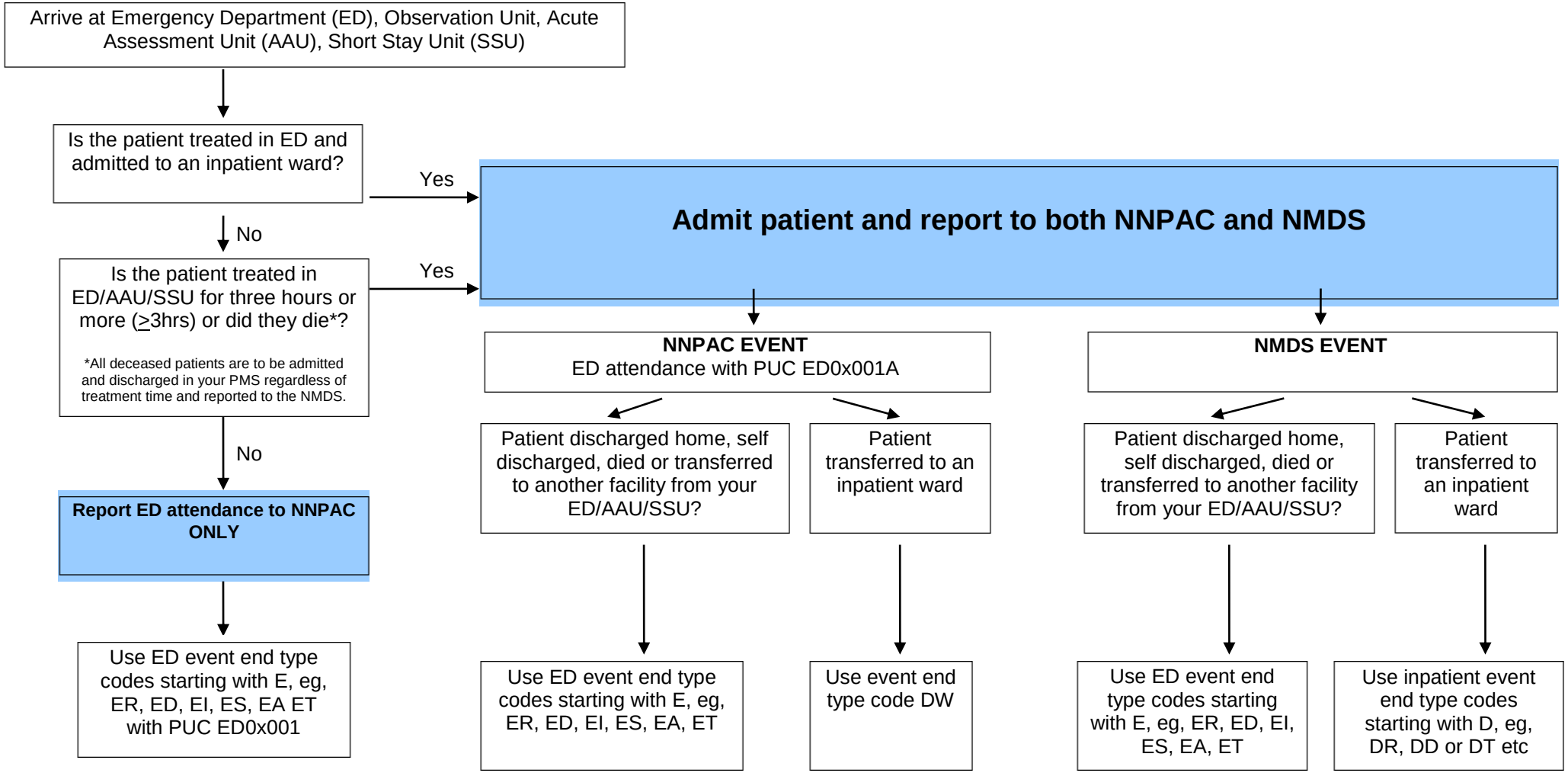


Appendix L: NMD Data Mart Data Model



Appendix M: Guide for Use of Emergency Department (ED) Event End Type Codes

***Please note:** when calculating the three hours, exclude waiting time in the waiting room, exclude triage and use only the duration of assessment/treatment. If part of the assessment/treatment includes observation, then this time contributes to the three hours. 'Assessment/treatment' is clinical assessment, treatment, therapy, advice, diagnostic or investigatory procedures from a nurse or doctor or other health professional.



