

# **National Minimum Dataset (Hospital Inpatient Events)**

## **DATA MART - DATA DICTIONARY**

**Version 7.5  
August 2012**



**MINISTRY OF  
HEALTH**

MANATŪ HAUORA

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## 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).

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## National Minimum Dataset (Hospital Inpatient Events)

<b>Purpose</b>	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.
<b>Content</b>	<p>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.</p> <p>Data has been submitted electronically in an agreed format by public hospitals since 1993.</p> <p>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.</p>
<b>Start date</b>	The current NMDS was introduced in 1999. The original NMDS was implemented in 1993 and back-loaded with public hospital discharge information from 1988.
<b>Guide for use</b>	<p>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.</p> <p>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.</p>
<b>Contact information</b>	<p>For further information about this collection or to request specific datasets or reports, contact the NZHIS Analytical Services team on</p> <ul style="list-style-type: none"><li>- Phone: (04) 816 2893 Fax: (04) 816 2898,</li><li>- or e-mail <a href="mailto:data-enquiries@moh.govt.nz">data-enquiries@moh.govt.nz</a></li></ul>
<b>Collection methods</b>	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.
<b>Frequency of updates</b>	<p>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.</p> <p>NZHIS has a team of staff who manually process private hospital electronic and paper reports.</p>
<b>Security of data</b>	<p>The NMDS is accessed by authorised NZHIS staff for maintenance, data quality, audit and analytical purposes.</p> <p>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.</p>
<b>Privacy issues</b>	<p>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.</p> <p>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.</p>

**National reports and publications**

NZHS 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 NZHS 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 NZHS Analytical Services team also offers a peer review service to ensure that NZHS data is reported appropriately when published by other organisations.

There may be charges associated with data extracts.



## NMD Admission Source table

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

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## **Admission source code**

<b>Definition</b>	A code used to describe the nature of admission (routine or transfer) for a hospital inpatient health event.
<b>Column name</b>	admission_source_code
<b>Table name</b>	dim_admission_source
<b>Data type</b>	char(1)
<b>Other names</b>	
<b>Context</b>	Hospital inpatient or day patient health event.
<b>Layout</b>	A
<b>Data domain</b>	R     Routine admission T     Transfer from another hospital facility
<b>Guide for use</b>	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.
<b>Verification rules</b>	Must be a valid code in the Admission Source code table.
<b>Collection methods</b>	
<b>Related data</b>	Admission Source code.
<b>Source document</b>	
<b>Source organisation</b>	National Data Policy Group

**Admission source description**

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

## NMD Admission Type table

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

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## Admission type

<b>Definition</b>	A code used to describe the type of admission for a hospital healthcare health event.
<b>Column name</b>	admission_type
<b>Table name</b>	dim_admission_type
<b>Data type</b>	varchar2(2)
<b>Other names</b>	Admission type
<b>Context</b>	Hospital inpatient or day patient health event. Used in the NMDS.
<b>Layout</b>	AA
<b>Data domain</b>	
<b>Guide for use</b>	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***

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

**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

<b>Table name</b>	dim_nmd_fac_cond_onset_rqrd_dte
<b>Definition</b>	Date when the facility implements the Condition Onset Flag in its Patient Management System (PMS) and reports to the NMDS.
<b>Primary key</b>	
<b>Business key</b>	
<b>Guide for use</b>	<p>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.</p> <p>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.</p> <p>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.</p> <p><a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a></p> <p>If facilities require further exemption from the date provided apply to Data Management Services, National Collections and Reporting, email <a href="mailto:compliance@moh.govt.nz">compliance@moh.govt.nz</a></p>
<b>Relational rules</b>	
<b>Data content</b>	

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## **Facility code**

<b>Definition</b>	A code that uniquely identifies a healthcare facility.
<b>Column name</b>	facility_code
<b>Table name</b>	dim_nmd_fac_cond_onset_rq_dte
<b>Data type</b>	varchar(64)
<b>Other names</b>	Health agency facility code, Hospital, HAF code, HAFC
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	See the Facility code table on the Ministry of Health web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information or a printed copy of the code table, contact Analytical Services.
<b>Guide for use</b>	<p>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.</p> <p>See Appendix: Duplicate and Overlapping Event Checking rules.</p>
<b>Verification rules</b>	<p>Must be a valid code in the Facility code table.</p> <p>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.</p>
<b>Collection methods</b>	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.
<b>Related data</b>	<p>Birth location</p> <p>Facility type</p>
<b>Source document</b>	
<b>Source organisation</b>	Ministry of Health

**Facility id****Definition****Column name** facility\_id**Table name** dim\_nmd\_fac\_cond\_onset\_rq\_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](mailto:compliance@moh.govt.nz)

### ***Verification rules***

### ***Collection methods***

### ***Related data***

### ***Source document***

### ***Source organisation***

## NMD Fact Diagnosis Procedure Table

<b>Table name</b>	fact_nmd_diagnosis_procedure
<b>Definition</b>	Details relating to diagnoses and procedures associated with a health event.
<b>Primary key</b>	
<b>Business key</b>	event_id
<b>Guide for use</b>	<p>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.</p> <p>Also contains information about accidents that caused health events or occurred during a health event, including adverse reactions.</p> <p>Diagnoses and procedures are held in multiple versions of the International Classification of Diseases. All events:</p> <ul style="list-style-type: none"> <li>- are stored in ICD-9-CM-A</li> <li>- with an Event end datetime on or after 1 July 1999 are stored in ICD-9-CM-A and ICD-10-AM 1st Edition</li> <li>- 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</li> <li>- 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.</li> </ul> <p>See Clinical code type for more information.</p> <p>The selection of codes are based on the guidelines provided in The Australian Coding Standards (ACS).</p> <p>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.</p> <p>The condition established after study may or may not confirm the admitting diagnosis.</p> <p>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.</p> <p>For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:</p> <ul style="list-style-type: none"> <li>- therapeutic treatment</li> <li>- diagnostic procedures</li> <li>- increased clinical care and/or monitoring.</li> </ul> <p>Coding procedures carried out in Emergency Department (ED) before admission:</p> <p>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.</p> <p>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</p>

the ambulance. If ventilation is commenced in the ambulance, it is counted only from the time of hospitalisation.

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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 1 July 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 s

**Relational rules**

Refer to Guide for Use above

**Data content**

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**Batch id**

<b>Definition</b>	A unique identifier for each batch.
<b>Column name</b>	batch_id
<b>Table name</b>	fact_nmd_diagnosis_procedure
<b>Data type</b>	integer
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	
<b>Guide for use</b>	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.
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	



## **Clinical code**

<b>Definition</b>	A code used to classify the clinical description of a condition.
<b>Column name</b>	clinical_code
<b>Table name</b>	fact_nmd_diagnosis_procedure
<b>Data type</b>	varchar2(8)
<b>Other names</b>	Diagnosis/procedure code
<b>Context</b>	Clinical information within a health event. Includes codes for diagnosis, injury, cause of intentional and unintentional injury, and procedure performed.
<b>Layout</b>	
<b>Data domain</b>	Must be a valid code in one of the clinical coding systems mentioned below.
<b>Guide for use</b>	<p>Clinical coding systems:</p> <ul style="list-style-type: none"> <li>- ICD-9-CM-A 2nd Edition - Australian Version of The International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition</li> <li>- ICD-10-AM 1st Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition</li> <li>- ICD-10-AM 2nd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition</li> <li>- ICD-10-AM 3rd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition</li> <li>- ICD-10-AM 6th Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 6th Edition.</li> </ul> <p>Depending on the context, this is also known as Diagnosis/procedure code (external cause).</p> <p>From 1 July 1995, this field contains the Clinical code as supplied by the provider.</p> <p>ICD-9-CM (TO 30 JUNE 1995)</p> <p>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.</p> <p>ICD-9-CM-A (1 JULY 1995 ONWARDS)</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>ICD-10-AM 1ST EDITION (1 JULY 1999 ONWARDS)</p>

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 Classificati

**Source organisation**

## ***Clinical code system***

<b><i>Definition</i></b>	A code identifying the clinical coding system used for diagnoses and procedures.
<b><i>Column name</i></b>	clinical_code_system
<b><i>Table name</i></b>	fact_nmd_diagnosis_procedure
<b><i>Data type</i></b>	varchar2(2)
<b><i>Other names</i></b>	
<b><i>Context</i></b>	Clinical information.
<b><i>Layout</i></b>	NN
<b><i>Data domain</i></b>	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
<b><i>Guide for use</i></b>	<p>Previously known as Diagnosis coding system code.</p> <p>Code '03' (Read) is used for primary care and not reported in the NMDS.</p> <p>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.</p> <p>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.</p> <p>From 1 July 2004 data is submitted in '12' (ICD-10-AM 3rd Edition) and mapped to '11' (ICD-10-AM 2nd Edition). Mappings from '11' to '10' and '10' or earlier classifications continues to be performed, where mappings exist.</p>
<b><i>Verification rules</i></b>	<p>Must be a valid code in the Clinical Coding System code table.</p> <p>Must form part of a valid combination of Clinical code, Clinical code type, and Clinical coding system ID.</p>
<b><i>Collection methods</i></b>	From 1 July 2004 data should be submitted using ICD-10-AM 3rd Edition, that is, the Clinical coding system ID should be '12'.
<b><i>Related data</i></b>	Diagnosis type Clinical code type Clinical code
<b><i>Source document</i></b>	Encoding software
<b><i>Source organisation</i></b>	Ministry of Health

## **Clinical code type**

<b>Definition</b>	A code denoting which section of the clinical code table the clinical code falls within.
<b>Column name</b>	clinical_code_type
<b>Table name</b>	fact_nmd_diagnosis_procedure
<b>Data type</b>	char(1)
<b>Other names</b>	
<b>Context</b>	Clinical information.
<b>Layout</b>	A
<b>Data domain</b>	'A' = Diagnosis 'B' = Injury 'D' = DSM-IV 'E' = External cause of injury 'M' = Morphology (pathology) 'O' = Operation/procedure 'V' = Supplementary classification/health factors
<b>Guide for use</b>	<p>Previously known as Clinical code table type.</p> <p>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.</p> <p>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.</p>
<b>Verification rules</b>	<p>Must be a valid code in the Clinical Code Type code table.</p> <p>Must form part of a valid combination of Clinical code, Clinical code type, and Clinical coding system ID.</p>
<b>Collection methods</b>	
<b>Related data</b>	Clinical coding system ID Diagnosis type Clinical code
<b>Source document</b>	
<b>Source organisation</b>	

## Condition onset code

<b>Definition</b>	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.
<b>Column name</b>	condition_onset_code
<b>Table name</b>	fact_nmd_diagnosis_procedure
<b>Data type</b>	varchar2(1)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	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)
<b>Guide for use</b>	<p>Condition Onset Flag will be included on all mappings of clinical code systems, eg 12=ICD10 Ed 3, 13=ICD10 Ed 6 etc.</p> <p>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.</p> <p>Each facility will have a Condition Onset Flag implementation date.</p> <p>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.</p> <p>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.</p> <p>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)</p>
<b>Verification rules</b>	Condition Onset Flag will be reported in the new file version V015.0
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	

## ***Diagnosis description***

<b><i>Definition</i></b>	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.
<b><i>Column name</i></b>	diagnosis_description
<b><i>Table name</i></b>	fact_nmd_diagnosis_procedure
<b><i>Data type</i></b>	varchar2(100)
<b><i>Other names</i></b>	Event diagnosis/procedure description
<b><i>Context</i></b>	Clinical information.
<b><i>Layout</i></b>	Free text
<b><i>Data domain</i></b>	
<b><i>Guide for use</i></b>	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***

<b><i>Definition</i></b>	A sequencing number for clinical codes derived from the diagnosis number as part of the mapping process.
<b><i>Column name</i></b>	diagnosis_sequence
<b><i>Table name</i></b>	fact_nmd_diagnosis_procedure
<b><i>Data type</i></b>	number(5)
<b><i>Other names</i></b>	
<b><i>Context</i></b>	
<b><i>Layout</i></b>	
<b><i>Data domain</i></b>	010 - 999
<b><i>Guide for use</i></b>	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.
<b><i>Verification rules</i></b>	
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	Diagnosis number
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	



