National Minimum Dataset (Hospital Inpatient Events)

DATA MART - DATA DICTIONARY

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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)

Purpose

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

Content

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

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

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

Start date

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

Guide for use

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

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

Contact information

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

- Ph: (04) 922 1800, fax 04 922 1897,
- or e-mail inquiries@moh.govt.nz, or
- visit the MoH web site www.moh.govt.nz.

Collection methods

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

Frequency of updates

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

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

Security of data

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

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

Privacy issues

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

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

National reports and publications

MoH publishes an annual report Selected Morbidity Data for Publicly Funded Hospitals in hard copy and on the MoH web site www.moh.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 MoH 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 MoH Analytical Services team also offers a peer review service to ensure that MoH data is reported appropriately when published by other organisations.

There may be charges associated with data extracts.

NMD Admission Source table

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

Admission source code

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

Admission source description

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

NMD Admission Type table

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

Admission type

Definition	A code used to describe the type of admission for a hospital healthcare health event.
Column name	admission_type
Table name	dim_admission_type
Data type	varchar2(2)
Other names	Admission type
Context	Hospital inpatient or day patient health event. Used in the NMDS.
Layout	AA
Data domain	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' = Waiting list/booking 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)
Guide for use	From 30 June 2004 Admission Types ZA, ZC, ZP and ZW were retired and ACC cases should be identified by use of the Accident Flag. As from July 01 2004, use of the retired codes will generate an error message.
Verification rules	The Event End Date must be on or prior to the Admission Type End date (if populated). Must be a valid code in the Admission Type code table.
Collection methods	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 with an Event End Date before 1 July 2008 will always be P10 Delivery Services (Mothers). For records with an Event End Date 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.

Related data

Source document

Source organisation

Admission type description

Definition	Description of the admssion type for the health care user event e.g. AA = Arranged Admission, WN = Admitted from waiting list - Normal,
Column name	admission_type_description
Table name	dim_admission_type
Data type	varchar2(70)
Other names	
Context	
Layout	
Data domain	Free text short description field
Guide for use	See Admission Type code in this table for further information. See Admission Type code table: http://www.nzhis.govt.nz/moh.nsf/pagesns/47
Verification rules	
Collection methods	
Related data	Admission Type code
Source document	
Source organisation	

Admission type end date

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

Admission type start date

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

NMD Fact Diagnosis Procedure table

Table name	fact_nmd_diagnosis_procedure
Definition	Details relating to diagnoses and procedures associated with a health event.
Primary key	
Business key	event_id
Guide for use	Contains clinical information about the reason for admission to hospital, procedures carried out while in hospital, and incidental or concurrent diseases that was a factor in the treatment. Also contains information about accidents that caused health events or occurred during a health event, including adverse reactions. Diagnoses and procedures are held in multiple versions of The International Classification of Diseases. All events: - are stored in ICD-9-CM-A - with an Event end date on or after 1 July 1999 are stored in ICD-9-CM-A and ICD-10-AM 1st Edition - with an Event end date on or after 1 July 2001 are stored in ICD-9-CM-A, ICD-10-AM 1st and 2nd Edition - with an Event end date on or after 1 July 2004 are stored in ICD-9-CM-A, ICD-10-AM 1st, 2nd and 3rd Edition - with an Event end date on or after 1 July 2008 are stored in ICD-9-CM-A, ICD-10-AM 1st, 2nd, 3rd and 6th Edition See Clinical code type for more information. The selection of codes is based on the Australian Coding Standards (ACS), as distributed by the National Centre for Classification in Health. The principal diagnosis (refer to ACS 0001 p10) is defined as the diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or attendance at the healthcare establishment, as represented by a code. 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 p13) is defined as a condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a healthcare establishment, as represented by a code. For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following: - commencement, alteration or adjustment of therapeutic treatment - diagnostic procedures - increased nursing care and/or monitoring. Coding procedures carried out in A&E before admission: If the patient is admitted, the time spent and the treatment carried out in

A&E is included. Procedures carried out in A&E before admissions are coded on the relevant inpatient event record. All hours on mechanical ventilation in A&E are coded, whether the patient is intubated in A&E or in the ambulance. If ventilation is commenced in the ambulance, it is counted only from the time of hospitalisation.

The structure of this table has been significantly changed from 1 July 2004.
- Prior to this change, the structure held each submitted diagnosis record received from a provider in the same row in the table as any records mapped to other clinical coding classifications. This necessitated the existence of sets of columns specifically for the ICD9, ICD10v1 and ICD10v2 clinical code classifications and the ongoing need to add additional sets of columns each time a new clinical coding classification is to be implemented.
- From 1July 2004, only one level of clinical code classification will be held per row in the table. Each new 'submitted' record will be loaded into a new row in the table, then a new row will be created for each record produced by mapping to another clinical coding classification version. These groups of rows are linked by common event id and diagnosis sequence values. The original submitted record is identified by the submitted system id value.
- Note: The new database structure still allows up to 99 diagnoses and procedures to be stored. Former file and database structures allowed fewer codes, so old records do not contain as many.

Relational rules

KEY:	LINKED TO:
Dim clinical code key	dim_clinical_code
Dim diagnosis type key	dim_diagnosis_type
Dim event end date key	dim_event_end_date(dim_global_time)
Dim event start date key	dim_event_start_date(dim_global_time)
Dim procedure ACC date key	dim_procedure_acc_date
Dim submitted coding s key	dim_submitted_coding_system
Event ID	fact_nmd_health_event

Data content

All events reported after 1 July 1995 contain the code and ICD version supplied by the provider.

Batch id

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

Clinical code

Definition	A code used to classify the clinical description of a condition.
Column name	clinical_code
Table name	fact_nmd_diagnosis_procedure
Data type	varchar2(8)
Other names	Diagnosis/procedure code
Context	Clinical information within a health event. Includes codes for diagnosis, injury, cause of intentional and unintentional injury, and procedure performed.
Layout	See Collection method.
Data domain	Must be a valid code in one of the following systems: - ICD-9-CM-A 2nd Edition - Australian Version of The International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition - ICD-10-AM 1st Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition - ICD-10-AM 2nd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition - ICD-10-AM 3rd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition - ICD-10-AM 6th Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 6th Edition - DSM-IV - Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. All events reported after 1 July 1995 contain the code and ICD version supplied by the provider.
Guide for use	Depending on the context, this is also known as Diagnosis/procedure code (external cause). From 1 July 1995, this field contains the Clinical code as supplied by the provider. ICD-9-CM (TO 30 JUNE 1995) In ICD-9-CM all codes have at least 3 digits and most have 4 or 5. Standard practice was to use a filler 4th digit of '9' for codes with only 3 digits and for codes which have a 5th digit but no 4th digit. ICD-9-CM-A (1 JULY 1995 ONWARDS) In 1995 codes were mapped to ICD-9-CM-A, and the place of occurrence, which had been separate, was mapped onto the 5th digit of the E code. Also, codes that only had 3 digits no longer required a filler digit: the fields for 4th and 5th digits could be left blank. ICD-9-CM-A codes which had a 5th digit but no 4th digit could have a filler 4th digit of '0' (zero) entered. E codes were mandatory for codes between 800 and 999. The location field and code E849 were not used. Instead, the digit to indicate place of occurrence of external cause of injury was recorded as the 5th digit for the following ranges of 4 digit 'E' codes: E810-E829, E846-E848, E850-E869, E880-E928, E950-E958, E960-E968, E980-E988.

ICD-10-AM 1ST EDITION (1 JULY 1999 ONWARDS)
In ICD-10-AM, codes V01 to Y98 were used to classify environmental events and circumstances as the external cause of injury, poisoning and other adverse effects. (It was intended that the nature of the condition would be indicated separately using the appropriate code, usually codes between S00 and T98.)

1. Place of Occurrence Code
The following 4th-character subdivisions of the external cause code were used with categories W00 to Y34 (except Y06 and Y07) to identify where the external cause occurred:
0 = home
1 = residential institution
2 = school, other institution, and public administrative area
3 = sports and athletics area
4 = street and highway
5 = trade and service area
6 = industrial and construction area
7 = farm
8 = other specified places
9 = unspecified place

2. Activity Code
The following 5th-character subdivision of the external cause code was used with categories V01 to Y34 to indicate the activity of the injured person at the time the event occurred. (This subclassification was used in addition to the 4th-character subdivisions indicating place of occurrence of events classifiable to W00-Y34.)
0 = while engaged in sports activity
1 = while engaged in leisure activity
2 = while working for income
3 = while engaged in other types of work
4 = while resting, sleeping, eating or engaging in other vital activities
8 = while engaged in other specified activities
9 = during unspecified activity

3. Example of the external cause code, place of occurrence and activity code:
Diagnosis type allocated by provider system - Description - ICD-10-AM code
A - # L shaft tibia and fibula, closed - S82.21
B - Laceration L elbow - S51.0
B - Contusion scalp - S00.05
O - Closed reduction of # tibia and fibula - 47564-00
E - Tripped over hose while gardening at home - W01.03*

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

Notes:
1. From July 1999 both ICD-9-CM-A and ICD-10-AM 1st Edition are recorded. From July 2001, ICD-10-AM 2nd Edition is recorded. From July 2004, ICD-10-AM 3rd Edition is recorded. From July 2008, ICD-10-AM 6th Edition is also recorded, ie, the clinical code is stored in all versions.
2. Clinical codes are reported without decimal points or hyphens. The formats above are how the codes appear in the coding manual.

Verification rules

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

Demographic and administrative data (eg, Sex, Date of birth, Event end type) is checked to ensure it is consistent with the Clinical code, as specified by the editing flags held against each Clinical code on the Clinical Code table.

Collection methods

From ICD-10-AM 1st Edition onwards, procedures are NNNNNNN, and diagnoses and injuries are ANNNN. In ICD-9-CM-A, procedures are NNNN, and all diagnoses except supplementary conditions are NNNNN.

Since 1 July 2004, the current ICD version is ICD-10-AM 3rd Edition.

Up to 99 diagnosis/procedure codes may be provided. No decimal points or extra characters should be included in the Clinical codes, for example, the ICD-10-AM 2nd Edition code 30496-02 should be sent as 3049602.

EXTERNAL CAUSES OF MORBIDITY
An external cause code is mandatory with codes from S00 to T98, as well as for Z03.6 and Z04.1-Z04.5.

Place of occurrence and activity have unique codes rather than using 4th and 5th character extensions as was done with ICD-10-AM 1st Edition:
- Y92 (Place of occurrence) codes should be assigned in addition to all external codes in the range V01-Y89.
- Y93 (Activity) codes should be assigned in addition to all external cause codes in the range V01-Y34.
Note: Accident date is optional for Y92 and Y93 codes.

The Event supplementary information field can be used to record additional information about the accident location.

Related data

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

Source document

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

For ICD-10-AM, refer to ICD-10-AM, the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, Ist Edition (4 volumes), 2nd Edition (4 volumes) or 3rd Edition (5 volumes).

Source organisation

National Centre for Classification in Health, University of Sydney, Australia

Clinical code system

Definition	A code identifying the clinical coding system used for diagnoses and procedures.
Column name	clinical_code_system
Table name	fact_nmd_diagnosis_procedure
Data type	varchar2(2)
Other names	
Context	Clinical information.
Layout	NN
Data domain	01 ICD-9 02 ICD-9-CM 03 Read 04 ICPC 05 Old AMR codes 06 ICD-9-CM-A 07 DSM IV (for MHINC only) 10 ICD-10-AM 1st Edition 11 ICD-10-AM 2nd Edition 12 ICD-10-AM 3rd Edition 13 ICD-10-AM 6th Edition
Guide for use	Previously known as Diagnosis coding system code. Code '03' (Read) is used for primary care and not reported in the NMDS. Code '02' (ICD-9-CM) was used between 1988 and 1995. When code '06' (ICD-9-CM-A) was introduced, the database was mapped to this new code. From July 1999 data was submitted in either ICD-9-CM-A or ICD-10-AM 1st Edition, and mapped so that it was held in both systems. Data for code '02' no longer exists in the database. Between 1 July 2001 and 30 June 2004, data was submitted in '11' (ICD-10-AM 2nd Edition) and mapped to ICD-9-CM-A and '10' (ICD-10-AM 1st Edition). All records in '10' continue to be mapped back to earlier classification versions where mappings exist. Between 1 July 2004 and 30 June 2008, data was submitted in '12' (ICD-10-AM 3rd Edition) and mapped to '06' (ICD-9-CM-A), '10' (ICD-10-AM 1st Edition) and '11' (ICD-10-AM 2nd Edition). From 1 July 2008 data is submitted in '13' (ICD-10-AM 6th Edition) and mapped to '12' (ICD-10-AM 3rd Edition). Mappings from '12' to '11', '10' or earlier classifications continue to be performed where mappings exist.
Verification rules	Must be a valid code in the Clinical Coding System code table. Must form part of a valid combination of Clinical code, Clinical code type, and Clinical coding system ID.
Collection methods	From 1 July 2008 data should be submitted using ICD-10-AM 6th Edition, that is, the Clinical coding system ID should be '13'.
Related data	Diagnosis type Clinical code type Clinical code

Source document	Encoding software
Source organisation	Ministry of Health

Clinical code type

Definition	A code denoting which section of the clinical code table the clinical code falls within.
Column name	clinical_code_type
Table name	fact_nmd_diagnosis_procedure
Data type	char(1)
Other names	
Context	Clinical information.
Layout	A
Data domain	'A' = Diagnosis 'B' = Injury 'D' = DSM-IV 'E' = External cause of injury 'M' = Morphology (pathology) 'O' = Operation/procedure 'V' = Supplementary classification/health factors
Guide for use	Previously known as Clinical code table type. This field is required to differentiate between different sections of the clinical code table. In ICD-9-CM-A code values could be repeated in different sections of the table. For example, '0101' is a diagnosis code as well as a procedure code. Note: M- Morphology (pathology) is historical and originally used for cancer diagnosis which has since been replaced with the introduction of the Cancer Registry data mart.
Verification rules	Must be a valid code in the Clinical Code Type code table. Must form part of a valid combination of Clinical code, Clinical code type, and Clinical coding system ID.
Collection methods	
Related data	Clinical coding system ID Diagnosis type Clinical code
Source document	
Source organisation	

Diagnosis description

Definition

Agencies are required 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.