PUC = Purchaser Unit Code
NNPAC = National Non Admitted Patient Collection
NMDS = National Minimum Dataset

Emergency Department (ED) Attendance ***NNPAC reporting***	**Emergency Department Short Stay (ED) Acute Assessment Unit (AAU) Short Stay Unit (SSU)** ***NMDS reporting***	**Hospital Inpatient Ward** ***NMDS reporting***
Patient arrives in ED via ambulance at 09.10am. Patient is stabilised and transferred (discharged) to another healthcare facility from ED at 10.27am ED attendance reported to NNPAC Purchase unit (ED0x001) Event end type = ET		
Patient presents to ED reception 01/03/2011 at 15.53pm. Triaged at 16.12pm returned to waiting room Patient taken through to ED 16.53pm. Assessment/treatment began at 16.48pm. Patient treated and discharged home 18.23pm ED attendance reported to NNPAC Purchase unit (ED0x001) Event end type = ER		
Patient presents to ED reception 01/03/2011 at 10.32am. Triaged at 10.56am returned to waiting room Patient was not willing to wait, therefore left at 12.32pm without being seen and did not want to sign indemnity ED attendance reported to NNPAC Purchase unit (ED00002) Event end type = ES		
Patient presents to ED reception 01/03/2011 at 22.53pm Triaged at 22.55pm and taken through to ED Assessment/treatment began at 23.02pm Patient stabilised, reviewed and requires diagnostic tests After review of results decision is to admit patient to inpatient ward Patient transferred to inpatient ward 02/03/2011 at 01.14am ED attendance reported to NNPAC Purchase unit (ED0x001A)		Patient transferred to inpatient ward from ED Patient discharged home 06/03/2011 at 13.32pm Report hospital inpatient event to the NMDS Event start datetime will be 01/03/2011 23.02pm

Event end type = DW

Event end datetime will be 06/03/2011 13.32pm
Event end type DR

Emergency Department (ED) Attendance ***NNPAC reporting***	**Emergency Department Short Stay (ED) Acute Assessment Unit (AAU) Short Stay Unit (SSU)** ***NMDS reporting***	**Hospital Inpatient Ward** ***NMDS reporting***
Patient presents to ED reception 01/03/2011 at 13.53pm Triaged at 14.02pm returned to waiting room Patient taken through to ED Assessment/treatment began at 14.48pm Patient reviewed, requires tests and observation/treatment Patient still present in ED at 18.10pm awaiting results and review	Patient meets 3 hour admission rule – admit patient as an ED short stay event Event start datetime will be 01/03/2011 14.48pm	
ED attendance reported to NNPAC for counting purposes only Purchase unit (ED0x001A) Event end type = ER	ED clinician reviewed results and cleared patient for discharge at 18.37pm. Discharged home from ED 18.53pm Event end datetime will be 01/03/2011 18.53pm, event end type will be ER Report ED short stay event to the NMDS	
Patient presents to ED reception at 01/03/2011 at 13.53pm Triaged at 14.02pm returned to waiting room Patient taken through to ED Assessment/treatment began at 14.48pm Patient reviewed, requires tests and observation/treatment Patient still present in ED at 18.10pm awaiting results and review	Patient meets 3 hour admission rule – admit patient as an ED short stay event Event start datetime will be 01/03/2011 14.48pm	
ED attendance reported to NNPAC for counting purposes only Purchase unit (ED0x001A) Event end type = DW	ED clinician reviewed results at 18.28pm and patient not improving, decision made to admit patient to hospital inpatient ward Patient transferred to inpatient ward - internal transfer only (no discharge)	Patient transferred to inpatient ward from ED Patient discharged home from inpatient ward 04/03/2011 at 11.10am Report hospital inpatient event to the NMDS

Event start datetime will be 01/03/2011 14.48pm
Event end datetime will be 04/03/2011 11.10am
Event end type DR

***Note:** the event start date/time of admission will be from the commencement of assessment/treatment in ED (NNPAC = datetime of first contact).