## ***Diagnosis number***

<b><i>Definition</i></b>	Sequential number for each clinical code in each event record to assist in unique identification.
<b><i>Column name</i></b>	diagnosis_number
<b><i>Table name</i></b>	fact_nmd_diagnosis_procedure
<b><i>Data type</i></b>	integer
<b><i>Other names</i></b>	Event diagnosis/procedure number
<b><i>Context</i></b>	
<b><i>Layout</i></b>	
<b><i>Data domain</i></b>	01 - 99
<b><i>Guide for use</i></b>	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.
<b><i>Verification rules</i></b>	
<b><i>Collection methods</i></b>	Up to 99 clinical codes may be provided with each event.
<b><i>Related data</i></b>	Used to calculate Diagnosis sequence
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

## Diagnosis type

<b>Definition</b>	A code that groups clinical codes, or indicates the priority of a diagnosis.
<b>Column name</b>	diagnosis_type
<b>Table name</b>	fact_nmd_diagnosis_procedure
<b>Data type</b>	char(1)
<b>Other names</b>	Diagnosis type code
<b>Context</b>	Clinical information within a health event.
<b>Layout</b>	
<b>Data domain</b>	<p>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)</p>
<b>Guide for use</b>	<p>Only codes 'A', 'B', 'E', 'M', 'O' and 'P' are found in the NMDS database.</p> <p>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.</p> <p>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.</p>
<b>Verification rules</b>	Must be a valid code in the Diagnosis Type code table. There must be one and only one type 'A' for each event.
<b>Collection methods</b>	
<b>Related data</b>	<p>Clinical code            Diagnosis/procedure description            Clinical coding system ID            Clinical code type            External cause date of occurrence</p>

### 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**

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

**Event id**

<b>Definition</b>	An internal reference number that uniquely identifies a health event.
<b>Column name</b>	event_id
<b>Table name</b>	fact_nmd_diagnosis_procedure
<b>Data type</b>	integer
<b>Other names</b>	
<b>Context</b>	Any event on the NMDS.
<b>Layout</b>	
<b>Data domain</b>	
<b>Guide for use</b>	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.
<b>Verification rules</b>	Add 1 to the previous maximum number.
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	

**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**

<b>Definition</b>	Flag to indicate whether the health event was privately funded.
<b>Column name</b>	private_hospital_flag
<b>Table name</b>	fact_nmd_diagnosis_procedure
<b>Data type</b>	char(1)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	A
<b>Data domain</b>	'Y' = Yes 'N' = No Null
<b>Guide for use</b>	
<b>Verification rules</b>	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'.
<b>Collection methods</b>	
<b>Related data</b>	Principal health service purchaser Facility type
<b>Source document</b>	
<b>Source organisation</b>	

**Procedure ACC date**

<b>Definition</b>	The date when the accident/injury occurred.
<b>Column name</b>	procedure_acc_date
<b>Table name</b>	fact_nmd_diagnosis_procedure
<b>Data type</b>	date
<b>Other names</b>	Accident date, Injury date
<b>Context</b>	Events resulting from an accident.
<b>Layout</b>	CCYYMMDD
<b>Data domain</b>	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.
<b>Guide for use</b>	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.
<b>Verification rules</b>	Optional.
<b>Collection methods</b>	This field is optional for ICD-10-AM 2nd Edition (and onwards) place of occurrence codes (Y92.x) and activity codes (Y93.x).
<b>Related data</b>	Diagnosis type Accident date flag
<b>Source document</b>	
<b>Source organisation</b>	

**Procedure ACC date flag**

<b>Definition</b>	Indicates whether the External cause date of occurrence stored is a partial date.
<b>Column name</b>	procedure_acc_date_flag
<b>Table name</b>	fact_nmd_diagnosis_procedure
<b>Data type</b>	char(1)
<b>Other names</b>	
<b>Context</b>	Events resulting from an accident.
<b>Layout</b>	
<b>Data domain</b>	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'
<b>Guide for use</b>	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'.
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	External cause date of occurrence
<b>Source document</b>	
<b>Source organisation</b>	

**Submitted system id**

<b>Definition</b>	The clinical coding system ID used by the provider when submitting their diagnosis record.
<b>Column name</b>	submitted_system_id
<b>Table name</b>	fact_nmd_diagnosis_procedure
<b>Data type</b>	varchar2(2)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	Refer 'Clinical coding system ID'
<b>Guide for use</b>	<p>This field identifies the system ID used on a diagnosis record submitted by the health provider.</p> <p>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.</p>
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	Ministry of Health

**Transaction id**

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

## 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**

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**Batch id**

<b>Definition</b>	A unique identifier for each batch.
<b>Column name</b>	batch_id
<b>Table name</b>	fact_nmd_event_legal_status
<b>Data type</b>	integer
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	
<b>Guide for use</b>	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.
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	

**Event id**

<b>Definition</b>	An internal reference number that uniquely identifies a health event.
<b>Column name</b>	event_id
<b>Table name</b>	fact_nmd_event_legal_status
<b>Data type</b>	integer
<b>Other names</b>	
<b>Context</b>	Any event on the NMDS.
<b>Layout</b>	
<b>Data domain</b>	
<b>Guide for use</b>	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.
<b>Verification rules</b>	Add 1 to the previous maximum number.
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	



## **Legal status code**

<b>Definition</b>	Code describing a healthcare user's legal status under the appropriate section of any of a number of Acts (see Guide for Use).
<b>Column name</b>	legal_status_code
<b>Table name</b>	fact_nmd_event_legal_status
<b>Data type</b>	varchar2(2)
<b>Other names</b>	
<b>Context</b>	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.
<b>Layout</b>	AA (or A and a space)
<b>Data domain</b>	See the Legal Status code table on the Ministry of Health web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information or a printed copy of the code table, contact Analytical Services.
<b>Guide for use</b>	- 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.
<b>Verification rules</b>	At least one required for psychiatric inpatient events.
<b>Collection methods</b>	A Legal status code is required for each Legal status date provided.
<b>Related data</b>	DRG code Legal status date
<b>Source document</b>	
<b>Source organisation</b>	

**Legal status date**

<b>Definition</b>	The date from which a healthcare user's legal status applies.
<b>Column name</b>	legal_status_date
<b>Table name</b>	fact_nmd_event_legal_status
<b>Data type</b>	date
<b>Other names</b>	Health event legal status date
<b>Context</b>	Defines a healthcare user's standing under the appropriate section of the Mental Health (Compulsory Assessment & Treatment), for example, compulsory treatment.
<b>Layout</b>	CCYYMMDD
<b>Data domain</b>	Valid dates
<b>Guide for use</b>	<p>Only used in the context of mental health admissions.</p> <p>From 1 July 1999 legal status can be reported with ID and IP events as well as IM event types.</p> <p>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.</p> <p>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 or 6.0 code.</p>
<b>Verification rules</b>	<p>Partial dates not allowed.</p> <p>At least one required for psychiatric inpatient events.</p>
<b>Collection methods</b>	A Legal status date is required for each Legal status code supplied.
<b>Related data</b>	<p>DRG code</p> <p>Legal status code</p>
<b>Source document</b>	
<b>Source organisation</b>	

**Private hospital flag**

<b>Definition</b>	Flag to indicate whether the health event was privately funded.
<b>Column name</b>	private_hospital_flag
<b>Table name</b>	fact_nmd_event_legal_status
<b>Data type</b>	char(1)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	A
<b>Data domain</b>	'Y' = Yes 'N' = No Null
<b>Guide for use</b>	
<b>Verification rules</b>	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'.
<b>Collection methods</b>	
<b>Related data</b>	Principal health service purchaser Facility type
<b>Source document</b>	
<b>Source organisation</b>	

**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***

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**ACC claim number**

<b>Definition</b>	This is a separate field to record the M46/45, ACC45 or AITC claim number for the event.
<b>Column name</b>	acc_claim_number
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(12)
<b>Other names</b>	
<b>Context</b>	Injury resulting from an accident.
<b>Layout</b>	Free text
<b>Data domain</b>	This is a free-text field to allow historical claim numbers, which come in a variety of formats, to be provided.
<b>Guide for use</b>	<p>This field is used to report the Accident Insurance Treatment Certificate (AITC) form number.</p> <p>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'.</p> <p>If the Accident flag is set to 'Y' (for any Principal health service purchaser code), then the ACC Claim Number field must be populated.</p> <p>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.</p> <p>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.</p>
<b>Verification rules</b>	Optional.
<b>Collection methods</b>	
<b>Related data</b>	Accident flag Principal health service purchaser
<b>Source document</b>	
<b>Source organisation</b>	Accident Compensation Corporation

## **Accident flag**

<b>Definition</b>	A flag that denotes whether a person is receiving care or treatment as the result of an accident.
<b>Column name</b>	accident_flag
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	char(1)
<b>Other names</b>	ACC flag
<b>Context</b>	Injury resulting from an accident.
<b>Layout</b>	A
<b>Data domain</b>	<p>Y The health event/treatment is assumed to be or is assessed as the result of an accident</p> <p>N The health event/treatment is the result of an illness.</p> <p>U Unknown.</p>
<b>Guide for use</b>	<p>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).</p> <p>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.</p> <p>Events where the accident flag is set to 'Y' may or may not have claims that are supported by Accident Compensation Corporation (ACC)</p>
<b>Verification rules</b>	Optional.
<b>Collection methods</b>	
<b>Related data</b>	<p>ACC claim number</p> <p>Clinical code (classifies the injuries and cause of accident)</p>
<b>Source document</b>	
<b>Source organisation</b>	



## **Admission source code**

<b>Definition</b>	A code used to describe the nature of admission (routine or transfer) for a hospital inpatient health event.
<b>Column name</b>	admission_source_code
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	char(1)
<b>Other names</b>	
<b>Context</b>	Hospital inpatient or day patient health event.
<b>Layout</b>	A
<b>Data domain</b>	R     Routine admission T     Transfer from another hospital facility
<b>Guide for use</b>	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.
<b>Verification rules</b>	Must be a valid code in the Admission Source code table.
<b>Collection methods</b>	
<b>Related data</b>	Admission Source code.
<b>Source document</b>	
<b>Source organisation</b>	National Data Policy Group

## Admission type

<b>Definition</b>	A code used to describe the type of admission for a hospital healthcare health event.
<b>Column name</b>	admission_type
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(2)
<b>Other names</b>	Admission type
<b>Context</b>	
<b>Layout</b>	AA
<b>Data domain</b>	See the Admission Type code table on the Ministry of Health web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information contact Analytical Services.
<b>Guide for use</b>	<p>From July 2004, Admission types 'ZA', 'ZC', 'ZP' and 'ZW' were retired, and ACC cases should be identified by the use of the Accident Flag.</p> <p>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).</p> <p>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.</p> <p>AP - ELECTIVE (introduced in 1996)  Elective admission of a privately funded patient in either a public or private hospital.</p> <p>RL - PSYCHIATRIC PATIENT RETURNED FROM LEAVE (introduced in 1994)  A sectioned mental health patient, returning from more than 14 days leave.</p> <p>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.</p> <p>'WU' (Waiting list - urgent) code not used from 20 August 1993.</p>
<b>Verification rules</b>	<p>Code must be present in the Admission Type code table.</p> <p>The date portion of Event End Datetime must be on or prior to the Admission type end date (if populated).</p> <p>As from 1 July 2004, using a retired code will generate an error message.</p>

**Collection methods**

**Related data** Accident Flag,

**Source document**

**Source organisation**

## **Age at admission**

<b>Definition</b>	The age of a patient on admission to hospital.
<b>Column name</b>	age_at_admission
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	integer
<b>Other names</b>	
<b>Context</b>	Demographic information.
<b>Layout</b>	
<b>Data domain</b>	000 - 120
<b>Guide for use</b>	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.
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	Event start datetime Date of birth
<b>Source document</b>	
<b>Source organisation</b>	

## ***Age at discharge***

<b><i>Definition</i></b>	The age of a patient on discharge from hospital.
<b><i>Column name</i></b>	age_at_discharge
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	integer
<b><i>Other names</i></b>	
<b><i>Context</i></b>	Demographic information.
<b><i>Layout</i></b>	
<b><i>Data domain</i></b>	000 - 120, XXX
<b><i>Guide for use</i></b>	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.
<b><i>Verification rules</i></b>	
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	Date of birth Event end datetime
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