From July 1 2008, the standard descriptions sent to the Ministry of Health by hospitals may be up to 100 characters long. Prior to 1 July 2008, descriptions were 50 characters long. 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.

Column name

diagnosis_description

Table name

fact_nmd_diagnosis_procedure

Data type

varchar2(100)

Other names

Event diagnosis/procedure description

Context

Clinical information.

Layout

Free text

Data domain

Guide for use

Depending on the context, this is also known as Diagnosis description (external cause), Accident description, Operation description, and Morphology description.

It is mandatory 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.

Verification rules

Collection methods

Agencies are required 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.

From July 1 2008, the standard descriptions sent to NZHIS by hospitals may be up to 100 characters long. Prior to 1 July 2008, descriptions were 50 characters long. 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.

Related data

Diagnosis type
Clinical code

Source document

Source organisation

Diagnosis number

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

Diagnosis sequence

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

Diagnosis type

Definition	A code that groups clinical codes, or indicates the priority of a diagnosis.
Column name	diagnosis_type
Table name	fact_nmd_diagnosis_procedure
Data type	char(1)
Other names	Diagnosis type code
Context	Clinical information within a health event.
Layout	
Data domain	A Principal diagnosis B Other relevant diagnosis E External cause of injury M Pathological nature of growth O Operation/procedure P Mental health provisional diagnosis (MHINC only)
Guide for use	Only codes 'A', 'B', 'E', 'M', 'O' and 'P' are found in the NMDS database.
Verification rules	Must be a valid code in the Diagnosis Type code table. There must be one and only one type 'A' for each event. Validation rules are held in the Event to Diagnosis Type table. Cardinality and optionality have been added. See Appendix E: Enhanced Event Type/Event Diagnosis Type Table.
Collection methods	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 p10) is defined as the diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or attendance at the healthcare establishment, as represented by a code. 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 p13) is defined as a condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a healthcare establishment, as represented by a code. For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following: - commencement, alteration or adjustment of therapeutic treatment

- diagnostic procedures
- increased clinical care and/or monitoring.

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

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	

Event end date

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

Event id

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

Event start date

Definition

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

Private hospital flag

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

Procedure acc date

Definition	The date when the accident/injury occurred.
Column name	procedure_acc_date
Table name	fact_nmd_diagnosis_procedure
Data type	date
Other names	Accident date, Injury date
Context	Events resulting from an accident.
Layout	CCYYMMDD
Data domain	Valid dates Partial dates are permissible. 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. Incomplete dates are stored as 'ccyy0101' or 'ccyymm01' and a partial date flag associated with the date is set to the appropriate value.
Guide for use	External cause date of occurrence and Operation/procedure date are sent in separately but both stored in the same field. If the diagnosis type is 'E' (ie, external cause event), the date is External cause date of occurrence.
Verification rules	Optional. Must be on or before the date of load, the Event end date, and the Psychiatric leave end date. Must be on or after the Date of birth. Only permitted if Diagnosis type is 'E'. Required for external cause of occurrence codes, but optional if Operation flag is set to 'Y'.
Collection methods	This field is optional for ICD-10-AM 2nd Edition place of occurrence codes (Y92.x) and activity codes (Y93.x). This field is optional for ICD-10-AM 3rd Edition (an onwards) place of occurrence codes (Y92.xx) and activity codes (U50 – U73.xx).
Related data	Diagnosis type Accident date flag
Source document	
Source organisation	

Procedure acc date flag

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

Submitted system id

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

Transaction id

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

NMD Fact Event Legal Status table

Table name	fact_nmd_event_legal_status
Definition	The legal status of a healthcare user 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,
Primary key	
Business key	event_id, legal_status_code
Guide for use	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 NZHIS. Admission information for mental health inpatients is required to be supplied with legal status and provisional diagnoses. It is a requirement to update leave/discharge data, legal status and principal diagnosis as they are obtained. Those facilities with electronic transfer should update legal status changes immediately they occur. This table only contains legal statuses pertaining to inpatient and day patient events. For more complete legal status histories, see the Mental Health Information National Collection.
Relational rules	
Data content	

Batch id

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

Event id

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

Legal status code

Definition	Code describing a healthcare user's legal status under the appropriate section of 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.
Column name	legal_status_code
Table name	fact_nmd_event_legal_status
Data type	varchar2(2)
Other names	
Context	Used for mental health healthcare users in respect of the current period of institutional care. Defines a healthcare user's standing in terms of the Mental Health (Compulsory Assessment & Treatment) Act 1992, for example, compulsory treatment.
Layout	AA (or A and a space)
Data domain	See the Legal Status code table on the NZHIS web site at http://www.nzhis.govt.nz/moh.nsf/pagesns/47. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.
Guide for use	Used only in the context of mental health admissions.
Verification rules	At least one required for psychiatric inpatient events. Code must be present in the Legal Status code table. The provided Legal Status Date must be on/after the start date, or on/before the end date in the Legal Status code table, for the code provided.
Collection methods	From 1 July 1999 legal status can be reported with ID and IP events as well as IM event types. More than one legal status can be entered for a health event, but the Legal status code and the Legal status date must form a unique combination for that health event. Legal status can be reported outside of the period of an event. If this is done, all Legal status codes for the event will be taken into account when determining the DRG code. Any non-voluntary Legal status code changes the DRG version 4.1, 4.2 or 5.0 code. A Legal status code is required for each Legal status date provided.
Related data	DRG code Legal status date
Source document	
Source organisation	

Legal status date

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

Private hospital flag

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

Transaction id

Definition

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

NMD Fact Health Event table

Table name fact_nmd_health_event

Definition The Fact NMD Health Event table contains non-diagnostic information about a patient's stay in hospital, such as demographic, administrative, and some summarised/grouped clinical and contracting information. It contains data for inpatient and day patient he

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

Data content

ACC claim number

Definition	This is a separate field to record the M46/45, ACC45 or AITC claim number for the event.
Column name	acc_claim_number
Table name	fact_nmd_health_event
Data type	varchar2(12)
Other names	
Context	Injury resulting from an accident.
Layout	Free text
Data domain	
Guide for use	
Verification rules	Optional. If the first character of the Principal health service purchaser code is 'A' (eg, 'A0', 'A1', etc) then the Accident flag should be set to 'Y'. If the Accident flag is set to 'Y' (for any Principal health service purchaser code), then the ACC Claim Number field should not be blank. 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.
Collection methods	This is a free-text field to allow historical claim numbers, which come in a variety of formats, to be provided. This field is used to report the Accident Insurance Treatment Certificate (AITC) form number. If the Principal health service purchaser code is any of the codes that start with 'A', then the Accident flag must be set to 'Y'. If the Accident flag is set to Y then the ACC claim number field must be populated. If the ACC claim number field is populated and the injury date is between the admission and discharge dates then the accident flag field can be N or Y. 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.
Related data	Accident flag Principal health service purchaser
Source document	
Source organisation	Accident Compensation Corporation

Accident flag

Definition	A flag that denotes whether a person is receiving care or treatment as the result of an accident.
Column name	accident_flag
Table name	fact_nmd_health_event
Data type	char(1)
Other names	ACC flag
Context	Injury resulting from an accident.
Layout	A
Data domain	Y The health event/treatment is assumed to be or is assessed as the result of an accident N The health event/treatment is the result of an illness. U Unknown.
Guide for use	
Verification rules	Optional. If the first character of the Principal health service purchaser code is 'A' (eg, 'A0', 'A1', etc) then the Accident flag should be set to 'Y'. If the Accident flag is set to 'Y' (for any Principal health service purchaser code), then the ACC Claim Number field should not be blank. If the injury date is between the admission and discharge dates (ie the accident happened while the patient was in hospital) then the ACC flag can be N and the ACC45 field populated.
Collection methods	For this 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 ACC Claim Number would be required). The accident flag can be set to N and an ACC45 number reported if a patient has an accident in hospital. In this case the injury date must be between the admission and discharge dates.
Related data	ACC claim number Clinical code (classifies the injuries and cause of accident)
Source document	
Source organisation	National Data Policy Group

Admission source code

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

Admission type

Definition	A code used to describe the type of admission for a hospital healthcare health event.
Column name	admission_type
Table name	fact_nmd_health_event
Data type	varchar2(2)
Other names	Admission type
Context	
Layout	AA
Data domain	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' = Waiting list/booking 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)
Guide for use	'WU' (Waiting list - urgent) code not used from 20 August 1993. From July 2004, Admission types 'ZA', 'ZC', ZP' and 'ZW' were retired, and ACC cases should be indentified by the use of the Accident Flag.
Verification rules	Code must be present in the Admission Type code table. The event end date must be on or prior to the Admission type end date (if populated). As from 1 July 2004, using a retired code will generate an error message.
Collection methods	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 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 with an Event End Date before 1 July 2008 will always be P10 Delivery Services (Mothers). For records with an Event End Date 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.

Related data Accident Flag,

Source document

Source organisation National Data Policy Group

Age at admission

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

Age at discharge

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

Age of mother

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

Agency code

Definition	A code that uniquely identifies an agency. An agency is an organisation, institution or group of institutions that contracts directly with the principal health service purchaser to deliver healthcare services to the community.
Column name	agency_code
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	Health agency code, DHB
Context	
Layout	XXXX
Data domain	See the Agency code table on the NZHIS web site at http://www.nzhis.govt.nz/moh.nsf/pagesns/47. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.
Guide for use	Historically, also known as CHE (Crown Health Enterprise), HHS (Hospitals and Health Services) and AHB (Area Health Board). Between 1988 and 1993 the Agency code was assigned based on the original 1993 agency groupings. If the facility on an event does not belong to the agency, it means that the agency has contracted a facility belonging to a different agency to treat the patient. Unit record information with Facility codes will not be provided to members of the public without the permission of the agency involved. See the Data Access Policy on the NZHIS web site at http://www.nzhis.govt.nz/access/index.html.
Verification rules	Must be a valid code in the Agency code table.
Collection methods	This is a key field for allocating purchase units. If agencies merge, a new code may be assigned or the new agency can negotiate with NZHIS to maintain the existing codes. NZHIS allocates codes on request. The code table is continually updated by NZHIS as hospitals open and close. See the NZHIS web site for the most recent version.
Related data	
Source document	
Source organisation	NZHIS

Batch id

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

Birth status

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

Birth weight

Definition	Weight of infant at time of birth, in grams.
Column name	birth_weight
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	Birth weight
Context	Birth event.
Layout	NNNN
Data domain	0001 - 9999
Guide for use	
Verification rules	Mandatory for birth events. Must not be supplied for other event types. 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. Must contain 4 characters. For infants under 1000 grams, the field must be supplied with a leading zero. No negative numbers.
Collection methods	Record as soon as practicable after the birth event. If not known, the default is '9000'. For birth events, Weight on admission will be identical to the Birthweight.
Related data	Weight on admission
Source document	
Source organisation	NZHIS