EMERGENCY DEPARTMENT SCENARIOS	NNPAC REPORTING	NNPAC EVENT END TYPE [ED attendance]	NMDS REPORTING	NMDS EVENT END TYPE [ED/AAU/SSU short stay event]
Patient in ED receives treatment <3hrs discharged home	Yes	ER	No	N/A - ED attendance only
Patient in ED/AAU/SSU receives treatment ≥3hrs discharged home	Yes - only for counting purposes – PUC ED0x001A	ER	Yes – short stay event	ER
Patient in ED receives treatment <3hrs self discharges without indemnity signed	Yes	ES	No	N/A - ED attendance only
Patient in ED/AAU/SSU receives treatment ≥3hrs self discharges without indemnity signed	Yes - only for counting purposes – PUC ED0x001A	ES	Yes – short stay event	ES
Patient in ED receives treatment <3hrs self discharges with indemnity signed	Yes	EI	No	N/A - ED attendance only
Patient in ED/AAU/SSU receives treatment ≥3hrs self discharges with indemnity signed	Yes - only for counting purposes – PUC ED0x001A	EI	Yes – short stay event	EI
Patient in ED receives treatment <3hrs and dies	Yes - only for counting purposes – PUC ED0x001A	ED	Yes	ED
Patient in ED/AAU/SSU receives treatment ≥3hrs and dies	Yes - only for counting purposes – PUC ED0x001A	ED	Yes	ED
Patient in ED receives treatment <3hrs transferred (discharged) to another facility	Yes	ET	No	N/A - ED attendance only
Patient in ED/AAU/SSU receives treatment ≥3hrs transferred (discharged) to another facility	Yes - only for counting purposes – PUC ED0x001A	ET	Yes – short stay event	ET
Neonatal or burns patient in ED/AAU/SSU receives treatment <3hrs transferred (discharged) to another facility	Yes	EA	No	N/A - ED attendance only

EMERGENCY DEPARTMENT SCENARIOS	NNPAC REPORTING	NNPAC EVENT END TYPE [ED attendance]	NMDS REPORTING	NMDS EVENT END TYPE [ED/AAU/SSU short stay event]
Neonatal or burns patient ED/AAU/SSU receives treatment ≥3hrs transferred (discharged) to another facility	Yes - only for counting purposes – PUC ED0x001A	EA	Yes – short stay event	EA
Patient in ED receives treatment <3hrs admitted to inpatient ward or straight to operating theatre	Yes - only for counting purposes – PUC ED0x001A	DW	Yes Inpatient event	N/A - admit as inpatient
Patient in ED/AAU/SSU receives treatment ≥3hrs admitted to inpatient ward or straight to operating theatre	Yes - only for counting purposes – PUC ED0x001A	DW	Yes Inpatient event	N/A - admit as inpatient
Patient in ED receives treatment <3hrs admitted to geriatric AT&R inpatient ward	Yes - only for counting purposes – PUC ED0x001A	DW	Yes Inpatient event	N/A - admit as inpatient
Patient in ED/AAU/SSU receives treatment ≥3hrs admitted to geriatric AT&R inpatient ward with 'D' health specialty code (*see Note 1 below)	Yes -only for counting purposes – PUC ED0x001A	DW	Yes – short stay event [see Note 1]	DW
Patient in ED/AAU/SSU receives treatment ≥3hrs admitted to geriatric AT&R inpatient ward with a medical/surgical health specialty code	Yes - only for counting purposes – PUC ED0x001A	DW	Yes Inpatient event	N/A - admit as inpatient
Patient transfers from smaller hospital to ED at your bigger hospital, receives treatment <3hrs and is then admitted to inpatient ward or straight to operating theatre	Yes - only for counting purposes – PUC ED0x001A	DW	Yes Inpatient event	N/A - admit as inpatient
Patient transfers from smaller hospital to ED/AAU/SSU at your bigger hospital, receives treatment ≥3hrs and is then admitted to inpatient ward or straight to operating theatre	Yes - only for counting purposes – PUC ED0x001A	DW	Yes Inpatient event	N/A - admit as inpatient
Patient transfers from smaller hospital to ED at your bigger hospital, receives treatment <3hrs and is then transferred (discharged) back to smaller hospital	Yes	ET	No	N/A - ED attendance only
Patient transfers from smaller hospital to ED/AAU/SSU at your bigger hospital, receives treatment ≥3hrs and is then transferred (discharged) back to smaller hospital	Yes - only for counting purposes – PUC ED0x001A	ET	Yes – short stay event	ET
Mental health patient in ED receives treatment for an acute condition (eg, self harm) <3hrs transferred (discharged) to inpatient psychiatric unit (within same facility)	Yes	DW	No	N/A - ED attendance only
Mental health patient in ED/AAU/SSU receives treatment for an acute condition (eg, self harm) ≥3hrs transferred (discharged) to inpatient psychiatric unit (within same facility)	Yes - only for counting purposes – PUC ED0x001A	DW	Yes – short stay event	DW