## **Age of mother**

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

## Agency code

<b>Definition</b>	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.
<b>Column name</b>	agency_code
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(4)
<b>Other names</b>	Health agency code, DHB
<b>Context</b>	
<b>Layout</b>	XXXX
<b>Data domain</b>	See the Agency code table on the Ministry of Health web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information or a printed copy of the code table, contact the Analytical Services.
<b>Guide for use</b>	<p>Historically, also known as CHE (Crown Health Enterprise), HHS (Hospitals and Health Services) and AHB (Area Health Board).</p> <p>Between 1988 and 1993 the Agency code was assigned based on the original 1993 agency groupings.</p> <p>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 <a href="http://www.health.govt.nz/nz-health-statistics/access-and-use">http://www.health.govt.nz/nz-health-statistics/access-and-use</a>.</p> <p>This is a key field for allocating purchase units.</p> <p>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.</p> <p>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.</p>
<b>Verification rules</b>	Must be a valid code in the Agency code table.
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	Ministry of Health

**Batch id**

<b>Definition</b>	A unique identifier for each batch.
<b>Column name</b>	batch_id
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	integer
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	
<b>Guide for use</b>	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.
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	



## ***Birth status***

<b><i>Definition</i></b>	Field which records whether an infant was still or liveborn.
<b><i>Column name</i></b>	birth_status
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	char(1)
<b><i>Other names</i></b>	
<b><i>Context</i></b>	Birth event.
<b><i>Layout</i></b>	A
<b><i>Data domain</i></b>	'L' = Liveborn 'S' = Stillborn
<b><i>Guide for use</i></b>	<p>Effectively only livebirths are reported to the NMDS.</p> <p>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).</p> <p>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.'</p> <p>For liveborn infants who die in hospital without ever going home, record the mother's address.</p>
<b><i>Verification rules</i></b>	Mandatory for birth events. Must not be supplied for other event types.
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

**Birth weight**

<b>Definition</b>	Weight of infant at time of birth, in grams.
<b>Column name</b>	birth_weight
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(4)
<b>Other names</b>	Birth weight
<b>Context</b>	Birth event.
<b>Layout</b>	NNNN
<b>Data domain</b>	0001 - 9999
<b>Guide for use</b>	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.
<b>Verification rules</b>	Mandatory for birth events.
<b>Collection methods</b>	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.
<b>Related data</b>	Weight on admission
<b>Source document</b>	
<b>Source organisation</b>	

## ***Client system identifier***

<b><i>Definition</i></b>	A unique identifier for the record stored within the health provider's system
<b><i>Column name</i></b>	client_system_identifier
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	varchar2(14)
<b><i>Other names</i></b>	
<b><i>Context</i></b>	
<b><i>Layout</i></b>	
<b><i>Data domain</i></b>	
<b><i>Guide for use</i></b>	<p>A unique identifier for each source system will be defined by the DHB and notified to the Ministry of Health. Thus each DHB may have multiple CSIs. To enable individual records to be identified, this will be combined with the PMS unique ID. This means individual records for an individual DHB can be readily identified when source systems use the same number range.</p> <p>This field is used as a reference field for checking data quality.</p>
<b><i>Verification rules</i></b>	
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	Related to PMS unique identifier.
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

## **Complication and comorbidity level (CCL)**

<b>Definition</b>	CCL - Complication/co-morbidity class level. This comes out of the DRG grouper program and identifies the clinical severity within a DRG code.
<b>Column name</b>	ccl
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	char(1)
<b>Other names</b>	
<b>Context</b>	DRG version 3.1
<b>Layout</b>	N
<b>Data domain</b>	<ul style="list-style-type: none"> <li>1 minor CC or non-CC</li> <li>2 moderate CC</li> <li>3 major CC</li> <li>4 extreme CC</li> </ul>
<b>Guide for use</b>	<p>Relates only to DRG Grouper versions 3.0 and 3.1.</p> <p>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.</p> <p>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.'</p>
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	DRG code version 3.1 PCCL
<b>Source document</b>	See the AN-DRG manual
<b>Source organisation</b>	The logic for the DRG software is specified by the Health Services Division of the Commonwealth Department of Health and Ageing, Australia

## **Cost weight**

<b>Definition</b>	Calculated value designed to weight a base rate payment.
<b>Column name</b>	cost_weight
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	number(9,4)
<b>Other names</b>	Cost weight, Case weight
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	
<b>Guide for use</b>	<p>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.</p> <p>Every event is given a Costweight, calculated from:</p> <ul style="list-style-type: none"> <li>- the DRG code and associated variables</li> <li>- Length of stay</li> <li>- Total hours on mechanical ventilation</li> <li>- some procedure codes and diagnosis codes.</li> </ul> <p>For details, see the Technical Documentation page on <a href="http://www.health.govt.nz/nz-health-statistics/data-references/weighted-inlier-equivalent-separations/wiesnz11-cost-weights">http://www.health.govt.nz/nz-health-statistics/data-references/weighted-inlier-equivalent-separations/wiesnz11-cost-weights</a>.</p> <p>It is used with the Financial year for calculating payments based on the year of Event end datetime in the patient record.</p>
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	DRG codes Costweight code Purchase unit DRG grouper type code Health specialty code
<b>Source document</b>	See <a href="http://www.health.govt.nz">http://www.health.govt.nz</a> .
<b>Source organisation</b>	National Centre for Classification in Health, University of Sydney, Australia (modified for New Zealand contracting)

**Cost weight code**

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

## Country code

<b>Definition</b>	Coded value for the country of birth as assigned from the Statistics NZ Country Code list (NZSCC86).
<b>Column name</b>	country_code
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(3)
<b>Other names</b>	
<b>Context</b>	Primarily used for epidemiological studies.
<b>Layout</b>	NNN
<b>Data domain</b>	004 - 999.  See the Country of Birth code table on the Ministry of Health web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a>
<b>Guide for use</b>	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.
<b>Verification rules</b>	Optional.
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	Statistics NZ

## **Date of birth**

<b>Definition</b>	The date on which the person was born.
<b>Column name</b>	date_of_birth
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	date
<b>Other names</b>	DOB, HCU date of birth, Birth date
<b>Context</b>	Required to derive age for demographic analyses.
<b>Layout</b>	
<b>Data domain</b>	Valid dates  Partial dates are permissible.
<b>Guide for use</b>	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.
<b>Verification rules</b>	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.
<b>Collection methods</b>	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.
<b>Related data</b>	DRG codes Event start datetime Event end datetime Operation/procedure date Age at admission Age at discharge Date of birth flag
<b>Source document</b>	
<b>Source organisation</b>	



**Date of birth flag**

<b>Definition</b>	Indicates whether the date of birth stored is a partial date.
<b>Column name</b>	date_of_birth_flag
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	char(1)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	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'
<b>Guide for use</b>	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'.
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	Date of birth
<b>Source document</b>	
<b>Source organisation</b>	

## ***Date psychiatric leave ends***

<b><i>Definition</i></b>	The date on which a committed mental health patient's period of leave ended.
<b><i>Column name</i></b>	date_psychiatric_leave_ends
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	date
<b><i>Other names</i></b>	Date psychiatric leave ended
<b><i>Context</i></b>	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.
<b><i>Layout</i></b>	
<b><i>Data domain</i></b>	Valid dates  Partial dates not allowed.
<b><i>Guide for use</i></b>	Not reliably reported since 1993.  Healthcare users can be on leave for up to 2 years under the Act.
<b><i>Verification rules</i></b>	Optional. Must only be present when Event end type is 'DL'.
<b><i>Collection methods</i></b>	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.
<b><i>Related data</i></b>	Psychiatric leave end code
<b><i>Source document</i></b>	Mental Health (Compulsory Assessment & Treatment) Act 1992
<b><i>Source organisation</i></b>	

***Date surgery decided***

<b><i>Definition</i></b>	The date on which the healthcare user was assessed as requiring surgery.
<b><i>Column name</i></b>	date_surgery_decided
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	date
<b><i>Other names</i></b>	
<b><i>Context</i></b>	Elective surgical events.
<b><i>Layout</i></b>	
<b><i>Data domain</i></b>	Valid dates
<b><i>Guide for use</i></b>	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.
<b><i>Verification rules</i></b>	
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	Surgical priority
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

***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**

<b>Definition</b>	Statistics NZ Health Domicile Code representing a person's usual residential address. Also used for facility addresses.
<b>Column name</b>	domicile_code
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(4)
<b>Other names</b>	
<b>Context</b>	Required for demographic analyses. Domicile codes are key variables for determining the characteristics of the population that are using the health sector.
<b>Layout</b>	
<b>Data domain</b>	See the Domicile code table on the Ministry of Health web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information or a printed copy of the code table, contact Analytical Services.
<b>Guide for use</b>	<p>Usual residential address is defined as the address at which the person has been, or plans to be, living for 3 months or more. (Statistics NZ definition of 'usually resident'.)</p> <p>If a person usually lives in a rest home or a hospital, that is considered their usual residential address.</p> <p>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).</p> <p>Before July 1993, domicile was coded using the 1986 census Domicile codes. This data has been mapped to the 1991 codes.</p> <p>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.</p> <p>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.</p> <ul style="list-style-type: none"> <li>- The 1991 code was used from 1988 to 30 June 1998. (1986 codes were converted to 1991 codes on migration into NMDS in 1993.)</li> <li>- The 1996 code was used from 1 July 1998 to 30 June 2003.</li> <li>- The 2001 code was used from 1 July 2003 to 30 June 2008.</li> <li>- The 2006 code has been in use since 1 July 2008.</li> </ul> <p>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.</p> <p>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</p>

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**

<b>Definition</b>	A diagnosis-related group (DRG) code produced by the current DRG grouper program version 6.0.
<b>Column name</b>	drg_code_current
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(4)
<b>Other names</b>	
<b>Context</b>	Clinical demographic and administrative information within a health event.
<b>Layout</b>	XXXX
<b>Data domain</b>	801A - 963Z, A01Z - Z65Z
<b>Guide for use</b>	<p>A diagnosis-related group (DRG) code of clinical version 4.1, 4.2, 5.0 or 6.0 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.</p> <p>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.</p> <p>Introduced on 1 July 2001 for DRG clinical version 4.1.</p> <p>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.</p> <p>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.</p> <p>If the date portion of Event end datetime is on or after 1 July 2005, this field contains a DRG code of clinical version 5.0.</p> <p>Calculated from:</p> <ul style="list-style-type: none"> <li>- personal information (eg, Sex, Date of birth), and</li> <li>- event information (eg, Admission date, Event end type), and</li> <li>- diagnosis and procedure information in the appropriate ICD code for the DRG Grouper (ICD-10-AM 3rd Edition).</li> <li>- 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.</li> <li>- 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.</li> <li>- From 1 July 2008, 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</li> </ul>
<b>Verification rules</b>	
<b>Collection methods</b>	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.
<b>Related data</b>	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**

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

**DRG code v31**

<b>Definition</b>	Diagnosis-related group code produced by clinical version 3.1 of AN-DRG Grouper.
<b>Column name</b>	drg_code_v31
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(3)
<b>Other names</b>	
<b>Context</b>	Clinical demographic and administrative information within a health event.
<b>Layout</b>	
<b>Data domain</b>	001 - 956
<b>Guide for use</b>	<p>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.</p> <p>This classifies the episodes of inpatient care into clinically meaningful groups with similar resource consumption.</p> <p>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.</p> <p>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.</p> <p>DRG codes of clinical version 3.1 are stored for all events, as this field is often used for analysis.</p>
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	CCL Costweight code Costweight Purchase unit MDC code MDC type DRG grouper type code
<b>Source document</b>	
<b>Source organisation</b>	

**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

**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' will be used from 1 July 2005.

The grouper software version produce a number of clinical versions. Ministry of Health is currently using software version 5.0 to produces DRG codes of clinical versions 3.1, 4.1, 4.2 and 5.0. 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***

<b>Definition</b>	The NHI number in encrypted form.
<b>Column name</b>	encrypted_hcu_id
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(11)
<b>Other names</b>	Encrypted HCU identifier, Encrypted NHI, etc. See other names for the NHI number under 'Guide for use' below.
<b>Context</b>	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.
<b>Layout</b>	
<b>Data domain</b>	System-generated
<b>Guide for use</b>	<p>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.</p> <p>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.</p> <p>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</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>VALIDATION</b></p> <p>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.</p> <p>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.</p>