CCL

Definition	CCL - Complication/co-morbidity class level. This comes out of the DRG grouper program and identifies the clinical severity within a DRG code.
Column name	ccl
Table name	fact_nmd_health_event
Data type	char(1)
Other names	
Context	DRG version 3.1
Layout	N
Data domain	1 minor CC or non-CC 2 moderate CC 3 major CC 4 extreme CC
Guide for use	Relates only to DRG Grouper versions 3.0 and 3.1. Serves the same purpose for DRG Grouper clinical versions 3.0 and 3.1 as PCCL does for DRG Grouper clinical versions 4.1, 4.2 and 5.0. The AR-DRG v4.1 Definitions Manual says CCLs 'are severity weights given to ALL additional diagnoses. They range in value from 0 to 4 for surgical and neonate episodes, and from 0 to 3 for medical episodes, and have been developed through a combination of medical judgement and statistical analysis. CCL values can vary between adjacent DRGs.'
Verification rules	
Collection methods	
Related data	DRG code version 3.1 PCCL
Source document	See the AN-DRG manual
Source organisation	The logic for the DRG software is specified by the Health Services Division of the Commonwealth Department of Health and Ageing, Australia

Client system identifier

Definition	A unique Identifier for each source system will be defined by the DHB and notified to NZHIS. 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.
Column name	client_system_identifier
Table name	fact_nmd_health_event
Data type	varchar2(14)
Other names	
Context	
Layout	
Data domain	
Guide for use	
	This field is used as a reference field for checking data quality.
Verification rules	
Collection methods	
Related data	Related to PMS unique identifier.
Source document	
Source organisation	

Cost weight

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

Cost weight code

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

Country code

Definition	Coded value for the country of birth as assigned from the Statistics NZ Country Code list (NZSCC86).
Column name	country_code
Table name	fact_nmd_health_event
Data type	varchar2(3)
Other names	
Context	Primarily used for epidemiological studies.
Layout	NNN
Data domain	004 - 999. See the Country of Birth code table on the NZHIS web site at http://www.nzhis.govt.nz/moh.nsf/pagesns/47
Guide for use	Mandatory for cancer patients until 1 July 2001. With the introduction of the Cancer Registry Act, pathologists were given responsibility to ensure that all specified primary cancer cases are reported, and the pathology report became the principal source of information identifying new cases of primary cancer. Because pathology reports do not contain all the information required to complete cancer registrations, Section 6 of the legislation also authorises the Cancer Registry to seek additional information from medical practitioners or hospitals. Information not available from laboratories is: Occupation code, Country of birth code, and Extent of cancer disease code.
Verification rules	Optional.
Collection methods	
Related data	
Source document	
Source organisation	Statistics NZ

Date of birth

Definition	The date on which the person was born.
Column name	date_of_birth
Table name	fact_nmd_health_event
Data type	date
Other names	DOB, HCU date of birth, Birth date
Context	Required to derive age for demographic analyses.
Layout	
Data domain	Valid dates Partial dates are permissible. 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. Incomplete dates are stored as 'ccyy0101' or 'ccyymm01' and a partial date flag associated with the date is set to the appropriate value.
Guide for use	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).
Verification rules	Must be on or before the Event start date. Must be consistent with diagnoses and procedure codes for the record to be loaded. Otherwise it will result in a warning.
Collection methods	
Related data	DRG codes Event start date Event end date Operation/procedure date Age at admission Age at discharge Date of birth flag
Source document	
Source organisation	National Data Policy Group

Date of birth flag

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

Date psychiatric leave ends

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

Date surgery decided

Definition	The date on which the healthcare user was assessed as requiring surgery.
Column name	date_surgery_decided
Table name	fact_nmd_health_event
Data type	date
Other names	
Context	Elective surgical events.
Layout	
Data domain	Valid dates
Guide for use	Previously known as Date on waiting list. Not reliably reported to the NMDS. From July 2000, this information is also collected in the Date certainty given field in the National Booking Reporting System (NBRS), which has more complete coverage.
Verification rules	Optional. Must be on or before the date of load, the Event start date, and the Event end date. Must be on or after the Date of birth. Partial dates not allowed.
Collection methods	Required for total hip replacement, total knee replacement and coronary artery bypass graft events.
Related data	Surgical priority
Source document	
Source organisation	

Domicile code

Definition Statistics NZ Health Domicile Code representing a person's usual residential address. Also used for facility addresses.

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'.)

If a person usually lives in a rest home or a hospital, that is considered their usual residential address.

Column name domicile_code

Table name fact_nmd_health_event

Data type varchar2(4)

Other names

Context Required for demographic analyses. Domicile codes are key variables for determining the characteristics of the population that are using the health sector.

Layout

Data domain See the Domicile code table on the NZHIS web site at http://www.nzhis.govt.nz/moh.nsf/pagesns/47. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.

Guide for use Before July 1993, domicile was coded using the 1986 census Domicile codes. This data has been mapped to the 1991 codes.

Care needs to be exercised when analysing pre-1993 data in terms of population, as the 1991 census split a large number of the 1986 codes into two or more new Domicile codes. As it was not possible to accurately attribute particular events to the correct new code, only one of the new multiple codes could be chosen for each old code. This can result in some areas showing no events for one code and an over-representation of events for the other domicile.

Since 1996, Domicile code has been automatically assigned on the NHI database using the address provided. This can result in rural addresses being assigned to an urban Domicile code where there is insufficient data to generate the correct code. This is because the automated software relies on generating a post code in order to determine where in a related table it should look to find the code. Most events in the NMDS contain a Domicile code that has been generated in this manner.

The 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 1991 code was used from 1988 to 30 June 1998. (1986 codes were converted to 1991 codes on migration into NMDS in 1993.)
- The 1996 code was used from 1 July 1998 to 30 June 2003.
- The 2001 code was used from 1 July 2003 to 30 June 2008.
- The 2006 code has been in use since 1 July 2008.

The series of Domicile codes used depends on the Event end date. If an event does not have an end date, the Event start date is used.

Verification rules Must be a valid code in the Domicile code table.

If the Event end date (or, if the Event end date is blank, the Event start

	date) is less than 1 July 1998 and Year of census is 1996 then convert the new domicile back to old 1991 code. For Event end dates on or after 1 July 1998 the 1996 codes apply. For Event end dates on or after 30 June 2003, the 2001 codes apply. (If the Event end date is blank, check the Event start date and that the status of the code is current. If not current, generate an error message.)
Collection methods	The code table contains current and retired codes (see status column: C = current and R = retired). Some of the codes from the 1991 census were replaced by new codes in the 1996 census, and these should not be used for events with an Event end date after 30 June 1998. The 1991 and 1996 Domicile codes made redundant by the 2001 census should not be used for events with an Event end date after 30 June 2003. New general codes have been added for DHBs from 1 July 2001. General DHB codes should be a last resort, used only if the correct Domicile code cannot be determined. Care should be taken to record accurate and useful residential addresses, since Domicile codes may be automatically assigned using this information.
Related data	TLA of domicile
Source document	
Source organisation	Statistics NZ

Drg code current

Definition	A diagnosis-related group (DRG) code of clinical version 4.1, 4.2 or 5.0 produced by invoking the current DRG grouper program version 5.0 which takes up to 30 diagnoses and 30 procedure codes in a health event and assigns a DRG code based on a complex algorithm. The version 4 groupers used 20 codes. This provides another way of analysing event information based on classifying episodes of inpatient care into clinically meaningful groups with similar resource consumption.
Column name	drg_code_current
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	
Context	Clinical demographic and administrative information within a health event.
Layout	XXXX
Data domain	901Z - 963Z, A01Z - Z65Z
Guide for use	Introduced on 1 July 2001 for DRG clinical version 4.1. If the Event end date is between 1 July 2001 and 30 June 2002, this field contains a DRG code of clinical version 4.1. If the Event end date is between 1 July 2002 and 30 June 2004, this field contains a DRG code of clinical version 4.2. If the Event end date is on or after 1 July 2005, this field contains a DRG code of clinical version 5.0. Calculated from: - personal information (eg, Sex, Date of birth), and - event information (eg, Admission date, Event end type), and - diagnosis and procedure information in the appropriate ICD code for the DRG Grouper (ICD-10-AM 3rd Edition). - Between 1 July 2004 and 30 June 2005, most hospitals supplied diagnosis and procedure information using ICD-10-AM 3rd Edition codes. As AR-DRG version 5.2 requires ICD-10-AM 2nd Edition codes, NZHIS will map the 3rd edition codes supplied by hospitals to 2nd edition codes and use these to assign an AR-DRG 4.2 code. - Between 1 July 2004 and 30 June 2008, most hospitals supplied diagnosis and procedure information using ICD-10-AM 3rd Edition codes. AR-DRG version 5.0 required no additional mapping. - 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
Verification rules	
Collection methods	The current DRG grouper is AR-DRG version 5.0, which uses up to 30 ICD diagnoses and up to 30 procedures. 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. The DRG code is calculated by NZHIS. It is not sent in to the NMDS by hospitals.
Related data	Costweight code Costweight

Purchase unit
PCCL
MDC code
MDC type
DRG grouper type code

Source document

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

Drg code v30

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

Drg code v31

Definition	Diagnosis-related group code produced by clinical version 3.1 of AN-DRG Grouper.
Column name	drg_code_v31
Table name	fact_nmd_health_event
Data type	varchar2(3)
Other names	
Context	Clinical demographic and administrative information within a health event.
Layout	
Data domain	001 - 956
Guide for use	A diagnosis-related group (DRG) produced by invoking a DRG program that compares all diagnostic codes in a health event and assigns a DRG code based on a complex series of decision trees. This classifies the episodes of inpatient care into clinically meaningful groups with similar resource consumption. Until 1 July 2001 the clinical version of AN-DRG 3.1 was produced by running 3M version 3.1 AN-DRG Grouper Program over ICD-9-CM-A version II diagnosis and procedure codes. Since July 2001, 3M AR-DRG version 4.2 of the Grouper Program has been used to generate clinical version 3.1 codes in this field. The current version (4.2) uses up to 20 diagnoses and 20 procedure codes. The previous version (3.1) used up to 15 diagnoses and 15 procedures. Before 1 July 1995 for DRG v3.1 data providers mostly reported only 4 diagnosis and 3 procedure codes, so that was all that was available for DRG assignment. DRG codes of clinical version 3.1 are stored for all events, as this field is often used for analysis.
Verification rules	
Collection methods	The current DRG grouper is AR-DRG version 4.2, which also produces codes in versions 3.1 and 4.1 or 4.2 as appropriate. The grouper accepts up to 20 diagnoses and 20 procedure codes for clinical version 3.1. External cause codes are not used by the grouper. Hospitals can report up to 99 diagnosis and procedure codes for each event, therefore it is recommended that hospitals prioritise diagnoses and procedure codes in order to present the grouper with the most severe diagnoses and operations.
Related data	CCL Costweight code Costweight Purchase unit MDC code MDC type DRG grouper type code
Source document	
Source organisation	The DRG code version 3.1 is currently calculated by NZHIS using the AR-DRG Grouper Program version 4.2. It is not sent in to the NMDS by hospitals.

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. NZHIS 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

Definition	The NHI number in encrypted form.
Column name	encrypted_hcu_id
Table name	fact_nmd_health_event
Data type	varchar2(11)
Other names	Encrypted HCU identifier, Encrypted NHI, etc. See other names for the NHI number under 'Guide for use' below.
Context	The NHI number is the cornerstone of NZHIS'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.
Layout	
Data domain	System-generated
Guide for use	THE NHI NUMBER 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. When duplicate records for a healthcare user are merged, one of their NHI numbers will be deemed to be the master (or primary), and the others become event (or secondary) NHI numbers. This does not affect which NHI numbers are used in local systems. In the NMDS, the NHI number that is sent in by the data provider is encrypted during the loading process. Only this encrypted NHI number is stored. For the analysis of healthcare information relating to a unique individual, the master NHI number should be used. Please contact an NZHIS information analyst for further information on how to obtain the master encrypted NHI number if you are performing your own data extraction. The Privacy Commissioner considers the NHI number to be personally identifying information (like name and address) so, if it is linked to clinical information, it must be held securely and the healthcare user's privacy protected. The Encrypted NHI number is not considered personally identifying. NZHIS will return data containing unencrypted NHI numbers to providers who have sent it in. Information with unencrypted NHI numbers may be disclosed to researchers on a case-by-case basis. VALIDATION The first three characters of an NHI number must be alpha (but not 'I' or 'O'). The 4th to 6th characters must be numeric. The 7th character is a check digit modulus 11. 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. The NHI number, Event type code, Event start date, Facility code, and Event local identifier form a unique key for checking for duplicates on insert, or checking for existence on delete. See Appendix F: Duplicate and overlapping event checking rules.
Collection methods	NHI numbers are often included on patient notes and other patient documentation. New numbers can be allocated by health providers who have direct access to the NHI Register. New NHI numbers are also allocated by HealthPAC for GPs and other primary care providers.
Related data	
Source document	http://www.nzhis.govt.nz/moh.nsf/indexns/nhi
Source organisation	NZHIS

Ethnic code

Definition

A social group whose members have one or more of the following four characteristics:
- they share a sense of common origins
- they claim a common and distinctive history and destiny
- they possess one or more dimensions of collective cultural individuality
- they feel a sense of unique collective solidarity.