EMERGENCY DEPARTMENT SCENARIOS	NNPAC REPORTING	NNPAC EVENT END TYPE [ED attendance]	NMDS REPORTING	NMDS EVENT END TYPE [ED/AAU/SSU short stay event]
Mental health patient in ED receives treatment for an acute condition (eg, self harm) <3hrs transferred (discharged) to inpatient psychiatric unit (another facility)	Yes	ET	No	N/A -ED attendance only
Mental health patient in ED/AAU/SSU receives treatment for an acute condition (eg, self harm) ≥3hrs transferred (discharged) to inpatient psychiatric unit (another facility)	Yes - only for counting purposes – PUC ED0x001A	ET	Yes – short stay event	ET
Mental health inpatient sustains an in hospital injury/accident/self harm etc transferred to ED receives treatment <3hrs then transferred back to inpatient psychiatric unit	Yes	DW	No	N/A - ED attendance only
Mental health inpatient sustains an in hospital injury/accident/self harm etc transferred to ED/AAU/SSU receives treatment ≥3hrs then transferred back to inpatient psychiatric unit	Yes - only for counting purposes – PUC ED0x001A	DW	Yes – short stay event	DW [Note 2]
Home hospital inpatient transferred to ED receives treatment <3hrs and is then transferred (discharged) back to home hospital services	Yes	ET	No	N/A - ED attendance only
Home hospital inpatient transferred to ED/AAU/SSU receives treatment ≥3hrs and is then transferred (discharged) back to home hospital services	Yes - only for counting purposes – PUC ED0x001A	ET	Yes – short stay event	ET

Short stay patients discharged from ED/AAU/SSU must have an ‘E’ event end type code reported to NNPAC and NMDS. The ‘E’ event end type code should be the same in both NNPAC and NMDS.

Where patients are admitted to an inpatient ward from ED/AAU/SSU the NNPAC event end type code will always be DW *Discharged to other service within same facility*.

Note 1:

‘Patient in ED/AAU/SSU receives treatment ≥3hrs admitted to Geriatric AT&R inpatient ward with ‘D’ health specialty code’. Older persons who present to ED with an acute condition who are admitted as an acute inpatient to a geriatric AT&R (older persons) inpatient ward with a ‘D’ health speciality code is not

common practice. However where this does occur the reporting requirements are that a separate ED short stay event is to be reported with an event end type of DW *Discharged to other service within same facility*.

Note 2:

For existing inpatients who are transferred from mental health or geriatric AT&R services to ED/AAU/SSU and meet the three (≥3) hour criteria who are then transfer back to these services, must have an ED/AAU/SSU short stay event reported to the NMDS with the health specialty code of **M05 Emergency Medicine**.

Event End Type	Event End Type Description	Separation Mode Code
EA	Discharge from Emergency department acute facility to specialist facility for neonates and burns only	**1 or 01**
ED	Died while still in Emergency department acute facility	**8 or 08**
EI	Self discharge from treatment in an Emergency department acute facility with indemnity signed	**6 or 06**
ER	Routine discharge from an Emergency department acute facility	**9 or 09**
ES	Self discharge from treatment in an Emergency department acute facility without indemnity	**6 or 06**
ET	**Discharge from Emergency department acute facility to another healthcare facility**	**4 or 04**

Event End Type Codes - Mapping to Separation Mode

3M™ Codefinder™ Separation Mode Codes and Descriptions

Separation Mode Code	3M Codefinder Separation Mode Description
1 or 01	**Discharge/Transfer to an Acute Hospital**
2 or 02	**Discharge/Transfer to a Residential Ageing Service**
3 or 03	**Discharge/Transfer to a Psychiatric Hospital**
4 or 04	**Discharge/Transfer to Other Health Care Accommodation**
5 or 05	**Statistical Discharge – Type Change**
6 or 06	**Left Against Medical Advice**
7 or 07	**Statistical Discharge from Leave**
8 or 08	**Died**
9 or 09	**Home/Other**