**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***

<b><i>Definition</i></b>	Ethnic affiliation
<b><i>Column name</i></b>	ethnic_code
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	varchar2(2)
<b><i>Other names</i></b>	Ethnicity
<b><i>Context</i></b>	
<b><i>Layout</i></b>	NN
<b><i>Data domain</i></b>	See the Ethnic Group code table on the Ministry of Health web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information or a printed copy of the code table, contact Analytical Services.
<b><i>Guide for use</i></b>	<p>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.</p> <p>See Appendix: Guide for use of Ethnic Codes.</p> <p>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.</p> <p>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).</p> <p>Each ethnic group as maintained by Statistics NZ has a 5-digit code. Ministry of Health collections use only the first 2 digits.</p> <p>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.</p> <p>Each ethnic group as maintained by Statistics NZ has a 5-digit code. Ministry of Health collections use only the first 2 digits.</p>
<b><i>Verification rules</i></b>	<p>Ethnicity 1 is mandatory.</p> <p>Ethnicity 2 and Ethnicity 3 are optional.</p> <p>Ethnicity 2 cannot be the same as Ethnicity 1 or 3. Ethnicity 3 cannot be the same as Ethnicity 2 or 1.</p> <p>Must be a valid code in the Ethnic code table.</p>
<b><i>Collection methods</i></b>	Ethnicity should be self-identified wherever possible. If the Ethnic group code changes for this event, please update the NHI.
<b><i>Related data</i></b>	Prioritised ethnicity
<b><i>Source document</i></b>	Smith, Anthony. 1981. The Ethnic Revival. Cambridge University Press.
<b><i>Source organisation</i></b>	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**

<b>Definition</b>	The date and time on which a healthcare user is discharged from a facility (ie, the date and time the healthcare event ended) or the date and time on which a sectioned mental health patient is discharged to leave.
<b>Column name</b>	event_end_date
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	date
<b>Other names</b>	Discharge date, Event end/leave date
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	Valid date and time
<b>Guide for use</b>	
<b>Verification rules</b>	Partial dates not allowed.  Optional for psychiatric inpatient events. Mandatory for births, intended day cases and non-psychiatric inpatient events.
<b>Collection methods</b>	
<b>Related data</b>	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
<b>Source document</b>	
<b>Source organisation</b>	



## **Event end type**

<b>Definition</b>	A code identifying how a healthcare event ended.
<b>Column name</b>	event_end_type
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(2)
<b>Other names</b>	Discharge type
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	See the Event End Type code table on the MoH web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information or a printed copy of the code table, contact Analytical Services.
<b>Guide for use</b>	'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.
<b>Verification rules</b>	Must be a valid code in the Event End Type code table. Optional for psychiatric inpatient events. Mandatory for all other event types.
<b>Collection methods</b>	Refer to notes in the National Minimum Dataset (Hospital Events) Data Dictionary on the Ministry of Health web site at <a href="http://www.health.govt.nz/publication/national-minimum-dataset-hospital-events-data-dictionary">http://www.health.govt.nz/publication/national-minimum-dataset-hospital-events-data-dictionary</a>
<b>Related data</b>	event_end_date, event_end_description
<b>Source document</b>	
<b>Source organisation</b>	National Data Policy Group

## ***Event extra information***

<b><i>Definition</i></b>	Enables extra information concerning an event to be recorded in a free-text format.
<b><i>Column name</i></b>	event_extra_information
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	varchar2(90)
<b><i>Other names</i></b>	Comment field, Free text field
<b><i>Context</i></b>	
<b><i>Layout</i></b>	Free text
<b><i>Data domain</i></b>	
<b><i>Guide for use</i></b>	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.
<b><i>Verification rules</i></b>	Optional.
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

**Event id**

<b>Definition</b>	An internal reference number that uniquely identifies a health event.
<b>Column name</b>	event_id
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	integer
<b>Other names</b>	
<b>Context</b>	Any event on the NMDS.
<b>Layout</b>	
<b>Data domain</b>	
<b>Guide for use</b>	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.
<b>Verification rules</b>	Add 1 to the previous maximum number.
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	

## ***Event leave days***

<b><i>Definition</i></b>	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.
<b><i>Column name</i></b>	event_leave_days
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	varchar2(3)
<b><i>Other names</i></b>	Leave days
<b><i>Context</i></b>	
<b><i>Layout</i></b>	NNN
<b><i>Data domain</i></b>	000 - 999
<b><i>Guide for use</i></b>	<p>Where there is more than one period of leave during an episode, accumulated leave days should be reported.</p> <p>This is not how leave is calculated for sectioned mental health patients, and their leave days should not be accumulated under this field.</p> <p>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.</p>
<b><i>Verification rules</i></b>	<p>Optional.</p> <p>Event leave days must be null or greater than zero.</p> <p>Event leave days must not be greater than the difference in days between Event start datetime and Event end datetime.</p>
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	<p>Event start datetime</p> <p>Event end datetime</p> <p>Length of stay</p>
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

**Event local id**

<b>Definition</b>	Local system-generated number to distinguish two or more events of the same type occurring on the same day at the same facility.
<b>Column name</b>	event_local_id
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	char(1)
<b>Other names</b>	Local ID
<b>Context</b>	
<b>Layout</b>	N
<b>Data domain</b>	1-Sep
<b>Guide for use</b>	
<b>Verification rules</b>	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.
<b>Collection methods</b>	Use 9 first then ' 8,7, ...,1'.
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	

## **Event start datetime**

<b>Definition</b>	The admission date on which a healthcare event began.
<b>Column name</b>	event_start_date
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	date
<b>Other names</b>	Admission date
<b>Context</b>	Admitted patients.
<b>Layout</b>	CCYYMMDDhhmm
<b>Data domain</b>	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).
<b>Guide for use</b>	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.
<b>Verification rules</b>	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.
<b>Collection methods</b>	
<b>Related data</b>	Date of birth Event end datetime Operation/procedure date Event leave days Age at admission Length of stay
<b>Source document</b>	
<b>Source organisation</b>	

## Event type

<b>Definition</b>	Code identifying the type of health event.
<b>Column name</b>	event_type
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(2)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	See the Event Type code table on the Ministry of Health web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information or a printed copy of the code table, contact Analytical Services.
<b>Guide for use</b>	<p>The presence of some fields depends on the Event type code. See Appendix : Enhanced Event Type/Event Diagnosis Type Table.</p> <p>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.</p> <p>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.</p> <p>'ID' is to be used where the intention at admission is that the event will be a day-case event.</p> <p>'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).</p>
<b>Verification rules</b>	Must be a valid code in the Event Type code table.
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	

## ***Excluded Purchase Unit***

<b><i>Definition</i></b>	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.
<b><i>Column name</i></b>	exclu_purchase_unit
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	varchar2(10)
<b><i>Other names</i></b>	
<b><i>Context</i></b>	
<b><i>Layout</i></b>	
<b><i>Data domain</i></b>	Purchase Units in the National Service Framework Data Dictionary.
<b><i>Guide for use</i></b>	Derived using a mapping table of Health Specialty Codes to Purchase Units.
<b><i>Verification rules</i></b>	
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	Purchase Unit, Health Specialty Code
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	Ministry of Health



## **Facility Transfer From**

<b>Definition</b>	For transfers, the facility that the healthcare user was transferred from.
<b>Column name</b>	facility_transfer_from
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(4)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	See the Facility code table on the Ministry of Health web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> For further information or a printed copy of the code table, contact Analytical Services.
<b>Guide for use</b>	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 <a href="http://www.health.govt.nz/nz-health-statistics/access-and-use">http://www.health.govt.nz/nz-health-statistics/access-and-use</a> .
<b>Verification rules</b>	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.
<b>Collection methods</b>	
<b>Related data</b>	Facility Code, Admission Source Code
<b>Source document</b>	
<b>Source organisation</b>	Ministry of Health

## **Facility Transfer To**

<b>Definition</b>	For transfers, the facility that the healthcare user was transferred to.
<b>Column name</b>	facility_transfer_to
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(4)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	See the Facility code table on the Ministry of Health web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information or a printed copy of the code table, contact Analytical Services.
<b>Guide for use</b>	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 <a href="http://www.health.govt.nz/nz-health-statistics/access-and-use">http://www.health.govt.nz/nz-health-statistics/access-and-use</a>
<b>Verification rules</b>	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.
<b>Collection methods</b>	
<b>Related data</b>	Facility Code, Event End Type Code
<b>Source document</b>	
<b>Source organisation</b>	Ministry of Health

## **Facility code**

<b>Definition</b>	A code that uniquely identifies a healthcare facility.
<b>Column name</b>	facility_code
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(4)
<b>Other names</b>	Health agency facility code, Hospital, HAF code, HAFC
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	See the Facility code table on the Ministry of Health web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information or a printed copy of the code table, contact Analytical Services.
<b>Guide for use</b>	<p>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.</p> <p>See Appendix: Duplicate and Overlapping Event Checking rules.</p>
<b>Verification rules</b>	<p>Must be a valid code in the Facility code table.</p> <p>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.</p>
<b>Collection methods</b>	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.
<b>Related data</b>	<p>Birth location</p> <p>Facility type</p>
<b>Source document</b>	
<b>Source organisation</b>	Ministry of Health

## **Facility type**

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

## **Financial year**

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

**First consult date**

<b>Definition</b>	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.
<b>Column name</b>	first_consult_date
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	date
<b>Other names</b>	
<b>Context</b>	Elective surgical events.
<b>Layout</b>	
<b>Data domain</b>	Valid dates. Partial dates permissible. At a minimum the century and year must be supplied.
<b>Guide for use</b>	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.
<b>Verification rules</b>	Optional.  Must be on or after the Date of birth.
<b>Collection methods</b>	Required for total hip replacement, total knee replacement and coronary artery bypass graft events.
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	

**Funding\_agency\_code**

<b>Definition</b>	The funding DHB code
<b>Column name</b>	funding_agency_code
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(64)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	See the Agency code table on the Ministry of Health web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information or a printed copy of the code table, contact the Analytical Services.
<b>Guide for use</b>	<p>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.</p> <p>Funding Agency must be reported in all the events reported in the v0r15.0 files regardless of the event end date.</p> <p>Funding Agency will be available for reporting in the warehouse and BO universes.</p> <p>Funding Agency will be used to determine if a health event is included in casemix funding.</p> <p>An IDF will occur when the DHB of domicile is not the same as the Funding Agency.</p> <p>Electives volumes will be calculated using the Funding Agency.</p> <p>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..</p> <p>Must be a valid code in the agency code table if the Principal health service purchaser = '20','35','55'</p> <p>Must be reported as 1236 if Principal health service purchaser = '35'</p> <p>Must be reported as 1237 if Principal health service purchaser = 'A0'</p> <p>For more details see Section 14.2 of the NMDS File Specification v015.2</p>
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	

## **Gender code**

<b>Definition</b>	The person's biological sex.
<b>Column name</b>	gender_code
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	char(1)
<b>Other names</b>	Sex type code
<b>Context</b>	Required for demographic analyses.
<b>Layout</b>	A
<b>Data domain</b>	M = Male F = Female U = Unknown I = Indeterminate
<b>Guide for use</b>	<p>Stored as Gender code.</p> <p>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).</p> <p>"U" codes must be updated as soon as possible after admission.</p> <p>'I' codes are for use in cases, usually newborns, where it is not possible to determine the sex of the healthcare user.</p> <p>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).</p> <p>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."</p>
<b>Verification rules</b>	<p>Must be a valid code in the Gender code table.</p> <p>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.</p> <p>Generate warning if Gender code is 'U'.</p>
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	



## ***Gestation period***

<b><i>Definition</i></b>	Time measured from the date of mother's last menstrual period to the date of birth and expressed in completed weeks.
<b><i>Column name</i></b>	gestation_period
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	varchar2(2)
<b><i>Other names</i></b>	Gestation
<b><i>Context</i></b>	Birth event.
<b><i>Layout</i></b>	XX
<b><i>Data domain</i></b>	XX = not stated 10 - 50 completed weeks
<b><i>Guide for use</i></b>	
<b><i>Verification rules</i></b>	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.
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