Column name

ethnic_code, ethnic_code_2, ethnic_code_3

Table name

fact_nmd_health_event

Data type

varchar2(2)

Other names

Ethnicity

Context

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.

Layout

NN

Data domain

10	European not further defined
11	New Zealand European
12	Other European
21	Maori
30	Pacific Peoples not further defined
31	Samoan
32	Cook Island Maori
33	Tongan
34	Niuean
35	Tokelauan
36	Fijian
37	Other Pacific Peoples
40	Asian not further defined
41	Southeast Asian
42	Chinese
43	Indian
44	Other Asian
51	Middle Eastern
52	Latin American/Hispanic
53	African (or cultural group of African origin)
54	Other (retired 01/07/2009)
61	Other ethnicity
94	Don t know
95	Refused to answer
97	Response unidentifiable
99	Not stated

Guide for use

See Appendix: Guide for use of Ethnic Codes.

From 1 July 1996 up to 3 Ethnic group codes can be collected for each healthcare user and each event. Where more than 3 Ethnic group codes are reported, the Statistics NZ prioritisation algorithm is used to report only 3 values.

Because ethnicity is self-identified, it can change over time. This is why NZHIS collects ethnicity information for each health event, rather than relying on the data in the National Health Index (which does not include historical data).

Verification rules

Ethnicity 1 is mandatory.

Ethnicity 2 and Ethnicity 3 are optional.

	Ethnicity 2 cannot be the same as Ethnicity 1 or 3. Ethnicity 3 cannot be the same as Ethnicity 2 or 1. Must be a valid code in the Ethnic code table.
Collection methods	Ethnicity should be self-identified wherever possible. If the Ethnic group code changes for this event, please update the NHI. Code '54' (Other) is retired from 01 July 2009 and should not be used after this date. Use of the code '61' (Other Ethnicity) is limited to a very small number of 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 using an appropriate residual response. See Appendix C: Collection of Ethnicity Data. Must be a valid code in the Ethnic code table. Each ethnic group as maintained by Statistics NZ has a 5-digit code at level 4. MoH collections use ethnicity coded at level 2. Each ethnic group as maintained by Statistics NZ has a 5-digit code. NZHIS collections use only the first 2 digits.
Related data	Prioritised ethnicity
Source document	Smith, Anthony. 1981. The Ethnic Revival. Cambridge University Press.
Source organisation	Statistics NZ, modified by the National Data Policy Group

Event end date

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

Event end type

Definition A code identifying how a healthcare event ended.

Column name event_end_type

Table name fact_nmd_health_event

Data type varchar2(2)

Other names Discharge type

Context

Layout

Data domain

DA: Discharge to an acute facility
DC: Psychiatric patient discharged to community care
DD: Died
DF: Statistical discharge for change in funder
DI: Self-discharge from hospital, indemnity signed
DL: Committed psychiatric patient discharged to leave for more than 10 days
DN: Psychiatric remand patient discharged without committal
DO: Discharge of a patient for organ donation
DP: Psychiatric patient transferred for further psychiatric care
DR: Ended routinely
DS: Self-discharge from hospital (no indemnity)
DT: Discharge of non-psychiatric patient to another healthcare facility
DW: Discharge to other service within same facility between the following types of specialty: AT&R, mental health, obstetric, and personal health. Not to be used for transfer between surgical and medical.
EA: Discharge from Emergency department acute facility to specialist facility for neonates and burns only
ED: Died while still in Emergency department acute facility
EI: Self discharge from treatment in an Emergency department acute facility with indemnity signed
ER: Routine discharge from an Emergency department acute facility
ES: Self discharge from treatment in an Emergency department acute facility without indemnity
ET: Discharge from Emergency department acute facility to another healthcare facility

Guide for use

'RO' was superseded on 1 July 1994.
'DA' and 'DW' were introduced in 1995.
'DO' was introduced in 1997.
'DF' was introduced in 2000.
EA, ED, EI, ER, ES and ET were introduced in 1 July 2007

See Appendix N for the allocation Guide for Use of NMDS Emergency Department (ED) Event End Type Codes, Emergency Department scenarios and Event End Type Code mappings for 3M CodefinderTM.

Verification rules

Must be a valid code in the Event End Type code table.
Optional for psychiatric inpatient events.
Mandatory for all other event types.

Collection methods

NOTES RE 'DA'
'DA' is only used in cases where the patient is being transferred within 5 days of admission, and:
- the patient being transferred has a principal diagnosis of stroke, or
- the discharge is directly due to the need for immediate treatment at a neonatal facility, a specialist burns unit, or a multiple trauma unit.

The code 'DA' is required for accurate classification to DRG for the following types of case:

1. An infant aged less than or equal to 28 days is required to be discharged directly to a specialist neonatal unit for acute care which is not available at the discharging facility.
For example, a newborn infant with a condition that cannot be treated adequately at the healthcare facility where the birth took place is transferred to the specialist neonatal unit at another healthcare facility for acute care. The discharge of the infant from the hospital of birth would be recorded as 'DA'.

2. A patient of any age required to be discharged directly to a specialist burns unit for acute care which is not available at the discharging facility.
For example, a person suffering burns in an accident is taken to the nearest healthcare facility for immediate treatment and assessment and then transferred to a specialist burns unit for acute care. The discharge of the patient from the hospital where immediate treatment and assessment took place would be recorded as 'DA'.

NOTES RE 'DW'
Discharge type 'DW' is available to be used for any internal transfers between any specialties except Surgical (S) and Medical (M) and vice versa. If the transfer is to another facility (using a different Facility code) then the discharge type 'DT' must be used.

Some examples showing the use of 'DW' are given below (this is not an exclusive list):

1. Assessment, Treatment and Rehabilitation Unit Services
Inpatient Assessment, Treatment and Rehabilitation (AT&R) care should be able to be identified separately. That is, all AT&R inpatient episodes of care should result in a discharge for which the Health Specialty Code is Geriatric AT&R (D00+D10) or Psychogeriatric AT&R (D20+D30), for the period in which the healthcare user was under the care of the inpatient AT&R service.

Healthcare users can arrive at an AT&R Unit by a number of means. Three examples follow:

a. The healthcare user is admitted to a healthcare facility with a medical (eg, acute stroke) or surgical (eg, fractured hip with reduction) problem. If a clinical decision is made to move the healthcare user to an AT&R unit within the same healthcare facility, then there must be a discharge from the Medical or Surgical Specialty with an Event end type of 'DW' and an admission to the AT&R unit.

b. The healthcare user is a Disability Support Service (DSS) resident. If the healthcare user develops a problem which requires AT&R unit services in the same healthcare facility, they should be discharged from the DSS Specialty with an Event end type of 'DW' and admitted to the AT&R unit.

c. The healthcare user, once admitted to an AT&R Specialty, develops the need for a significant medical or surgical intervention. When this need is above and beyond what would be expected to be delivered in an AT&R Specialty, the healthcare user should be discharged from the AT&R Specialty with an Event end type of 'DW' and admitted to the appropriate medical/surgical specialty. They may later be discharged (DW) and readmitted to AT&R for post-treatment care.

This example would result in three separate inpatient events (and three DRGs) during one continuing episode of inpatient care.

2. Health Agency DSS Long-term Resident Inpatient Services
Personal Health inpatient services provided to DSS long-term inpatients should be identified separately. That is, Personal Health episodes of

care should result in a discharge using a Personal Health specialty code and Event end type 'DW', for the period in which the healthcare user was under the care of the Personal Health inpatient specialty. This applies to Personal Health inpatient services for people under the care of specialists within Geriatric and Psychogeriatric Long-term Care, Rest Home, IH, Physical Disability and Long-term Psychiatric.

When the responsibility for the care of eligible people who are long-term DSS 'residents' in a facility is to be reassigned to a Personal Health specialty within the same facility, they should be discharged from the DSS specialty and admitted to the relevant Personal Health Specialty. In most cases there will be a physical transfer of the person, but this is not the determining factor. Instead, the issue is the change in responsible clinician during the period in which the Personal Health treatment is undertaken.

At the time the responsibility for the person's care reverts back to the DSS specialty, the person should be discharged from the Personal Health specialty with an Event end type of 'DW' and admitted again to the DSS specialty. Refer to the ACC booklet 'Accident Services - Who Pays' available from http://www.acc.co.nz/for-providers/resources/.

NOTE RE 'DT'
Event end type 'DT' now includes discharge to another healthcare facility for care (except for discharges to a specialist neonatal unit or specialist burns unit; see 'DA'). Transfers to rest homes for convalescence or rehabilitation are included, provided that the rest home is not the usual place of residence.

NOTE RE 'DF'
'DF' may be used when the acute period of care for an accident case ends and the event continues but is funded by a private insurer. Refer to the ACC booklet 'Accident Services - Who Pays' for further information on these cases.

Related data event_end_date, event_end_description

Source document

Source organisation National Data Policy Group

Event extra information

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

Event id

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

Event leave days

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

Event local id

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

Event start date

Definition	The admission date on which a healthcare event began.
Column name	event_start_date
Table name	fact_nmd_health_event
Data type	date
Other names	Admission date
Context	Admitted patients.
Layout	CCYYMMDD
Data domain	Valid date
Guide for use	
Verification rules	Must be on or before the Date of load and the Event end date. Must be the same as the Date of birth for Birth Events. Partial dates not allowed. The NHI number, Event type code, Event start date, Facility code, and Event local identifier form a unique key for checking for duplicates on insert, or checking for existence on delete. See Appendix F: Duplicate and overlapping event checking rules.
Collection methods	
Related data	Date of birth Event end date Operation/procedure date Event leave days Age at admission Length of stay
Source document	
Source organisation	

Event type

Definition	Code identifying the type of health event.
Column name	event_type
Table name	fact_nmd_health_event
Data type	varchar2(2)
Other names	Event type
Context	
Layout	
Data domain	Event Type: Event Type code description BT = Birth event CM = Community CO = Cultural setting, non-Maori CS = Cultural Setting DM = Domiciliary DP = Day patient DT = Death event GP = General Practitioner event ID = Intended day case IM = Psychiatric inpatient event IP = Non-psychiatric inpatient event MC = Maori cultural setting NP = Non-psychiatric OP = Outpatient event
Guide for use	The presence of some fields depends on the Event type code. See Appendix: Enhanced Event Type/Event Diagnosis Type Table.
Verification rules	Must be a valid code in the Event Type code table. Only one birth event is allowed for each NHI number. Babies born before mother's admission to hospital or transferred from the hospital of birth are recorded as IP. The NHI number, Event type code, Event start date, Facility code, and Event local identifier form a unique key for checking for duplicates on insert, or checking for existence on delete. See Appendix F: Duplicate and overlapping event checking rules.
Collection methods	'ID' is to be used where the intention at admission is that the event will be a day-case event. '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).
Related data	
Source document	
Source organisation	

Excluded Purchase Unit

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

Facility Transfer From

Definition	For transfers, the facility that the healthcare user was transferred from.
Column name	facility_transfer_from
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	
Context	
Layout	
Data domain	See the Facility code table on the NZHIS web site at http://www.nzhis.govt.nz/moh.nsf/pagesns/47 For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.
Guide for use	Unit record information with Facility codes will not be provided to members of the public without the permission of the agency involved. See the Data Access Policy on the NZHIS web site at http://www.nzhis.govt.nz/moh.nsf/pagesns/75
Verification rules	Mandatory for Admission Source Code = 'T' (Transfers) for the events ending on or after 1 July 2008. Must be a valid code in the Facility code table.
Collection methods	
Related data	Facility Code, Admission Source Code
Source document	
Source organisation	NZHIS

Facility Transfer To

Definition	For transfers, the facility that the healthcare user was transferred to.
Column name	facility_transfer_to
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	
Context	
Layout	
Data domain	See the Facility code table on the NZHIS web site at http://www.nzhis.govt.nz/moh.nsf/pagesns/47. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.
Guide for use	Unit record information with Facility codes will not be provided to members of the public without the permission of the agency involved. See the Data Access Policy on the NZHIS web site at http://www.nzhis.govt.nz/moh.nsf/pagesns/75
Verification rules	Mandatory for Event End Type Code = 'DA', 'DP', 'DT', 'EA' or 'ET' (Transfers) for the events ending on or after 1 July 2008. Must be a valid code in the Facility code table.
Collection methods	
Related data	Facility Code, Event End Type Code
Source document	
Source organisation	NZHIS

Facility code

Definition	A code that uniquely identifies a healthcare facility. 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.
Column name	facility_code
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	Health agency facility code, Hospital, HAF code, HAFC
Context	
Layout	
Data domain	See the Facility code table on the NZHIS web site at http://www.nzhis.govt.nz/moh.nsf/pagesns/47. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.
Guide for use	See Appendix: Duplicate and Overlapping Event Checking rules.
Verification rules	Must be a valid code in the Facility code table at the event start date for the events ending on or after 01 July 09. The NHI number, Event type code, Event start date, Facility code, and Event local identifier form a unique key for checking for duplicates on insert, or checking for existence on delete.
Collection methods	NZHIS allocates codes on request. The code table is continually updated by NZHIS as hospitals open and close. See the NZHIS web site for the most recent version.
Related data	Birth location Facility type
Source document	
Source organisation	NZHIS

Facility type

Definition	A code that categorises facilities into particular types.
Column name	facility_type
Table name	fact_nmd_health_event
Data type	varchar2(2)
Other names	
Context	
Layout	NN
Data domain	01 Public hospital 02 Private hospital 03 Psychiatric hospital 04 GP practice 10 Health centre 11 Local cancer registry 12 Mental health outpatient service 13 Cervical screening programme 14 Drug and alcohol treatment facility 15 Mental health community skills enhancement facility 16 Kaupapa Maori service 17 Pacific Island service 18 Mental health community team 19 Child, adolescent and family service 20 Mental health day hospital 21 Mental health residential 1 to 5 facility 22 Mental health residential and skills enhancement facility 23 Forensic mental health treatment facility 24 Intellectual disability facility 25 Charitable trust facility 99 Other
Guide for use	Used with Principal health service purchaser in determining whether an event is publicly funded.
Verification rules	
Collection methods	
Related data	Facility code Birth location Private flag
Source document	Create using the Facility type from the Facility table
Source organisation	

Financial year

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

First consult date

Definition	The date of the first specialist consultation which led to this event (including consultation with specialist in private practice). It may be the same date as the date of referral, eg, emergency admissions.
Column name	first_consult_date
Table name	fact_nmd_health_event
Data type	date
Other names	
Context	Elective surgical events.
Layout	
Data domain	Valid dates Partial dates are permissible. 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. Incomplete dates are stored as 'ccyy0101' or 'ccyymm01' and a partial date flag associated with the date is set to the appropriate value.
Guide for use	Not reliably reported to the NMDS. From July 2000, this information is also collected in the Date of first specialist assessment field in the National Booking Reporting System (NBRS), which has more complete coverage.
Verification rules	Optional. Must be on or before the date of load, the Event start date, and the Event end date. Must be on or after the Date of birth.
Collection methods	Required for total hip replacement, total knee replacement and coronary artery bypass graft events.
Related data	First specialist consultation date flag
Source document	
Source organisation	

Gender code

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

Gestation period

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

Health specialty code

Definition	A classification describing the specialty or service to which a healthcare user has been assigned, which reflects the nature of the services being provided.
Column name	health_specialty_code
Table name	fact_nmd_health_event
Data type	varchar2(3)
Other names	HSC, Service code, Department code
Context	Healthcare user on discharge.
Layout	
Data domain	See the Health Specialty code table on the NZHIS web site at http://www.nzhis.govt.nz/moh.nsf/pagesns/47. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.
Guide for use	Generalist and specialist subspecialty medical and surgical health specialty codes were retired from 1 July 2001. On 1 July 2007 the following changes took place: M20: Endocrinology and Diabetology ..was discontinued and replaced with.. M95: Endocrinology M96: Diabetology M24: Paediatric Endocrinology and Diabetology ..was discontinued and replaced with.. M97: Specialist Paediatric Endocrinology M98: Specialist Paediatric Diabetology The need to separate diabetes out from other endocrinology events is because diabetes is the strategic area that the government has targeted and there is no other way to differentiate outpatient activity. On 1 July 2008 the following changes took place: P00 Antenatal services P10 Delivery services [mother] P11 Primary delivery services [midwife] P20 Postnatal services [mother] P30 Postnatal services [well newborn] P35 Primary postnatal services [specialist] Were retired and replaced with: P60 Maternity services – mother [no community LMC] P61 Maternity services – well newborn [no community LMC] P70 Maternity services – mother [with community LMC] P71 Maternity services – well newborn [with community LMC] 'With a Community LMC' should be defined as: At the time of the event, the woman and her baby(s) are registered with and under the care of a Lead Maternity Carer (LMC) under Section 88 Notice for primary Maternity Services (see subpart DA). Registered being as defined in the notice (clause DA2). For clarity, this should not include women or babies who have been transferred over to secondary maternity, tertiary maternity or specialist neonatal services (clause

DA8).

Note:
That this is the specialty on admission
- Community means not employed by the DHB - ie, a section 88 claim will be made for this birth or postnatal care.

For 'Section 88 Notice for Primary Maternity Services' refer to the Ministry of Health website:
http://www.moh.govt.nz/moh.nsf/indexmh/maternity-section88notice

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

Validation was introduced on 1 July 2007 to reject events with an end date outside the Health
Specialty Code's start and end date. Events with an end date before 1 Jul 2007 and having a Health
Specialty 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 date is used when validating against the Health Specialty Code's start
and end dates.

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

National Data Policy Group

Hours on cpap

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

Column name hours_on_cpap

Table name fact_nmd_health_event

Data type varchar2(5)

Other names CPAP hours

Context

Layout NNNNN

Data domain 00000 - 99999

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

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

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

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

Note:
The logical back mapping tables (from 6th edition to 3rd edition) convert the three NIV procedure codes (above) to the CPAP procedure code 9203800. Therefore, any data extract based on the CPAP procedure code 9203800 for events with an Event end date 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].

Verification rules Optional.

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

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

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

Generate warning if not present when a CPAP procedure (as defined in

Guide for use above) is present, unless:
- Total hours on mechanical ventilation is present, or
- age at Event end date is more than 364 days, or
- age is between 28 days and 364 days and Weight on admission is more than 2500 g.

Generate warning if present and Health specialty code not in the P30 and P40 ranges.

For records with an Event end date 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.

Generate error if CPAP hours submitted with the events ending on or after 1 July 2009 if file version is 013.0.

Collection methods

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.

Related data

Total hours on mechanical ventilation

Source document

Source organisation

Hours on ventilation

Definition	The total number of hours on mechanical ventilation while the patient was under the principal care of the ICU team.
Column name	hours_on_ventilation
Table name	fact_nmd_health_event
Data type	varchar2(5)
Other names	Hours on mechanical ventilation, HMV
Context	Total hours for the health event.
Layout	NNNNN
Data domain	00000 - 99999
Guide for use	Hours on mechanical ventilation has been used in determining the DRG code since 1 July 1999.
Verification rules	Optional. Generate warnings if: - not present when a Mechanical Ventilation procedure is present (i.e, ICD-10-AM 1st, 2nd, 3rd or 6th Edition Clinical Code = 1388200 or 1388201 or 1388202 (Clinical Code Type = 'O'); or ICD-9 or ICD-9-CM-A Clinical Code = 96.70 or 96.71 or 96.72 (Clinical Code Type = 'O')), and/or - greater than the calculated number of hours from Event start date to Event end date inclusive.
Collection methods	Include only ventilated hours received under the care of the ICU team. (In smaller hospitals there may not be an ICU team, in which case the definition should be applied if the emergency care specialist initiates the mechanical ventilation.) Include hours of weaning if under the care of the ICU team, regardless of the physical location in which the patient was treated. Exclude time spent being ventilated while undergoing surgery (the fact of being ventilated while undergoing surgery is not an indicator of severity), but hours where the patient is in radiology or emergency care should be included in the total mechanical ventilation hours for reporting purposes. All hours on mechanical ventilation in A&E should be coded, whether the patient is intubated in A&E or in the ambulance. If ventilation is commenced in the ambulance, it will be counted only from the time of hospitalisation. An incomplete hour is rounded up to the next hour; eg, if the time ventilated under the care of the ICU team is 98 hours 10 minutes, then the reported time will be '00099'. Time spent weaning with other types of ventilation such as continuous positive airways pressure (CPAP) or intermittent mechanical ventilation (IMV) is included if the patient is still intubated and under the care of the ICU team. Apart from weaning as described, other forms of ventilation should not be included (eg, non-intubated CPAP, IPPB, BiPAP). CLINICAL CODING Hours on continuous ventilatory support (CVS) (mechanical ventilation) should be interpreted as completed cumulative hours. 1. If more than one period of CVS (mechanical ventilation) occurs during the same hospitalisation when used for treatment (not weaning) should be added together. For example, if a patient is on CVS for the first day of their admission, then on CVS again on the fourth day of their admission, the CVS hours should be added together to arrive at the

correct CVS code.

2. ICD coding includes all time spent ventilated from time of arrival (or time of intubation), whether or not the patient is under the care of the ICU team.

3. For ICD coding the minimum number of completed hours is 1 (see ACS 1006 point f page 178). The minimum number for the field 'Total hours on mechanical ventilation' is 1.

4. Partially completed hours are not counted when allocating a procedure code, ie, they are rounded down for ICD procedure coding but rounded up for calculating this field.

WORKED EXAMPLE
Calculation of the 'Total hours on mechanical ventilation' field and procedure code:
A patient is admitted to ICU at 1200 h, and at 1300 h is intubated and started on CVS. On day two, the patient is transferred to theatre for a tracheostomy and other procedures. Total time in theatre is 4.8 hours. The patient returns to ICU and remains ventilated via tracheostomy until CVS ceases at 1200 h on day three.

Total ventilation hours: (Day 1) 11 + (Day 2) 24 + (Day 3) 12 = (Total) 47 hours

CODING:
13882-01 [569] Management of continuous ventilatory support, > 24 and < 96 hours
41881-00 [536] Open tracheostomy, temporary
Total mechanical ventilation hours reported: 47 h minus 4.8 h in theatre = 42.2 h = 43 hours (rounded up).

Related data Total hours on continuous positive airway pressure

Source document See the AR-DRG manual

Source organisation

Length of stay

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

Location code

Definition

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

MDC code

Definition The Major Diagnostic Category (MDC) is a category generally based on a medical classification that is associated with a particular medical speciality. MDCs are assigned by the DRG grouper program.

Column name mdc_code

Table name fact_nmd_health_event

Data type varchar2(2)

Other names

Context

Layout NN

Data domain

00 Pre-MDC
01 Diseases and disorders of the nervous system
02 Diseases and disorders of the eye
03 Diseases and disorders of the ear, nose, mouth and throat
04 Diseases and disorders of the respiratory system
05 Diseases and disorders of the circulatory system
06 Diseases and disorders of the digestive system
07 Diseases and disorders of the hepatobiliary system and pancreas
08 Diseases and disorders of the musculoskeletal system and connective tissue
09 Diseases and disorders of the skin, subcutaneous tissue and breast
10 Endocrine, nutritional and metabolic diseases and disorders
11 Diseases and disorders of the kidney and urinary tract
12 Diseases and disorders of the male reproductive system
13 Diseases and disorders of the female reproductive system
14 Pregnancy, childbirth and the puerperium
15 Newborn and other neonates
16 Diseases and disorders of blood, blood-forming organs and immunological disorders
17 Neoplastic disorders (haematological and solid neoplasms)
18 Infectious and parasitic diseases (systemic or unspecified sites)
19 Mental diseases and disorders
20 Alcohol/drug use and alcohol/drug-induced organic mental conditions
21 Injuries, poisoning and toxic effects of drugs
22 Burns
23 Factors influencing health status and other contacts with health services
99 Error DRG's

Guide for use See MDC code table: http://www.nzhis.govt.nz/moh.nsf/pagesns/47

Verification rules

Collection methods

Related data MDC type
DRG codes
DRG grouper type

Source document

Source organisation National Centre for Classification in Health, University of Sydney, Australia

MDC type

Definition	A code denoting which clinical version of a grouper a Major Diagnostic Category (MDC) code belongs to.
Column name	mdc_type
Table name	fact_nmd_health_event
Data type	char(1)
Other names	
Context	
Layout	A
Data domain	A AN-DRG version 3.1 B AR-DRG version 4.1 C AR-DRG version 4.2 D AR-DRG version 5.0
Guide for use	Derived from the clinical version of the grouper used to create the DRG code.
Verification rules	
Collection methods	
Related data	MDC code DRG codes DRG grouper type code
Source document	
Source organisation	National Centre for Classification in Health, University of Sydney, Australia