## Health specialty code

<b>Definition</b>	A classification describing the specialty or service to which a healthcare user has been assigned, which reflects the nature of the services being provided.
<b>Column name</b>	health_specialty_code
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(3)
<b>Other names</b>	HSC, Service code, Department code
<b>Context</b>	Healthcare user on discharge.
<b>Layout</b>	
<b>Data domain</b>	See the Health Specialty code table at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information or a printed copy of the code table, contact Analytical Services.
<b>Guide for use</b>	<p>Generalist and specialist subspecialty medical and surgical health specialty codes were retired from 1 July 2001.</p> <p>On 1 July 2007 the following changes took place:</p> <p>M20: Endocrinology and Diabetology ..was discontinued and replaced with..</p> <p>M95: Endocrinology M96: Diabetology</p> <p>M24: Paediatric Endocrinology and Diabetology ..was discontinued and replaced with..</p> <p>M97: Specialist Paediatric Endocrinology M98: Specialist Paediatric Diabetology</p> <p>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.</p> <p>On 1 July 2008 the following changes took place:</p> <p>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]</p> <p>Were retired and replaced with:</p> <p>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]</p> <p>'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).</p> <p>Note: - That this is the specialty on admission</p>

- 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***

## Hours on cpap

<b>Definition</b>	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.
<b>Column name</b>	hours_on_cpap
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(5)
<b>Other names</b>	CPAP hours
<b>Context</b>	
<b>Layout</b>	NNNNN
<b>Data domain</b>	00000 - 99999
<b>Guide for use</b>	<p>Hours on continuous positive airway pressure has been used in determining the DRG code since 1 July 2001.</p> <p>A CPAP CPAP procedure is:</p> <ul style="list-style-type: none"> <li>- an ICD-10-AM 6th Edition Clinical codes of 9220900,9220901,9220902 (Clinical code type = 'O') or</li> <li>- an ICD-10-AM 1st, 2nd, 3rd Edition Clinical code of 9203800 (Clinical code type = 'O'), or</li> <li>- an ICD-9-CM or ICD-9-CM-A Clinical code of 93.90 (Clinical code type = 'O').</li> </ul> <p>There is no specific procedure code for CPAP in ICD-10-AM 6th edition; it is included in the non invasive ventilation (NIV) codes:</p> <ul style="list-style-type: none"> <li>9220900 [570] Management of noninvasive ventilatory support, &lt;= 24 hours</li> <li>9220901 [570] Management of noninvasive ventilatory support, &gt; 24 and &lt; 96 hours</li> <li>9220902 [570] Management of noninvasive ventilatory support, &gt;= 96 hours</li> </ul> <p>Note:</p> <p>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].</p> <p>Generate warning if infant is:</p> <ul style="list-style-type: none"> <li>- more than 364 days old at Event end datetime, or</li> <li>- between 28 and 364 days old and Weight on admission is more than 2500 g at Event end datetime.</li> </ul> <p>Generate warning if:</p> <ul style="list-style-type: none"> <li>- more than 100, or</li> <li>- more than calculated number of hours from Event start datetime to Event end datetime inclusive.</li> </ul> <p>For records with the date portion of Event end datetime before 1 July 2008</p> <p>Generate warning if present and a CPAP procedure (as defined in Guide for use above) is not present.</p> <p>Generate warning if not present when a CPAP procedure (as defined in Guide for use above) is present, unless:</p> <ul style="list-style-type: none"> <li>- Total hours on mechanical ventilation is present, or</li> <li>- age at Event end datetime is more than 364 days, or</li> <li>- age is between 28 days and 364 days and Weight on admission is</li> </ul>

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**

## **Hours on ventilation**

<b>Definition</b>	The total number of hours on mechanical ventilation.
<b>Column name</b>	hours_on_ventilation
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(5)
<b>Other names</b>	Hours on mechanical ventilation, HMV
<b>Context</b>	Total hours for the health event irrespective of the specialty team treating the patient
<b>Layout</b>	NNNNN
<b>Data domain</b>	00000 - 99999
<b>Guide for use</b>	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
<b>Verification rules</b>	Optional.
<b>Collection methods</b>	
<b>Related data</b>	Total hours on continuous positive airway pressure Total noninvasive ventilation hours
<b>Source document</b>	See the AR-DRG manual
<b>Source organisation</b>	

## ***Length of stay***

<b><i>Definition</i></b>	Length of stay in a facility in days.
<b><i>Column name</i></b>	length_of_stay
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	varchar2(5)
<b><i>Other names</i></b>	LOS
<b><i>Context</i></b>	
<b><i>Layout</i></b>	NNNNN
<b><i>Data domain</i></b>	00001 - 99999
<b><i>Guide for use</i></b>	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.
<b><i>Verification rules</i></b>	
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	Event start datetime Event end datetime Event leave days
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

**Location code**

<b>Definition</b>	Birth location
<b>Column name</b>	location_code
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	integer
<b>Other names</b>	Birth location code, Birth/death location code
<b>Context</b>	Birth event.
<b>Layout</b>	
<b>Data domain</b>	
<b>Guide for use</b>	
<b>Verification rules</b>	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.
<b>Collection methods</b>	
<b>Related data</b>	Facility code Facility type
<b>Source document</b>	
<b>Source organisation</b>	Ministry of Health



**Major diagnostic category (MDC) code**

<b>Definition</b>	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.
<b>Column name</b>	mdc_code
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(2)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	NN
<b>Data domain</b>	See the MDC code table on the Ministry of Health web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information or a printed copy of the code table, contact Analytical Services.
<b>Guide for use</b>	
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	MDC type DRG codes DRG grouper type
<b>Source document</b>	AR_DRG Definitions Manual
<b>Source organisation</b>	

**Major diagnostic category (MDC) type**

<b>Definition</b>	A code denoting which version of a grouper a Major Diagnostic Category (MDC) code belongs to.
<b>Column name</b>	mdc_type
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	char(1)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	A
<b>Data domain</b>	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
<b>Guide for use</b>	Derived from the version of the grouper used to create the DRG code.
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	MDC code DRG codes DRG grouper type code
<b>Source document</b>	
<b>Source organisation</b>	

**Month of data**

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

## ***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**

<b>Definition</b>	A diagnosis-related group (DRG) code produced by the current DRG grouper program version 6.0.
<b>Column name</b>	nz_drg_code
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(4)
<b>Other names</b>	
<b>Context</b>	Clinical demographic and administrative information within a health event.
<b>Layout</b>	
<b>Data domain</b>	801A - 963Z, A01Z - Z65Z
<b>Guide for use</b>	<p>A diagnosis-related group (DRG) code of clinical version 4.1, 4.2, 5.0 or 6.0 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.</p> <p>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.</p> <p>Introduced on 1 July 2001 for DRG clinical version 4.1.</p> <p>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.</p> <p>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.</p> <p>If the Event end datetime is on or after 1 July 2005, this field contains a DRG code of clinical version 5.0.</p> <p>Calculated from:</p> <ul style="list-style-type: none"> <li>- personal information (eg, Sex, Date of birth), and</li> <li>- event information (eg, Admission date, Event end type), and</li> <li>- diagnosis and procedure information in the appropriate ICD code for the DRG Grouper (ICD-10-AM 3rd Edition).</li> <li>- 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.</li> <li>- 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.</li> <li>- From 1 July 2008, 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</li> </ul> <p>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.</p>
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	Costweight code

NMD Data Mart Data Dictionary

NMD Fact Health Event table

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***

<b><i>Definition</i></b>	A code identifying resident status at the time of this event.
<b><i>Column name</i></b>	nz_resident_flag
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	char(1)
<b><i>Other names</i></b>	HCU resident status, Residency, Resident status, HCU NZ resident status
<b><i>Context</i></b>	Used to identify overseas residents treated in New Zealand. Tied to public funding of events.
<b><i>Layout</i></b>	A
<b><i>Data domain</i></b>	'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)
<b><i>Guide for use</i></b>	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.
<b><i>Verification rules</i></b>	
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	
<b><i>Source document</i></b>	Immigration Act 1987
<b><i>Source organisation</i></b>	

## Occupation code

<b>Definition</b>	A code for an occupation of the healthcare user, classified according to the Statistics NZ Standard Classification of Occupations (NZSCO90).
<b>Column name</b>	occupation_code
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(4)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	0111 - 9900. See the Occupation code table at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information or a printed copy of the code table, contact Analytical Services.
<b>Guide for use</b>	
<b>Verification rules</b>	Optional.
<b>Collection methods</b>	Occupation free-text is preferred.
<b>Related data</b>	Occupation description
<b>Source document</b>	NZSCO90 - Statistics NZ Standard Classification of Occupations
<b>Source organisation</b>	Statistics NZ



## **Occupation free text**

<b>Definition</b>	A free-text description of the healthcare user's occupation.
<b>Column name</b>	occupation_free_text
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(70)
<b>Other names</b>	Occupation free-text, Occupation text
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	
<b>Guide for use</b>	<p>Introduced in November 2001.</p> <p>Since September 2008, Cancer Registry staff have not been able to populate or update this field.</p> <p>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.</p>
<b>Verification rules</b>	Optional
<b>Collection methods</b>	Should be reported for cancer patients
<b>Related data</b>	Occupation code
<b>Source document</b>	
<b>Source organisation</b>	

**Patient clinical complexity level (PCCL)**

<b>Definition</b>	Patient Clinical Complexity Level (PCCL) data identifies the clinical severity of the patients symptoms, within the patient record.
<b>Column name</b>	pccl
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	char(1)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	
<b>Guide for use</b>	<p>Relates only to DRG Grouper versions 4.1, 4.2, 5.0 and 6.0.</p> <p>Serves the same purpose for DRG Grouper clinical versions 4.1, 4.2, 5.0 and 6.0 as CCL does for DRG Grouper clinical versions 3.1 and 3.2.</p> <p>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'.</p>
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	DRG code current CCL
<b>Source document</b>	AR-DRG Definitions Manual
<b>Source organisation</b>	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***

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

## ***Principal diag 06 clin code***

<b><i>Definition</i></b>	A code used to classify the principal diagnosis/clinical description of a condition.
<b><i>Column name</i></b>	principal_diag_06_clin_code
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	varchar2(8)
<b><i>Other names</i></b>	
<b><i>Context</i></b>	
<b><i>Layout</i></b>	
<b><i>Data domain</i></b>	Must be a valid code in one of the clinical systems mentioned below.
<b><i>Guide for use</i></b>	Clinical coding systems: <ul style="list-style-type: none"><li>- ICD-9-CM-A 2nd Edition - Australian Version of The International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition</li><li>- ICD-10-AM 1st Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition</li><li>- ICD-10-AM 2nd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition</li><li>- ICD-10-AM 3rd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition</li><li>- DSM-IV - Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.</li></ul>
<b><i>Verification rules</i></b>	
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

## ***Principal diag 10 clin code***

<b><i>Definition</i></b>	A code used to classify the clinical description of a condition.
<b><i>Column name</i></b>	principal_diag_10_clin_code
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	varchar2(8)
<b><i>Other names</i></b>	
<b><i>Context</i></b>	
<b><i>Layout</i></b>	See Collection method.
<b><i>Data domain</i></b>	Must be a valid code in one of the clinical coding systems mentioned below.
<b><i>Guide for use</i></b>	Clinical coding systems: <ul style="list-style-type: none"><li>- ICD-9-CM-A 2nd Edition - Australian Version of The International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition</li><li>- ICD-10-AM 1st Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition</li><li>- ICD-10-AM 2nd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition</li><li>- ICD-10-AM 3rd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition</li><li>- DSM-IV - Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.</li></ul>
<b><i>Verification rules</i></b>	
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

## ***Principal diag 11 clin code***

<b><i>Definition</i></b>	A code used to classify the clinical description of a condition.
<b><i>Column name</i></b>	principal_diag_11_clin_code
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	varchar2(8)
<b><i>Other names</i></b>	
<b><i>Context</i></b>	
<b><i>Layout</i></b>	See Collection method.
<b><i>Data domain</i></b>	Must be a valid code in one of the clinical coding systems mentioned below.
<b><i>Guide for use</i></b>	Clinical coding systems: <ul style="list-style-type: none"><li>- ICD-9-CM-A 2nd Edition - Australian Version of The International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition</li><li>- ICD-10-AM 1st Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition</li><li>- ICD-10-AM 2nd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition</li><li>- ICD-10-AM 3rd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition</li><li>- DSM-IV - Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.</li></ul>
<b><i>Verification rules</i></b>	
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