Month of data

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

Mother's Encrypted NHI

Definition	For birth events, the Mother's NHI in encrypted form.
Column name	mothers_encrypted_hcu_id
Table name	fact_nmd_health_event
Data type	varchar2(11)
Other names	Mother's NHI
Context	The NHI number is the cornerstone of NZHIS'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.
Layout	
Data domain	System-generated
Guide for use	Only reported for Birth events
Verification rules	Must be registered on the NHI database before the NHI number can be used in the NMDS. 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. • Mother's NHI is mandatory for BT (birth) events with an event end date on or after 1 July 2008. • Events with an event end date before 1 July 2008 and a value in the Mother s NHI field will be rejected with an error. ENCRYPTION The NHI number is encrypted using a one-way encryption algorithm when the record is transferred from the NMDS transactional system to the data warehouse. The aim is to provide an encrypted number that can be sent across public (unsecured) networks.
Collection methods	NHI numbers are often included on patient notes and other patient documentation. New numbers can be allocated by health providers who have direct access to the NHI Register. New NHI numbers are also allocated by HealthPAC for GPs and other primary care providers.
Related data	Encrypted NHI Number
Source document	http://www.nzhis.govt.nz/moh.nsf/indexns/nhi
Source organisation	NZHIS

NZ drg code

Definition

Column name	nz_drg_code
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	
Context	
Layout	
Data domain	
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

NZ resident flag

Definition	A code identifying resident status at the time of this event. 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.
Column name	nz_resident_flag
Table name	fact_nmd_health_event
Data type	char(1)
Other names	HCU resident status, Residency, Resident status, HCU NZ resident status
Context	Used to identify overseas residents treated in New Zealand. Tied to public funding of events.
Layout	A
Data domain	'Y' = Permanent resident (New Zealand citizen or classified as 'ordinarily resident in New Zealand') 'N' = Temporary (not a New Zealand citizen, does not have New Zealand 'ordinarily resident' status)
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	Immigration Act 1987
Source organisation	National Data Policy Group

Occupation code

Definition	The current occupation of a healthcare user, classified according to the Statistics NZ Standard Classification of Occupations (NZSCO90).
Column name	occupation_code
Table name	fact_nmd_health_event
Data type	varchar2(4)
Other names	
Context	At time of admission, outpatient event or death.
Layout	NNNN
Data domain	0111 - 9900. See the Occupation code table on the NZHIS web site at http://www.nzhis.govt.nz/moh.nsf/pagesns/47. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.
Guide for use	
Verification rules	Optional.
Collection methods	Optional for all health events. Must be a valid code in the code table.
Related data	occupation_code_description
Source document	
Source organisation	

Occupation free text

Definition	Free-text description of the patient's occupation.
Column name	occupation_free_text
Table name	fact_nmd_health_event
Data type	varchar2(70)
Other names	
Context	At the time of admission
Layout	Free text
Data domain	
Guide for use	Introduced on 1 July 1999. With the introduction of the Cancer Registry Act, pathologists were given responsibility to ensure that all specified primary cancer cases are reported, and the pathology report became the principal source of information identifying new cases of primary cancer. Because pathology reports do not contain all the information required to complete cancer registrations, Section 6 of the legislation also authorises the Cancer Registry to seek additional information from medical practitioners or hospitals. Information not available from laboratories is: Occupation code, Country of birth code, and Extent of cancer disease code.
Verification rules	Optional. May be sent for all events.
Collection methods	Should be reported for cancer patients.
Related data	Occupation code
Source document	
Source organisation	

PCCL

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

Pms unique identifier

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

Principal diag 06 clin code

Definition	A code used to classify the principal diagnosis/clinical description of a condition.
Column name	principal_diag_06_clin_code
Table name	fact_nmd_health_event
Data type	varchar2(8)
Other names	
Context	
Layout	
Data domain	Must be a valid code in one of the following systems: - ICD-9-CM-A 2nd Edition - Australian Version of The International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition - ICD-10-AM 1st Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition - ICD-10-AM 2nd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition - ICD-10-AM 3rd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition - DSM-IV - Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Principal diag 10 clin code

Definition	A code used to classify the clinical description of a condition.
Column name	principal_diag_10_clin_code
Table name	fact_nmd_health_event
Data type	varchar2(8)
Other names	
Context	
Layout	See Collection method.
Data domain	Must be a valid code in one of the following systems: - ICD-9-CM-A 2nd Edition - Australian Version of The International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition - ICD-10-AM 1st Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition - ICD-10-AM 2nd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition - ICD-10-AM 3rd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition - DSM-IV - Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Principal diag 11 clin code

Definition	A code used to classify the clinical description of a condition.
Column name	principal_diag_11_clin_code
Table name	fact_nmd_health_event
Data type	varchar2(8)
Other names	
Context	
Layout	See Collection method.
Data domain	Must be a valid code in one of the following systems: - ICD-9-CM-A 2nd Edition - Australian Version of The International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition - ICD-10-AM 1st Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition - ICD-10-AM 2nd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition - ICD-10-AM 3rd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition - DSM-IV - Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Principal diag 12 clin code

Definition	A code used to classify the clinical description of a condition.
Column name	principal_diag_12_clin_code
Table name	fact_nmd_health_event
Data type	varchar2(8)
Other names	
Context	
Layout	
Data domain	Must be a valid code in one of the following systems: - ICD-9-CM-A 2nd Edition - Australian Version of The International Classification of Diseases, 9th Revision, Clinical Modification, 2nd Edition - ICD-10-AM 1st Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition - ICD-10-AM 2nd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition - ICD-10-AM 3rd Edition - The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition - DSM-IV - Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.
Guide for use	
Verification rules	
Collection methods	
Related data	
Source document	
Source organisation	

Principal diag 13 clin code

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

Prioritised ethnic code

Definition	The most highly prioritised ethnicity of the three ethnic groups recorded for the healthcare user, determined according to a Statistics NZ algorithm.
Column name	prioritised_ethnic_code
Table name	fact_nmd_health_event
Data type	varchar2(2)
Other names	
Context	Demographic information.
Layout	NN
Data domain	See the Ethnic code table table on the NZHIS web site at http://www.nzhis.govt.nz/moh.nsf/pagesns/47. For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.
Guide for use	Ethnic codes are ranked on the Ethnic code table from '1' (highest priority) to '21' (lowest priority), with '99' for not stated. Prioritised ethnicity is the healthcare user's ethnic code with the highest priority. Prioritising ethnic codes simplifies analysis. See Appendix: Guide for Use of Ethnic Codes.
Verification rules	
Collection methods	
Related data	Ethnic group Ethnic group 2 Ethnic group 3
Source document	
Source organisation	Statistics NZ

Private hospital flag

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

Psychiatric leave end type

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

Public birth

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

Purchase unit

Definition	Purchase unit indicates which contract the event is funded under.
Column name	purchase_unit
Table name	fact_nmd_health_event
Data type	varchar2(10)
Other names	
Context	
Layout	
Data domain	
Guide for use	It is derived directly from Health specialty. Some events have a purchase unit of 'EXCLU' (ie, not eligible). This depends on criteria available at http://www.nzhis.govt.nz/moh.nsf/pagesns/300
Verification rules	
Collection methods	
Related data	DRG codes Costweight Costweight code Health specialty code
Source document	
Source organisation	Cost Weights Working Group

Purchaser code

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

Column name purchaser_code

Table name fact_nmd_health_event

Data type varchar2(2)

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

Context

Layout XN

Data domain

CURRENT
06 Privately funded
16 Independent Practice Association
17 Accredited employer
19 Overseas chargeable
20 Overseas eligible
34 MOH-funded purchases
35 DHB-funded purchases
55 Due to strike
98 Mixed funding where no Ministry of Health, DHB or ACC purchase is involved, eg, some hospice cases
A0 ACC - direct purchase
A1 FIS - direct purchase, Fusion Insurance Services
A2 NZI - direct purchase, NZ Insurance Ltd
A3 HIH - direct purchase, HIH Work Able Ltd
A4 MMI - direct purchase, MMI General Insurance (NZ) Ltd
A5 FMG - direct purchase, Farmers' Mutual Accident Care Ltd
A6 @WK or AWK - direct purchase, At Work Insurance Ltd
A7 CIG - direct purchase, Cigna Insurance Ltd

RETIRED
01 HFA Northern Office (retired 1 July 1999)
02 HFA Midland Office (retired 1 July 1999)
03 HFA Central Office (retired 1 July 1999)
04 HFA Southern Office (retired 1 July 1999)
05 ACC (direct) (retired 1 July 1999: use 'A0')
07 HFA Southern Office Waiting Times Fund (retired 30 June 2004)
08 HFA Central Office Waiting Times Fund (retired 30 June 2004)
09 HFA Midland Office Waiting Times Fund (retired 30 June 2004)
10 HFA Northern Office Waiting Times Fund (retired 30 June 2004)
11 Supplementary purchase (NB: does not include 'new money') (retired 30 June 2004)
12 Paediatric purchase (retired 30 June 2004)
13 Base purchase (retired 30 June 2007)
14 HFA additional sustainable purchase (retired 30 June 2004)
15 BreastScreen Aotearoa (retired 30 June 2009)
18 DHB accident purchase - overseas patients, non-MVA, non-work-related (retired 30 June 2007)

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.

On 1 July 2009, Purchaser code ‘15’ Breast Screen Aotearoa was retired and replaced with '35’ DHB-funded purchase.

'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.

Verification rules

Code must be present in the Purchaser code table.
The event end date must be on or prior to the Purchaser code end date (if populated).

If the Principal Health Service Purchaser Code is between 'A0' and 'A7', the Accident Flag should be set to 'Y'.

If the Accident Flag has been set to 'Y' then the ACC Claim Number field should not be blank.

As from 1 July 2004, using a retired code will generate an error message.

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 date is used when validating against the Purchaser Code’s start and end dates.

Collection methods

Prior to 1 July 2007 acute, arranged and booking list cases would normally be assigned the base funding code ('13').
On or after 1 July 2007 acute or arranged cases should be reported with purchaser code 35- DHB Funded.
The Additional Electives funding (Orthopeadics Initiative, Cataract Initiative and Additional Elective Services Initiative) should be reported as 35- DHB Funded. This is because the Ministry now pays the money to the DHB funder arm, who then contracts with the DHB provider arm, or makes IDF payments for the work.

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.acc.co.nz/for-providers/resources/ 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 Event end date 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.moh.govt.nz/.

Related data

ACC claim number
Private Flag

Source document

Source organisation

Referral date

Definition	The date of the doctor's referral letter, or date presented for self-referral, or date of transfer which resulted in this event, whichever date is earlier. This date is required for select surgical procedures.
Column name	referral_date
Table name	fact_nmd_health_event
Data type	date
Other names	
Context	Elective surgical events.
Layout	
Data domain	Valid dates Partial dates are permissible. At a minimum the century and year must be supplied. 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.
Guide for use	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.
Verification rules	Optional. Must be on or before the date of load, the Event start date, and the Event end date. Must be on or after the Date of birth.
Collection methods	Required for total hip replacement, total knee replacement and coronary artery bypass graft events.
Related data	Referral date flag
Source document	
Source organisation	

Suppression flag

Definition	A flag signifying that the healthcare user has requested that details of this event not be passed to the event summary extract for display in the MWS system.
Column name	suppression_flag
Table name	fact_nmd_health_event
Data type	char(1)
Other names	
Context	
Layout	A
Data domain	Y suppress this event summary N allow this event summary to be displayed
Guide for use	
Verification rules	
Collection methods	Providers should inform patients that their data will be sent to NZHIS 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.
Related data	
Source document	
Source organisation	

Surgical priority

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

TLA of domicile

Definition Territorial local authority of domicile.

Column name tla

Table name fact_nmd_health_event

Data type varchar2(3)

Other names

Context Geographical aggregation.

Layout NNN

Data domain

TLA	TLA name
001	Far North
002	Whangarei
003	Kaipara
004	Rodney
005	North Shore
006	Waitakere
007	Auckland
008	Manakau
009	Papakura
010	Franklin
011	Thames-Coromandel
012	Hauraki
013	Waikato
015	Matamata-Piako
016	Hamilton
017	Waipa
018	Otorohanga
019	South Waikato
020	Waitomo
021	Taupo
022	Western BOP
023	Tauranga
024	Rotorua
025	Whakatane
026	Kawerau
027	Opotiki
028	Gisborne
029	Wairoa
030	Hastings
031	Napier
032	Central Hawke's Bay
033	New Plymouth
034	Stratford
035	South Taranaki
036	Ruapehu
037	Wanganui
038	Rangitikei
039	Manawatu
040	Palmerston North
041	Tararua
042	Horowhenua
043	Kapiti Coast
044	Porirua
045	Upper Hutt
046	Lower Hutt
047	Wellington
048	Masterton
049	Carterton
050	South Wairarapa

051 Tasman
052 Nelson
053 Marlborough
054 Kaikoura
055 Buller
056 Grey
057 Westland
058 Hurunui
059 Waimakariri
060 Christchurch
061 Banks Peninsula
062 Selwyn
063 Ashburton
064 Timaru
065 Mackenzie
066 Waimate
067 Chatham Islands
068 Waitaki
069 Central Otago
070 Queenstown Lakes
071 Dunedin
072 Clutha
073 Southland
074 Gore
075 Invercargill
998/9999 Overseas/other

Guide for use

The TLA of domicile roughly equates to local council boundaries. Populated from 1988.

Derived from the NZHIS mapping of Domicile code to TLA. No code table exists.

Domicile code 3402 Oceanic - Chatham Islands is included in TLA 'other' as it is not a Land Authority and is classified as subregion 15 'Hawke's Bay' which is not shown in this table.

Verification rules

Collection methods

Related data

Domicile code

Source document

Source organisation

Total ICU Hours

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

Total NIV Hours

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

Column name total_niv_hours

Table name fact_nmd_health_event

Data type number(5)

Other names

Context Total hours for the health event.

Layout NNNNN

Data domain 00001-99999 or NULL

Guide for use

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

Types/modes of noninvasive ventilatory support are:

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

Total hours on noninvasive ventilation (NIV) is used to capture the number of hours a patient is on NIV during an episode of care. As in the total hours on mechanical ventilation variable, part hours are rounded up.

NIV hours should not be collected when NIV is used as a method of weaning from continuous ventilatory support (CVS) or performed by endotracheal tube (ETT) or tracheostomy. If NIV is used to wean a patient from CVS, the time on NIV will be added to the hours on CVS.

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

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

CLINICAL CODING GUIDELINES

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).

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

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

If more than one period of NIV occurs during the same episode of care when used for treatment (not weaning) should be added together. For example, if a patient is on NIV for the first day of their admission, then on NIV again on the fourth day of their admission, the NIV hours should

be added together to arrive at the correct NIV procedure code.

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

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

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

Verification rules

Optional. If reported, must be a positive integer.

Generate warning if:

- not present when a noninvasive ventilation procedure is present (ie, ICD-10-AM 6th edition Clinical Code = 9220900 or 9220901 or 9220902 (Clinical Code Type = 'O')
- present and noninvasive procedure is not present (ie, ICD-10-AM 6th edition Clinical Code = 9220900 or 9920901 or 9920902 (Clinical Code Type = 'O')
- greater than the calculated number of hours from Event start date to Event end date inclusive.
- Generate error if NIV hours submitted for an event end date before 1 July 2009
- Generate error if CPAP hours submitted with the events ending on or after 1 July 2009 if file version is 013.0

Collection methods

Related data

Total hours on mechanical ventilation.

Source document

Source organisation

Transaction id

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

Weight on admission

Definition	The weight in grams at time of admission for infants less than 29 days old.
Column name	weight_on_admission
Table name	fact_nmd_health_event
Data type	integer
Other names	HCU weight on admission, Admission weight
Context	Used in DRG calculations.
Layout	NNNN
Data domain	0001 - 9999 grams
Guide for use	A reported admission weight of less than 2500 grams for infants older than 28 days means these infants are allocated to the low-weight neonatal DRGs. Failure to supply Weight on admission data will result in inappropriate DRG code assignment. Records reporting 0001 to 0399 grams are returned with a warning message that weight on admission is unusually low. Hospitals will need to confirm this value before the record will be loaded into the NMDS. This is not the same field as Birthweight. In some instances the weight on admission of previously discharged neonates may be the same as the recorded birthweight, but this will not generally be the case. There will be instances when the weight on admission is lower than that recorded at birth. NZHIS started collecting this information on 1 July 1995.
Verification rules	Mandatory if age at admission is less than 29 days. Optional for all babies between 29 and 365 days old (inclusive) who weigh less than 2500 g. Values between 0001 and 0399 generate a warning message. Must be sent as 4 characters. For infants under 1000 grams, the field must be supplied with a leading zero. No negative numbers.
Collection methods	With the introduction of ICD-10-AM 2nd Edition, this field should be reported for all infants: - aged less than 29 days, or - aged between 29 and 365 days (inclusive) who weigh less than 2500 g. It may be optionally sent for any infant less than one year old. For newborn infants, weight on admission will be identical to the birth weight. Newborn infants discharged and readmitted to the same or another healthcare facility after birth will need to have their weight on admission for the subsequent event recorded and reported. If not known, the default is '9000'.
Related data	Birthweight DRG code (used as key input for the AR-DRG grouper, so many of these rules are derived from the grouper logic)
Source document	

Source organisation National Data Policy Group

Year of data

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

NMD Psych leave end type table

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

Psychiatric leave description

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

Psychiatric leave end type

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

Appendix A: Logical to Physical Table Mapping

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

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

Appendix B: List of Shared Dimensions

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

Dimension Table	*Description*
Affiliation table (dim_affiliation)	This table is a matrix of gender and ethnicity code combination. Each row denotes the gender and ethnicity combination applicable to a person at the time of a transaction, i.e. it does not change over time.
Age Band table (dim_age_band)	This dimension table contains a record for each age from 0 to 115 years. The ages are also grouped into 5 and 10 year age bands, the GMS age bands and the PHO CBF Bands
Agency Facility table (dim_agency_facility)	This table stores details of organisations, institutions or groups of institutions that contract directly with the principal health service purchaser to deliver healthcare services to the community.
Clinical Code table (dim_clinical_code)	This table contains a repository of all clinical codes.
Country table (dim_country)	This table holds a list of all countries. Used to provide details of the health care user's country of birth.
Diagnosis Type table (dim_diagnosis_type)	This dimension table hold the details of the diagnosis type and the associated diagnosis type description.
DRG table (dim_drg)	Dimension table of Diagnostic Related Groups (DRG).
Event End Type table (dim_event_end_type)	This table holds values that describe the end type to the HCU event.
Event Type table (dim_event_type)	This table holds values that describe the event type for the HCU event.
Geo table (dim_geo)	This table holds a geographical breakdown of NZ domicile codes and areas.
Health Care User table (dim_health_care_user)	This reference table contains information about all people who have received healthcare directly from healthcare providers.
Health Specialty table (dim_health_specialty)	A classification describing the specialty or service to which a healthcare user has been assigned, which reflects the nature of the services being provided.
Legal Status table (dim_legal_status)	The legal status table relates to Mental Health events only. It holds values associated with the legal, mental health status of a patient.
Occupation table (dim_occupation)	This dimension table holds values for the occupation of the health care user.
Purchase Unit table (dim_purchase_unit)	The purchase unit (PU) indicates what contract the event is funded under. PUs are in fact a classification system. Purchase units (PUs) are a means of quantifying (volume) and valuing (price) a service. The NSF provides tools and methodologies to be use
Purchaser Code table (dim_purchaser_code)	This table holds values that defines the organisation or body that purchased the healthcare service provided.

Appendix C: List of Views

The table views used in this datamart are shown below.

View Name	*Description*
Admission Age view (dim_admission_age)	A view of the shared Age Band dimension table.
Birth Location view (dim_birth_location)	A view of the Location table.
Discharge Age view (dim_discharge_age)	A view of the shared Age Band dimension table.
Event Agency view (dim_event_agency)	A view of the shared Agency Facility dimension table.
Mothers Age view (dim_mothers_age)	A view of the shared Age Band dimension table.
Psych leave end date view (dim_psych_lv_end_date)	A view of the shared Global Time dimension table.

Appendix D: Index of Element Names

Appendix E: Data Dictionary Template

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

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

Template This table explains the template.

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

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

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

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

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

Version date The date the new version number was assigned.

Identifying and defining attributes

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

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

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

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

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

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

Relational and representational attributes

Data type	The type of field in which a data element is held. For example, character, integer, or numeric.
Field size	The maximum number of storage units (of the corresponding data type) to represent the data element value. Field size does not generally include characters used to mark logical separations of values, eg, commas, hyphens or slashes.
Layout	The representational layout of characters in data element values expressed by a character string representation. For example: - 'CCYYMMDD' for calendar date - 'N' for a one-digit numeric field - 'A' for a one-character field - 'X' for a field that can hold either a character or a digit, and - '$$$,$$$,$$$' for data elements about expenditure.
Data domain	The permissible values for the data element. The set of values can be listed or specified by referring to a code table or code tables, for example, ICD-10-AM 6th 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 F: Code Table Index

Code table	Location
Admission Source	See the NZHIS web site: http://www.nzhis.govt.nz/moh.nsf/pagesns/47
Admission Type	See the NZHIS web site.
Agency Type	See the NZHIS web site.
Clinical coding system	See the NZHIS web site.
Costweight	See the NZHIS web site.
Domicile code	See the NZHIS web site.
DRG Grouper Type	See the NZHIS web site.
Ethnic Group	See the NZHIS web site. See .
Event Clinical Code Type	See the NZHIS web site.
MDC	See the NZHIS web site.
MDC Type	See the NZHIS web site.
Principal Health Service Purchaser	See the NZHIS web site. See *Appendix L: Guide for Use of NMDS Purchaser Code.*
Sex Type (Gender)	See the NZHIS web site.

Code tables on web site

For code tables on the NZHIS web site go to http://www.nzhis.govt.nz/moh.nsf/pagesns/47 For further information or a printed copy of the code table, contact the Publications Officer. Contact details are given at the front of this dictionary.

Appendix G: 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 hospital 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
NZ Resident Status
Occupation code
Occupation free-text
Prioritised ethnicity
Gender code (Sex)

DRG

CCL
Cost weight code
Cost weight
DRG code
DRG code version 3.1
DRG grouper type code
Excluded Purchase Unit
MDC code
MDC type
PCCL
Purchase unit

Birth Event

Age of mother
Birth location
Birth status
Birth weight
Gestation period

Mental Health Events

Legal status code
Legal status start 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
Total NIV 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
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

File and Record Administration

Batch ID
Date updated
Transaction ID

Appendix H: Collection of Ethnicity Data

Introduction

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

Points to remember

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

About ethnicity

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

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

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

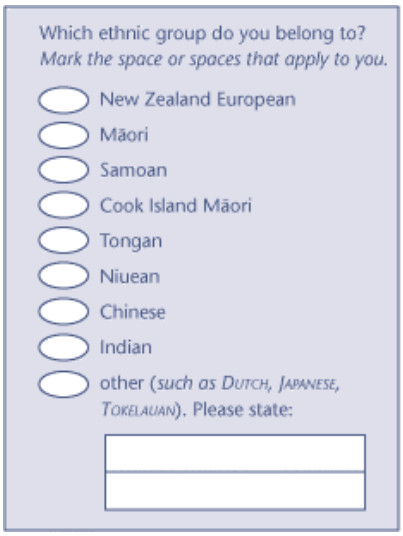
Purpose

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

Collection of data

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

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



Coding data

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

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

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

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

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

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

'Not Specified' and 'Other'

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

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

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

Detailed code table

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

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

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

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

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

MOH Ethnicity code	Country of Ethnicity Affiliation
51	Middle Eastern nfd
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

MOH Ethnicity code	Country of Ethnicity Affiliation
31	Samoan
37	Santa Cruz Islander
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
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 I: 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 and 5.0 no historical data is available, so no average values are stored.

Current software

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

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 and 5.0 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	The diagnosis and procedure information are mapped to different ICD codes, so that codes are held in: • ICD-9-CM-A, and • ICD-10-AM 1st Edition, and • ICD-10-AM 2nd Edition, and • ICD-10-AM 3rd Edition, and • ICD-10-AM 6th Edition **Note:** 1. The diagnosis_procedure_tab.submitted_system_id indicates which version of the ICD the clinical code was reported in. 2. For the 2004-2005 financial year, NZHIS will continue to apply ICD-10-AM 2nd Edition codes to the Grouper 3. For the 2005 to 2009 financial year, NZHIS will apply ICD-10-AM 3rd Edition code to the Grouper.
2	The DRG Grouper Program version 5.0 processes information about an event for each grouper clinical version, including: • personal information (eg, Sex, Date of birth), and • event information (eg, Admission date, Event end type), and • diagnosis and procedure information in the appropriate ICD code for the DRG Grouper.