## ***Principal diag 12 clin code***

<b><i>Definition</i></b>	A code used to classify the clinical description of a condition.
<b><i>Column name</i></b>	principal_diag_12_clin_code
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	varchar2(8)
<b><i>Other names</i></b>	
<b><i>Context</i></b>	
<b><i>Layout</i></b>	
<b><i>Data domain</i></b>	Must be a valid code in one of the clinical coding systems mentioned below.
<b><i>Guide for use</i></b>	Clinical coding systems: <ul style="list-style-type: none"><li>- ICD-9-CM-A 2nd Edition - Australian Version of The International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition</li><li>- ICD-10-AM 1st Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition</li><li>- ICD-10-AM 2nd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition</li><li>- ICD-10-AM 3rd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition</li><li>- DSM-IV - Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.</li></ul>
<b><i>Verification rules</i></b>	
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

**Principal diag 13 clin code**

<b>Definition</b>	A code used to classify the clinical description of a condition.
<b>Column name</b>	principal_diag_13_clin_code
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(8)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	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.
<b>Guide for use</b>	
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	



## ***Prioritised ethnic code***

<b><i>Definition</i></b>	The most highly prioritised ethnicity of the three ethnic groups recorded for the healthcare user, determined according to a Statistics NZ algorithm.
<b><i>Column name</i></b>	prioritised_ethnic_code
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	varchar2(2)
<b><i>Other names</i></b>	
<b><i>Context</i></b>	Demographic information.
<b><i>Layout</i></b>	NN
<b><i>Data domain</i></b>	See the Ethnic code table table on the Ministry of Health web site at <a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables</a> . For further information or a printed copy of the code table, contact Analytical Services.
<b><i>Guide for use</i></b>	<p>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.</p> <p>See Appendix: Guide for Use of Ethnic Codes.</p>
<b><i>Verification rules</i></b>	
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	Ethnic group Ethnic group 2 Ethnic group 3
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	Statistics NZ

**Private hospital flag**

<b>Definition</b>	Flag to indicate whether the health event was privately funded.
<b>Column name</b>	private_hospital_flag
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	char(1)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	A
<b>Data domain</b>	'Y' = Yes 'N' = No Null
<b>Guide for use</b>	
<b>Verification rules</b>	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'.
<b>Collection methods</b>	
<b>Related data</b>	Principal health service purchaser Facility type
<b>Source document</b>	
<b>Source organisation</b>	

## ***Psychiatric leave end type***

<b><i>Definition</i></b>	A code describing how a period of leave ended for a committed mental health patient.
<b><i>Column name</i></b>	psychiatric_leave_end_type
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	char(1)
<b><i>Other names</i></b>	
<b><i>Context</i></b>	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.
<b><i>Layout</i></b>	A
<b><i>Data domain</i></b>	D Discharged E Died R Returned to the same psychiatric institution T Transferred to another psychiatric institution
<b><i>Guide for use</i></b>	Not reliably reported since 1993.  Healthcare users can be on leave for up to 2 years under the Act.
<b><i>Verification rules</i></b>	Optional. Must only be present if Event end type is 'DL'.
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	Psychiatric leave end date
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

**Public birth**

<b>Definition</b>	A flag to indicate whether a birth is publicly funded.
<b>Column name</b>	public_birth
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	char(1)
<b>Other names</b>	
<b>Context</b>	Birth event.
<b>Layout</b>	
<b>Data domain</b>	
<b>Guide for use</b>	Not used.
<b>Verification rules</b>	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.
<b>Collection methods</b>	
<b>Related data</b>	Principal health service purchaser
<b>Source document</b>	
<b>Source organisation</b>	

## **Purchase unit**

<b>Definition</b>	Purchase unit indicates which contract the event is funded under.
<b>Column name</b>	purchase_unit
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(10)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	
<b>Guide for use</b>	<p>It is derived directly from Health specialty.</p> <p>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. <a href="http://www.health.govt.nz/nz-health-statistics/data-references/weighted-inlier-equivalent-separations">http://www.health.govt.nz/nz-health-statistics/data-references/weighted-inlier-equivalent-separations</a>.</p>
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	DRG codes Costweight Costweight code Health specialty code
<b>Source document</b>	New Zealand Casemix Framework for Publicly Funded Hospitals including WIES methodology and Casemix Purchase Unit Allocation
<b>Source organisation</b>	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 (Orthopaedics 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.  
 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](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->

**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**

<b>Definition</b>	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.
<b>Column name</b>	referral_date
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	date
<b>Other names</b>	
<b>Context</b>	Elective surgical events.
<b>Layout</b>	
<b>Data domain</b>	Valid dates  Partial dates are permissible. At a minimum the century and year must be supplied.
<b>Guide for use</b>	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.
<b>Verification rules</b>	Optional.
<b>Collection methods</b>	Required for total hip replacement, total knee replacement and coronary artery bypass graft events.
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	



## **Suppression flag**

<b>Definition</b>	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.
<b>Column name</b>	suppression_flag
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	char(1)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	A
<b>Data domain</b>	Y suppress this event summary N allow this event summary to be displayed
<b>Guide for use</b>	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.
<b>Verification rules</b>	
<b>Collection methods</b>	See Guide for Use
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	

## ***Surgical priority***

<b><i>Definition</i></b>	A code defining the severity of a healthcare user's condition at the date surgery was decided.
<b><i>Column name</i></b>	surgical_priority
<b><i>Table name</i></b>	fact_nmd_health_event
<b><i>Data type</i></b>	char(1)
<b><i>Other names</i></b>	
<b><i>Context</i></b>	Elective surgical events.
<b><i>Layout</i></b>	A
<b><i>Data domain</i></b>	R     Routine S     Semi-urgent U     Urgent
<b><i>Guide for use</i></b>	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.
<b><i>Verification rules</i></b>	Optional.
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	Date surgery decided
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

## **TLA of domicile**

<b>Definition</b>	Territorial local authority of domicile.
<b>Column name</b>	tla
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(3)
<b>Other names</b>	
<b>Context</b>	Geographical aggregation.
<b>Layout</b>	NNN
<b>Data domain</b>	See TLA code table in Appendix.
<b>Guide for use</b>	<p>The TLA of domicile roughly equates to local council boundaries. Populated from 1988.</p> <p>Derived from the Ministry of Health mapping of Domicile code to TLA. No code table exists.</p> <p>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.</p>
<b>Verification rules</b>	
<b>Collection methods</b>	
<b>Related data</b>	Domicile code
<b>Source document</b>	
<b>Source organisation</b>	

## Total ICU Hours

<b>Definition</b>	Total duration of stay (hours) in an Intensive Care Unit (ICU) during this episode of care.
<b>Column name</b>	total_icu_hours
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	number(5)
<b>Other names</b>	
<b>Context</b>	Total hours for the health event.
<b>Layout</b>	NNNNN
<b>Data domain</b>	00001-99999 or NULL
<b>Guide for use</b>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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'.</p>
<b>Verification rules</b>	Optional. If reported, must be positive
<b>Collection methods</b>	
<b>Related data</b>	
<b>Source document</b>	
<b>Source organisation</b>	

## Total NIV hours

<b>Definition</b>	The total number of hours on noninvasive ventilation during an episode of care.
<b>Column name</b>	total_niv_hours
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	number(5)
<b>Other names</b>	
<b>Context</b>	
<b>Layout</b>	
<b>Data domain</b>	00001-99999 or NULL
<b>Guide for use</b>	<p>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.</p> <p>Types/modes of noninvasive ventilatory support are:</p> <ul style="list-style-type: none"> <li>Bi-level positive airway pressure [BiPAP]</li> <li>Continuous positive airway pressure [CPAP]</li> <li>Intermittent mask [CPAP]</li> <li>Intermittent positive pressure breathing [IPPB]</li> <li>Intermittent positive pressure ventilation [IPPV]</li> <li>Noninvasive mask ventilation [NIMV]</li> <li>Noninvasive pressure ventilation [NIPV]</li> </ul> <p>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.</p> <p>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.</p> <p>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.</p> <p>Subsequent periods of NIV when used for treatment (not weaning) should be added together.</p> <p><b>CLINICAL CODING AND REPORTING GUIDELINES</b></p> <p>When coding in ICD-10-AM 6th 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).</p> <p>Hours on noninvasive ventilation (NIV) should be interpreted as completed cumulative hours.</p> <p>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.</p> <p>If more than one period of NIV occurs during the same episode of care</p>

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.

**Collection methods****Related data**

Total hours on mechanical ventilation

**Source document****Source organisation**

## ***Transaction id***

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

## **Weight on admission**

<b>Definition</b>	The weight in grams at time of admission for infants less than 29 days old.
<b>Column name</b>	weight_on_admission
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	integer
<b>Other names</b>	HCU weight on admission, Admission weight
<b>Context</b>	Used in DRG calculations.
<b>Layout</b>	NNNN
<b>Data domain</b>	0001 - 9999 grams
<b>Guide for use</b>	<p>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.</p> <p>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.</p> <p>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.</p> <p>The Ministry of Health started collecting this information on 1 July 1995.</p> <p>With the introduction of ICD-10-AM 2nd Edition, this field should be reported for all infants:</p> <ul style="list-style-type: none"> <li>- aged less than 29 days, or</li> <li>- aged between 29 and 365 days (inclusive) who weigh less than 2500 g.</li> </ul> <p>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.</p> <p>If not known, the default is '9000'.</p>
<b>Verification rules</b>	<p>Mandatory if age at admission is less than 29 days.</p> <p>Optional for all babies between 29 and 365 days old (inclusive) who weigh less than 2500 g.</p>
<b>Collection methods</b>	
<b>Related data</b>	<p>Birthweight</p> <p>DRG code (used as key input for the AR-DRG grouper, so many of these rules are derived from the grouper logic)</p>
<b>Source document</b>	
<b>Source organisation</b>	



## **Year of data**

<b>Definition</b>	Field identifying which calendar year data belongs to.
<b>Column name</b>	year_of_data
<b>Table name</b>	fact_nmd_health_event
<b>Data type</b>	varchar2(4)
<b>Other names</b>	Calendar year
<b>Context</b>	
<b>Layout</b>	CCYY
<b>Data domain</b>	Range from 1960, XXXX.
<b>Guide for use</b>	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 is 1923.
<b>Verification rules</b>	Derived from year of discharge where present. If Event end datetime is missing then set to 'XXXX'.
<b>Collection methods</b>	
<b>Related data</b>	Event end datetime
<b>Source document</b>	
<b>Source organisation</b>	

***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**

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## ***Psychiatric leave description***

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

## ***Psychiatric leave end type***

<b><i>Definition</i></b>	A code describing how a period of leave ended for a committed mental health patient.
<b><i>Column name</i></b>	psychiatric_leave_end_type
<b><i>Table name</i></b>	dim_psych_lv_end_type
<b><i>Data type</i></b>	char(1)
<b><i>Other names</i></b>	
<b><i>Context</i></b>	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.
<b><i>Layout</i></b>	A
<b><i>Data domain</i></b>	D Discharged E Died R Returned to the same psychiatric institution T Transferred to another psychiatric institution
<b><i>Guide for use</i></b>	Not reliably reported since 1993.  Healthcare users can be on leave for up to 2 years under the Act.
<b><i>Verification rules</i></b>	Optional. Must only be present if Event end type is 'DL'.
<b><i>Collection methods</i></b>	
<b><i>Related data</i></b>	Psychiatric leave end date
<b><i>Source document</i></b>	
<b><i>Source organisation</i></b>	

## 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.

<b><i>Logical (Business) Table Name</i></b>	<b><i>Physical Table Name</i></b>
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_rq_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.

<b><i>Dimension Table</i></b>	<b><i>Description</i></b>
<b><i>Affiliation table</i></b> <b><i>(dim_affiliation)</i></b>	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.
<b><i>Clinical Code table</i></b> <b><i>(dim_clinical_code)</i></b>	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
<b><i>Country table</i></b> <b><i>(dim_country)</i></b>	This table holds a list of all countries. Used to provide details of the health care user's country of birth.
<b><i>Diagnosis Type table</i></b> <b><i>(dim_diagnosis_type)</i></b>	This dimension table hold the details of the diagnosis type and the associated diagnosis type description.
<b><i>DRG table</i></b> <b><i>(dim_drg)</i></b>	Dimension table of Diagnostic Related Groups (DRG).
<b><i>Event End Type table</i></b> <b><i>(dim_event_end_type)</i></b>	This table holds values that describe the end type to the HCU event.
<b><i>Event Type table</i></b> <b><i>(dim_event_type)</i></b>	This table holds values that describe the event type for the HCU event.
<b><i>Geo table</i></b> <b><i>(dim_geo)</i></b>	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.
<b><i>Health Care User table</i></b> <b><i>(dim_health_care_user)</i></b>	This reference table contains information about all people who have received healthcare directly from healthcare providers.
<b><i>Health Specialty table</i></b> <b><i>(dim_health_specialty)</i></b>	A classification describing the specialty or service to which a healthcare user has been assigned, which reflects the nature of the services being provided.
<b><i>Legal Status table</i></b> <b><i>(dim_legal_status)</i></b>	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,
<b><i>Occupation table</i></b> <b><i>(dim_occupation)</i></b>	This dimension table holds values for the occupation of the health care user.
<b><i>Purchase Unit table</i></b> <b><i>(dim_purchase_unit)</i></b>	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.
<b><i>Purchaser Code table</i></b> <b><i>(dim_purchaser_code)</i></b>	This table holds values that defines the organisation or body that purchased the healthcare service provided.
<b><i>dim_submitted_coding_system</i></b> <b><i>(dim_submitted_coding_system)</i></b>	

## Appendix C: List of Views

The table views used in this datamart are shown below.

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

***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

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<b>Introduction</b>	This appendix explains how data element attributes are organised in the data dictionary template.
<b>Order of elements</b>	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.
<b>Template</b>	This table explains the template.
<b>Administrative status</b>	The operational status (eg, CURRENT, SUPERSEDED) of the data element. No SUPERSEDED data elements will be included in the Dictionaries.
<b>Reference ID</b>	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.
<b>Version number</b>	<p>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:</p> <ul style="list-style-type: none"> <li>– name</li> <li>– definition</li> <li>– data domain, eg, adding a new value to the field.</li> </ul> <p>Elements with frequently updated code tables, such as the Facility code table, will not be assigned a new version for changes to data domain.</p>
<b>Version date</b>	The date the new version number was assigned.
<b>Identifying and defining attributes</b>	
<b>Name</b>	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.
<b>Data element type</b>	<p>DATA ELEMENT—a unit of data for which the definition, identification, representation and permissible values are specified by means of a set of attributes.</p> <p>DERIVED DATA ELEMENT—a data element whose values are derived by calculation from the values of other data elements.</p> <p>COMPOSITE DATA ELEMENT—a data element whose values represent a grouping of the values of other data elements in a specified order.</p>
<b>Definition</b>	A statement that expresses the essential nature of a data element and its differentiation from all other data elements.
<b>Context (optional)</b>	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.
<b>Relational and representational attributes</b>	
<b>Data type</b>	The type of field in which a data element is held. For example, character, integer, or numeric.
<b>Field size</b>	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	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/admission-source-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/admission-source-code-table</a>
Admission Type code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/admission-type-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/admission-type-code-table</a>
Agency code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/agency-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/agency-code-table</a>
Agency Type code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/agency-type-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/agency-type-code-table</a>
Birth/Death Location code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/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</a>
Clinical code table	See <i>Clinical code</i> on page 39
Clinical Code Table Type code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/clinical-code-type">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/clinical-code-type</a>
Clinical Coding System code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/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</a>
Country of Birth code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/country-birth-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/country-birth-code-table</a>
Domicile code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/domicile-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/domicile-code-table</a>
DRG code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/drg-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/drg-code-table</a>
DRG Grouper Type code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/drg-grouper-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/drg-grouper-code-table</a>
Ethnicity code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/ethnicity-code-tables">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/ethnicity-code-tables</a>
Event Clinical Code Type code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-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</a>
Event Type code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/event-type-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/event-type-code-table</a>
Facility code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/facility-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/facility-code-table</a>
Facility Type code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/facility-type-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/facility-type-code-table</a>
Health Specialty code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/health-specialty-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/health-specialty-code-table</a>
Legal Status code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/legal-status-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/legal-status-code-table</a>
MDC code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/mdc-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/mdc-code-table</a>

	<a href="#">table</a>
MDC Type code table	See <i>MDC type</i> on page 141
Occupation code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/occupation-code-table">http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/occupation-code-table</a>
Principal Health Service Purchaser code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/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</a>
Psychiatric Leave End code table	<a href="http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/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</a>

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**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

<b>Introduction</b>	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.
<b>Points to remember</b>	<ul style="list-style-type: none"> <li>• Ethnicity is self-identified and can change over time.</li> <li>• The Ministry of Health (MOH) can record up to three ethnic group codes for a healthcare user.</li> <li>• An algorithm is used to automatically prioritise ethnic group codes if more than one is reported.</li> <li>• 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).</li> <li>• 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.</li> </ul>
<b>About ethnicity</b>	<p>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.</p> <p>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).</p> <p>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.</p>
<b>Purpose</b>	Information about ethnicity is used extensively in planning and resourcing health services, developing and monitoring health policies, and measuring health outcomes.
<b>Collection of data</b>	<p>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.</p> <p><b>Important:</b> 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.</p>

Which ethnic group do you belong to?  
 Mark the space or spaces that apply to you.

New Zealand European

Māori

Samoan

Cook Island Māori

Tongan

Niuean

Chinese

Indian

other (such as DUTCH, JAPANESE, TOKELAUAN). Please state:

**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). Prioritisation 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.

<b>Ethnic code</b>	<b>Ethnic code description</b>	<b>Priority</b>
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	MOH Ethnicity code	Country of Ethnicity Affiliation
37	Admiralty Islander	12	Channel Islander
44	Afghani	52	Chilean
53	African American	42	Chinese nec
53	African nec	42	Chinese nfd
53	African nfd	52	Colombian
12	Afrikaner	32	Cook Island Maori nfd
32	Aitutaki Islander	12	Cornish
12	Albanian	12	Corsican
51	Algerian	52	Costa Rican
12	American (US)	52	Creole (Latin America)
51	Arab	53	Creole (US)
52	Argentinian	12	Croat/Croatian
12	Armenian	12	Cypriot nfd
44	Asian nec	12	Czech
40	Asian nfd	12	Dalmatian
51	Assyrian	12	Danish
32	Atiu Islander	12	Dutch/Netherlands
37	Austral Islander	37	Easter Islander
12	Australian	52	Ecuadorian
37	Australian Aboriginal	51	Egyptian
12	Austrian	12	English
37	Banaban	53	Eritrean
44	Bangladeshi	12	Estonian
37	Belau/Palau Islander	53	Ethiopian
12	Belgian	44	Eurasian
12	Belorussian	10	European nfd
43	Bengali	12	Falkland Islander/Kelper
37	Bismark Archipelagoan	36	Fijian (except Fiji Indian/ Indo-Fijian)
52	Bolivian	43	Fijian Indian/Indo-Fijian
12	Bosnian	41	Filipino
37	Bougainvillean	12	Finnish
52	Brazilian	12	Flemish
12	British nec	12	French
12	British nfd	12	Gaelic
12	Bulgarian	12	Gambier Islander
12	Burgher	37	Gambier Islander
41	Burmese	12	German
12	Byelorussian	53	Ghanian
41	Cambodian	12	Greek (incl Greek Cypriot)
42	Cambodian Chinese	12	Greenlander
12	Canadian	37	Guadalcanalian
37	Caroline Islander	37	Guam Islander/Chamorro
12	Celtic nfd	52	Guatemalan
61	Central American Indian	43	Gujarati
37	Chamorro	52	Guyanese

MOH Ethnicity code	Country of Ethnicity Affiliation
37	Hawaiian
52	Honduran
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

MOH Ethnicity code	Country of Ethnicity Affiliation
32	Mitiaro Islander
51	Moroccan
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

MOH Ethnicity code	Country of Ethnicity Affiliation
12	Sardinian
12	Scottish (Scots)
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

MOH Ethnicity code	Country of Ethnicity Affiliation
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 and 6.0 no historical data is available, so no average values are stored.

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

**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 on or after 1 July 2005, DRG codes are calculated and stored in clinical version 5.0.  
 Note: The 4.1, 4.2, 5.0 and 6.0 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	<p>The diagnosis and procedure information are mapped to different ICD codes, so that codes are held in:</p> <ul style="list-style-type: none"> <li>• ICD-9-CM-A, and</li> <li>• ICD-10-AM 1st Edition, and</li> <li>• ICD-10-AM 2nd Edition, and</li> <li>• ICD-10-AM 3rd Edition, and</li> <li>• ICD-10-AM 6th Edition</li> </ul> <p><b>Note:</b></p> <ol style="list-style-type: none"> <li>1. The diagnosis_procedure_tab.submitted_system_id indicates which version of the ICD the clinical code was reported in.</li> <li>2. For the 2004-2005 financial year, NMDS will continue to apply ICD-10-AM 2<sup>nd</sup> Edition code to the Grouper</li> <li>3. For the 2005 to 2010 financial years, NMDS will apply ICD-10-AM 3<sup>rd</sup> Edition codes to the Grouper.</li> <li>4. For the 2011 financial yeas, NMDS will apply ICD-10-AM 6<sup>th</sup> Edition codes to the Grouper.</li> </ol>
2	<p>The DRG Grouper Program version 6.0 processes information about an event for each grouper clinical version, including:</p> <ul style="list-style-type: none"> <li>• personal information (eg, Sex, Date of birth), and</li> <li>• event information (eg, Admission date, Event end type), and</li> <li>• diagnosis and procedure information in the appropriate ICD code for the DRG Grouper.</li> </ul>

<p>3</p>	<p>For each clinical version of the Grouper (3.1, 4.1, 4.2, 5.0 and 6.0), the DRG Grouper Program version 6.0 calculates (for that event):</p> <ul style="list-style-type: none"> <li>• a DRG code (of the DRG grouper type)</li> <li>• an MDC code (of an MDC type that is the same as the DRG grouper type)</li> <li>• CCL or PCCL (as appropriate for that clinical version of the Grouper)</li> </ul>
<p>4</p>	<p>NMDS processing calculates the Cost weight (using the WIES methodology) and Purchase unit from:</p> <ul style="list-style-type: none"> <li>• the DRG and associated variables</li> <li>• Length of stay</li> <li>• Total hours on mechanical ventilation</li> <li>• some diagnosis and procedure codes</li> <li>• Health specialty code</li> </ul> <p>For details, see <a href="http://www.health.govt.nz/nz-health-statistics/data-references/weighted-inlier-equivalent-separations">http://www.health.govt.nz/nz-health-statistics/data-references/weighted-inlier-equivalent-separations</a></p>

## 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

## 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)

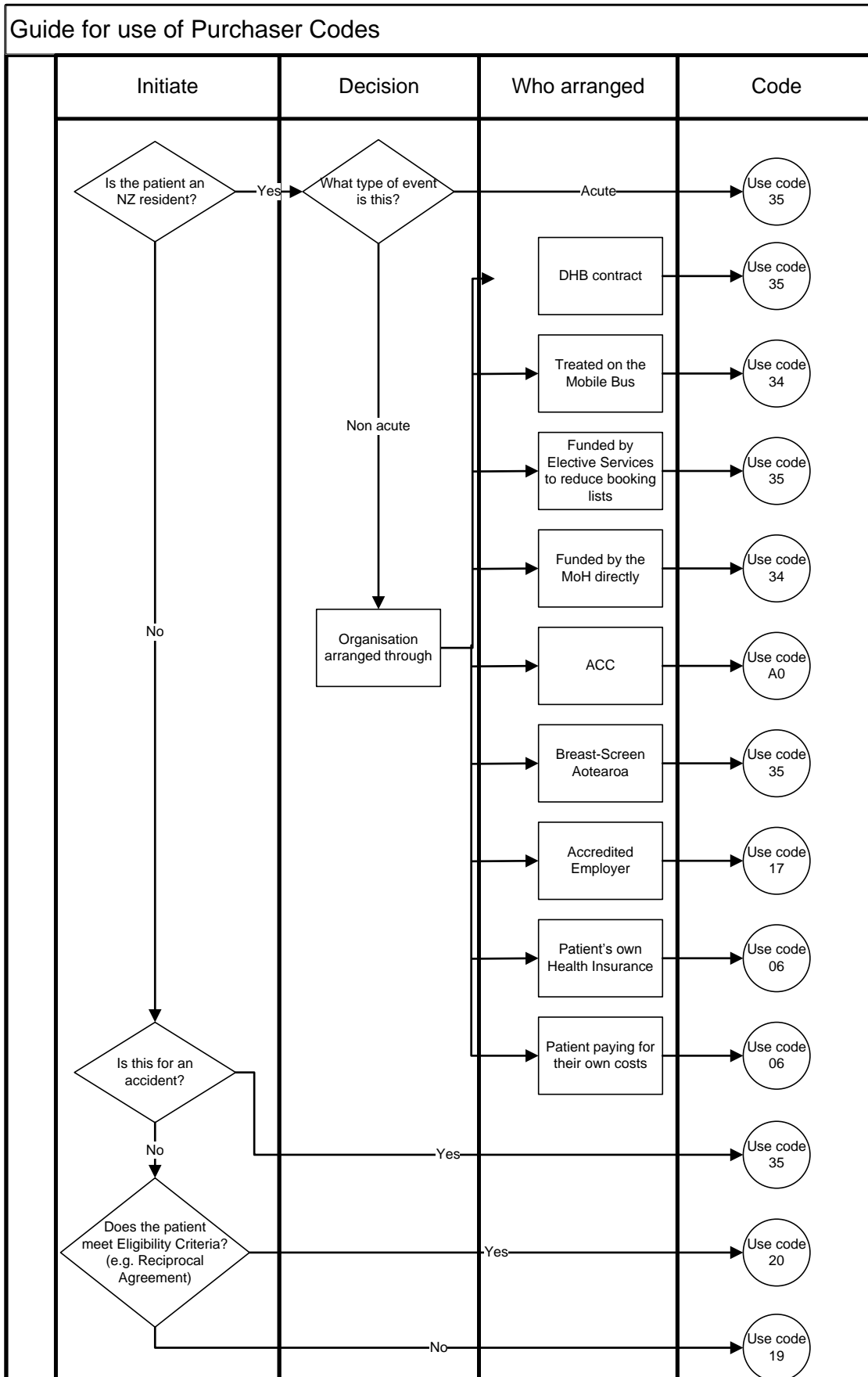
A day case (Event type either ID or IP and Length of stay 0 days) may occur within an IP or IM event for the same master\_hcu\_id where the Length of stay is not zero.

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.

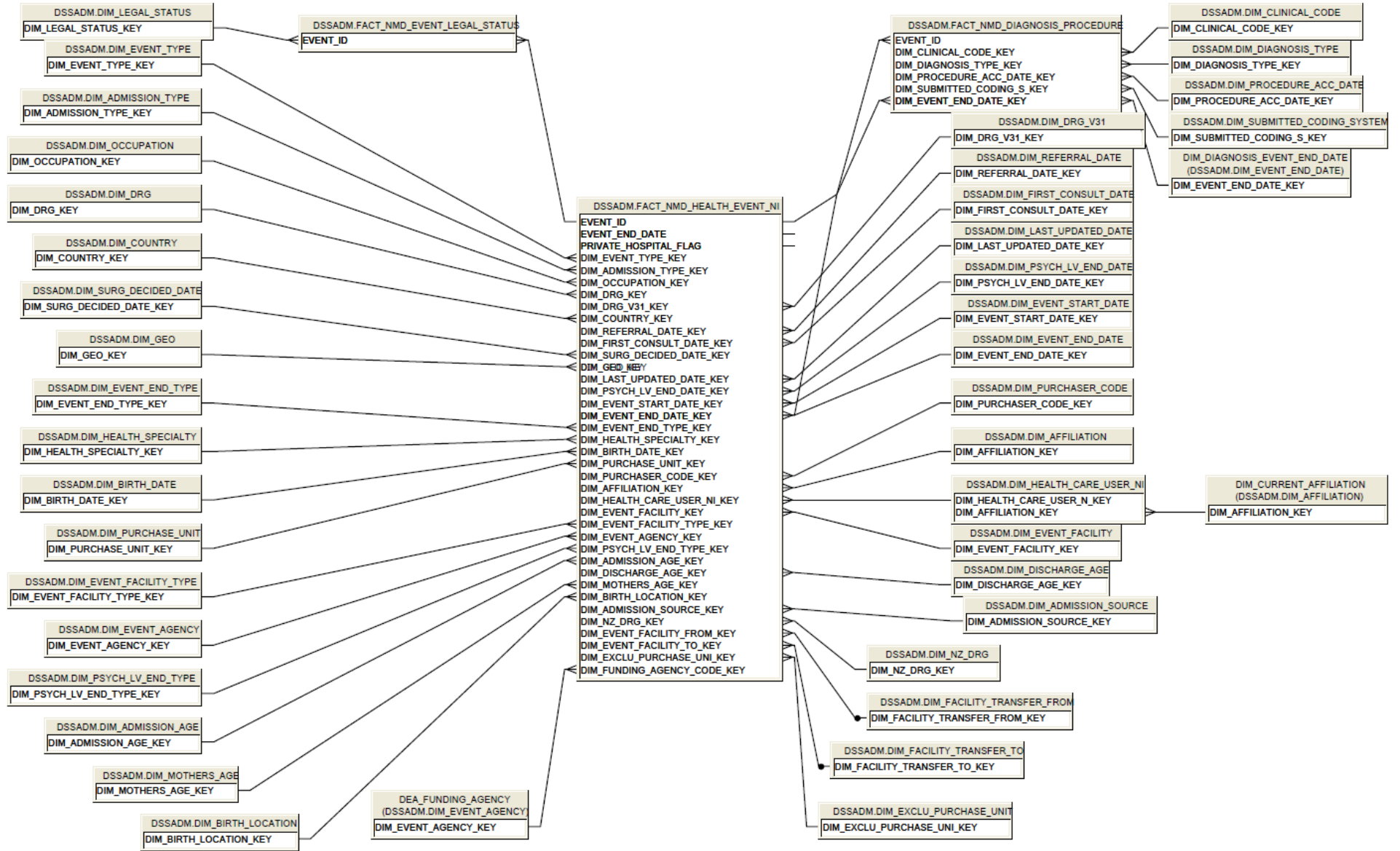
If Length of stay is greater than zero for both events and the Length of stay for both events for the same master\_hcu\_id is the same then reject.

## Appendix K: Guide for Use of NMDS Purchaser Code



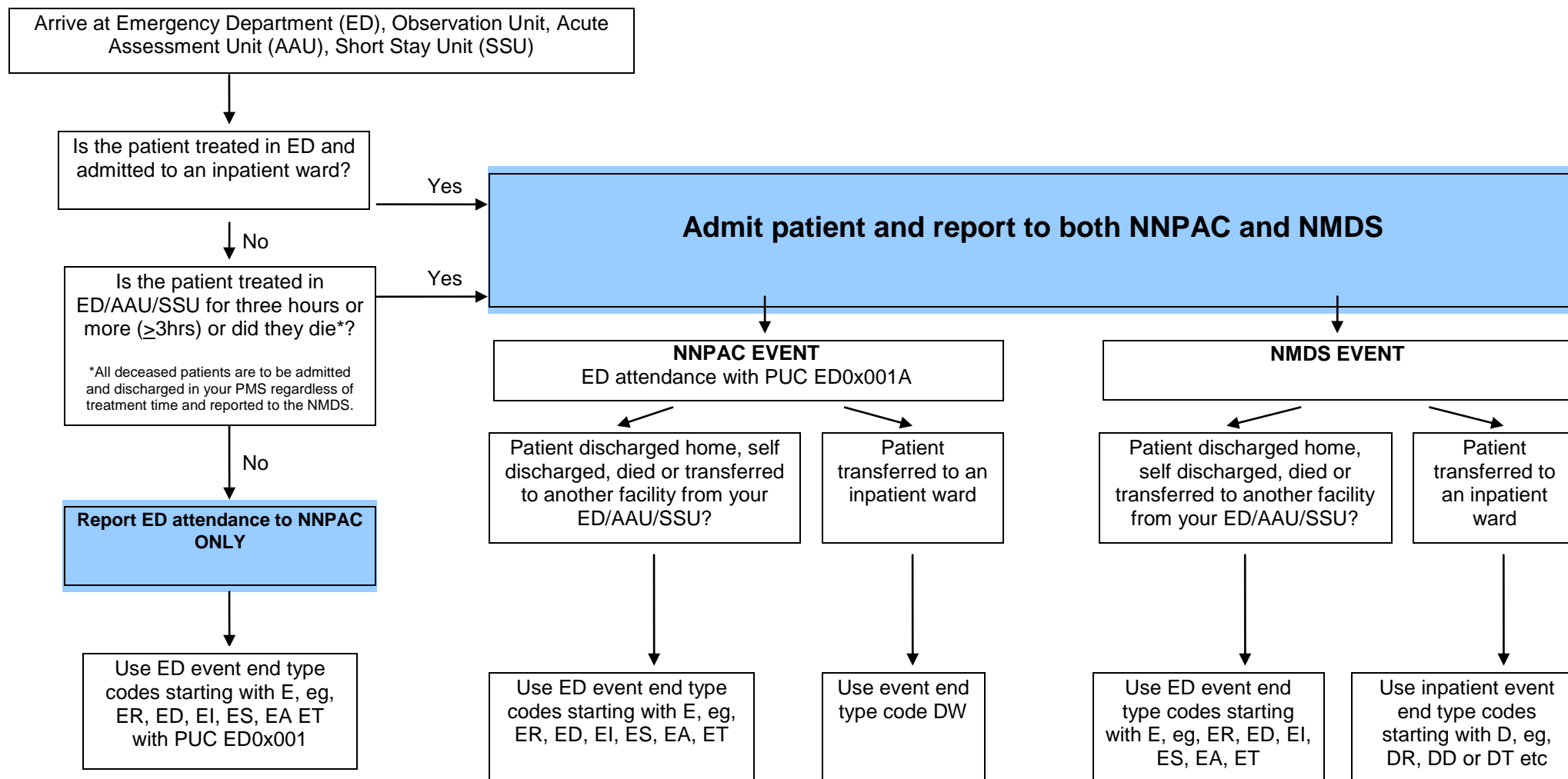


## Appendix L: NMD Data Mart Data Model



## 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



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

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.

**Emergency Department (ED) Attendance**

**Emergency Department Short Stay (ED)  
Acute Assessment Unit (AAU)  
Short Stay Unit (SSU)**

**Hospital Inpatient Ward**

***NNPAC reporting***

***NMDS reporting***

***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.  
Triage 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

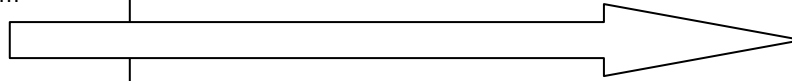
Patient presents to ED reception 01/03/2011 at 10.32am.  
Triage at 10.56am returned to waiting room  
Patient was not willing to wait, therefore left at 12.32pm without  
being seen and did not want to sign indemnity

ED attendance reported to NNPAC  
Purchase unit (ED00002)  
Event end type = ES

Patient presents to ED reception 01/03/2011 at 22.53pm  
Triage 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



**Emergency Department (ED) Attendance**

**Emergency Department Short Stay (ED) Acute Assessment Unit (AAU) Short Stay Unit (SSU)**

**Hospital Inpatient Ward**

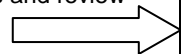
***NNPAC reporting***

***NMDS reporting***

***NMDS reporting***

Patient presents to ED reception 01/03/2011 at 13.53pm  
 Triage 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

ED attendance reported to NNPAC for counting purposes only  
 Purchase unit (ED0x001A)  
 Event end type = ER



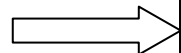
Patient meets 3 hour admission rule – admit patient as an ED short stay event  
 Event start datetime will be 01/03/2011 14.48pm

ED 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  
 Triage 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

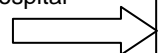
ED attendance reported to NNPAC for counting purposes only  
 Purchase unit (ED0x001A)  
 Event end type = DW



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 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

\***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 ( $\geq 3$ ) 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**.

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

### Event End Type Codes - Mapping to Separation Mode

### 3M™ Codefinder™ Separation Mode Codes and Descriptions

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