3	For each clinical version of the Grouper (3.1, 4.1, 4.2 and 5.0), the DRG Grouper Program version 5.0 calculates (for that event): • a DRG code (of the DRG grouper type) • an MDC code (of an MDC type that is the same as the DRG grouper type) • CCL or PCCL (as appropriate for that clinical version of the Grouper)
4	NMDS processing calculates the Cost weight (using the WIES methodology) and Purchase unit from: • the DRG and associated variables • Length of stay • Total hours on mechanical ventilation • some diagnosis and procedure codes • Health specialty code For details, see the Technical documentation section of http://www.nzhis.govt.nz/.

Appendix J: 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 K: 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

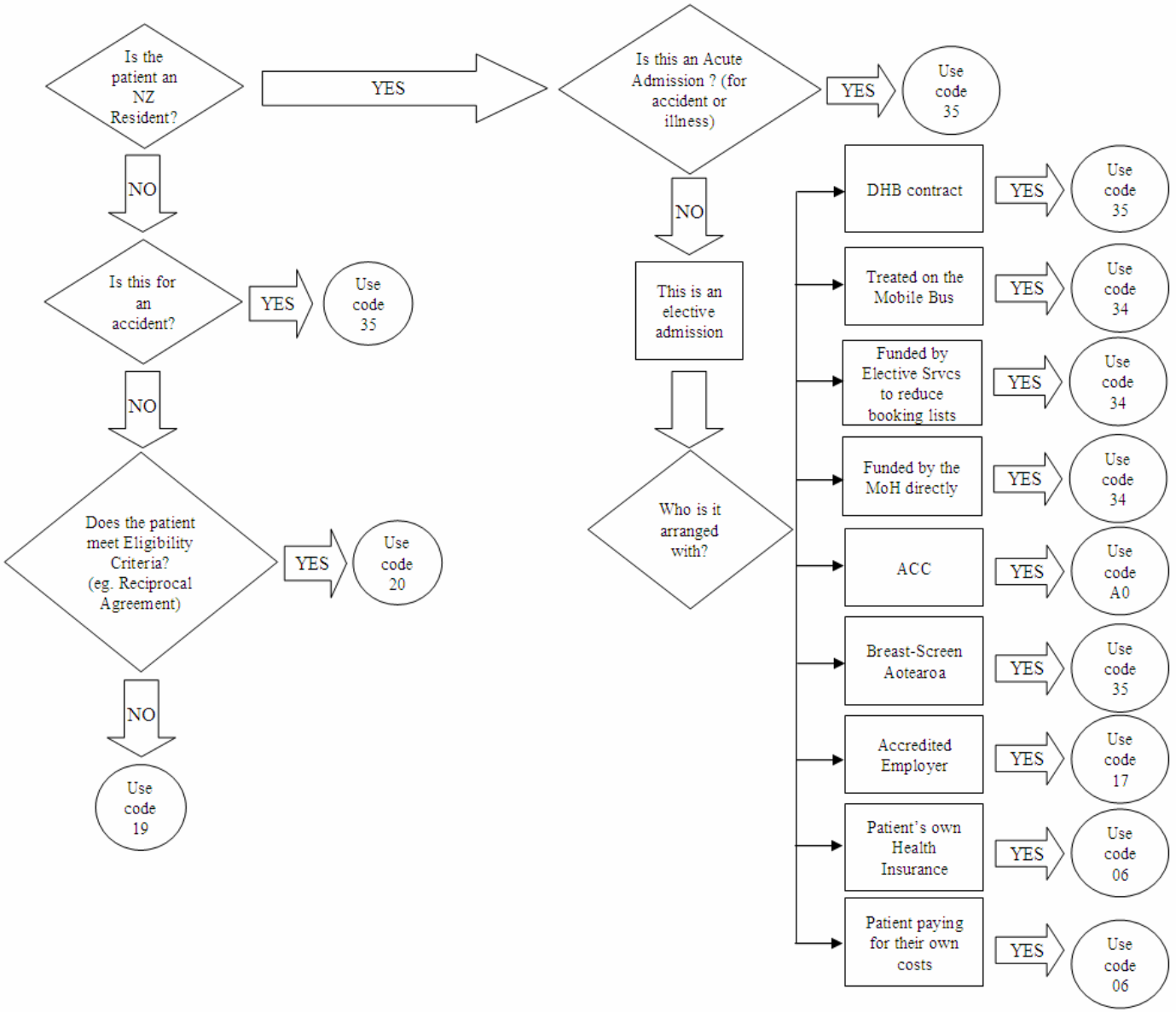
A day case (Event type either ID or IP and Length of stay 0 days) may occur within an IP or IM event for the same master_hcu_id where the Length of stay is not zero.

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.

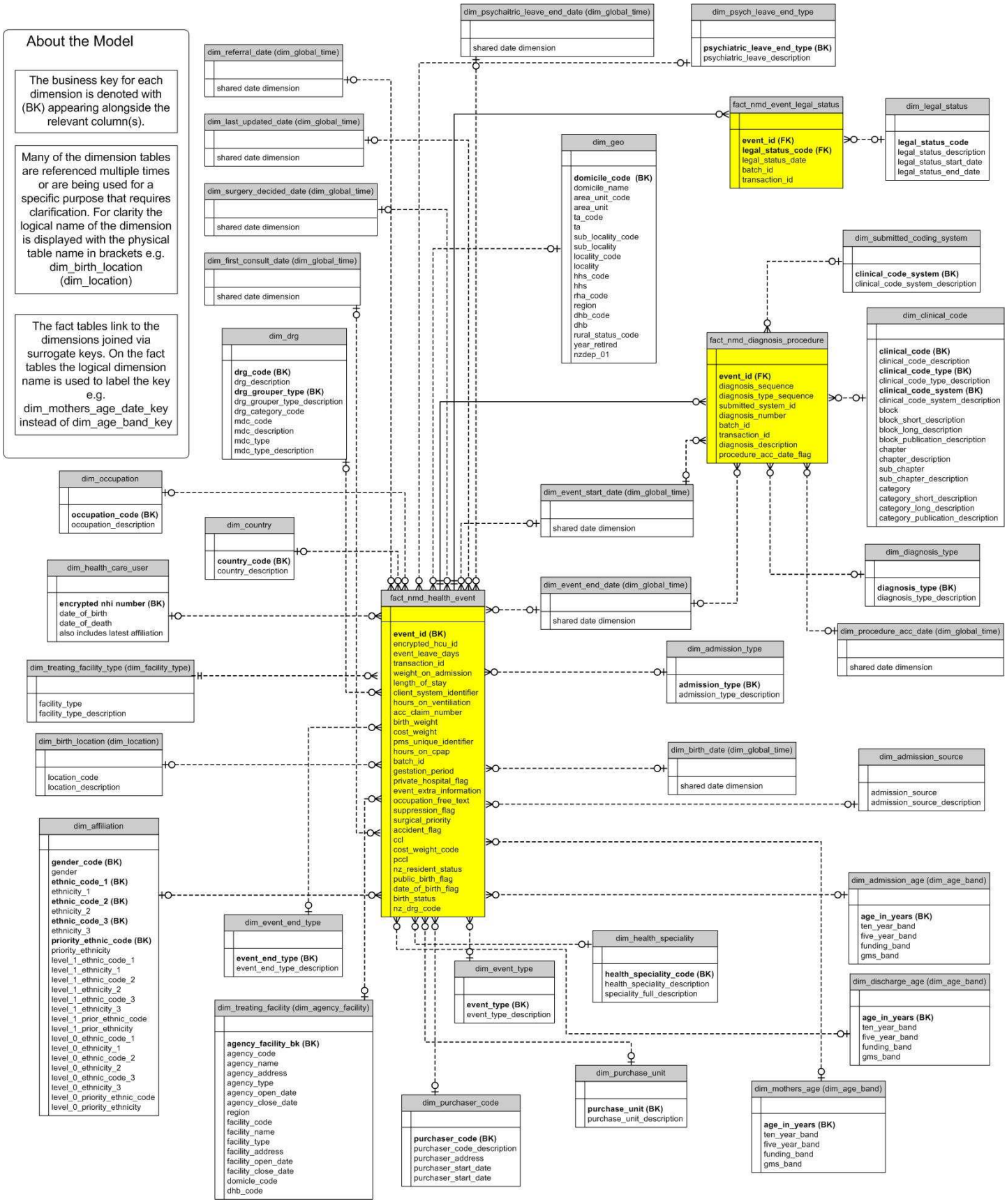
An IP or IM event where Length of stay is greater than zero may exist within an IM event for the same master_hcu_id.

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.

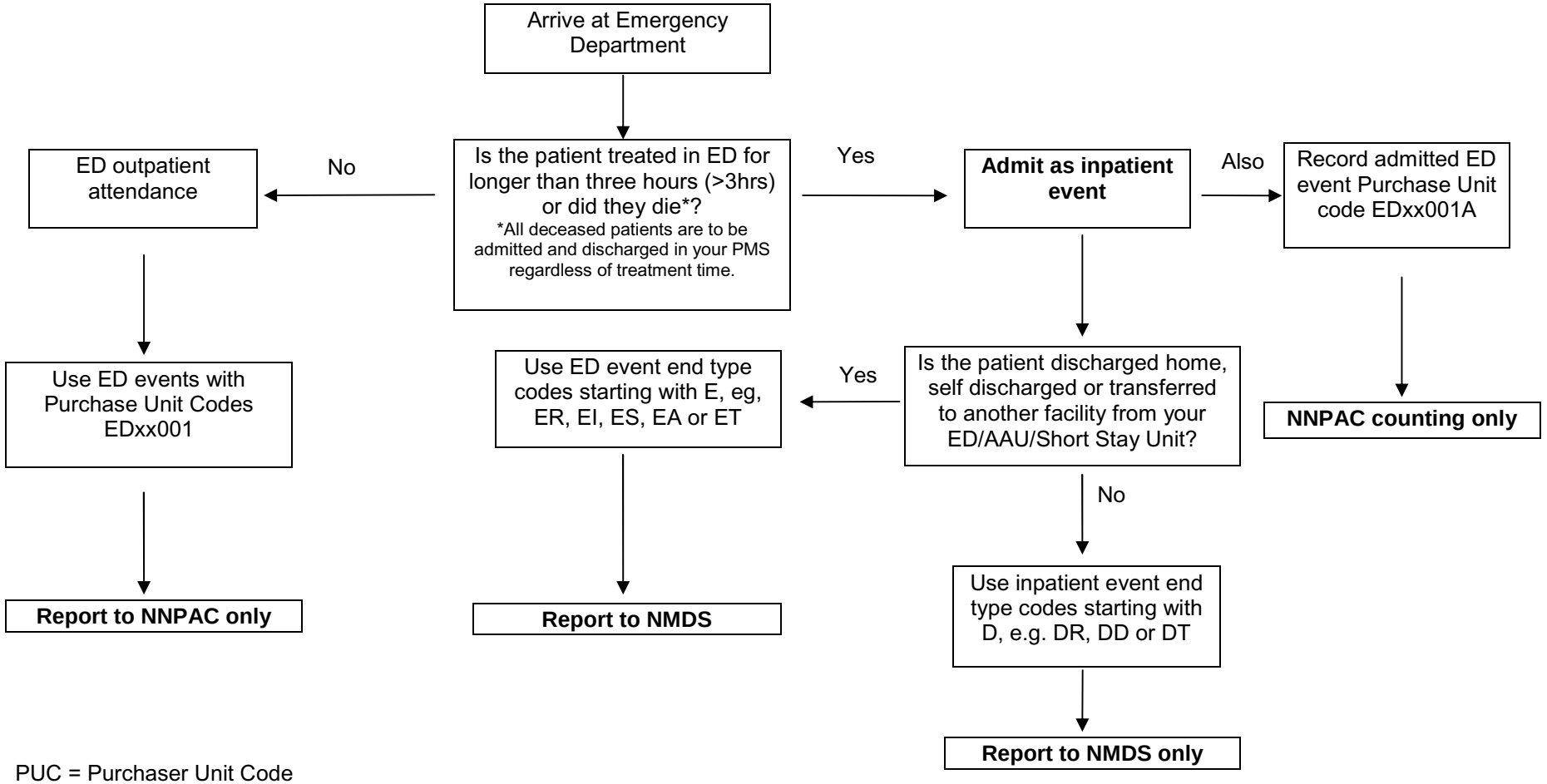
Appendix L: Guide for Use of NMDS Purchaser Code



Appendix M: NMDS Data Mart model



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



PUC = Purchaser Unit Code
NNPAC = National Non Admitted Patient Collection

EMERGENCY DEPARTMENT SCENARIOS	EVENT END TYPE	NMDS REPORTING	NNPAC REPORTING
Patient in ED receives treatment <3hrs discharged home	N/A ED event only	No	Yes
Patient in ED receives treatment >3hrs discharged home	ER	Yes	Only for counting purposes – PUC Edxx001A
Patient in ED receives treatment <3hrs self discharges without indemnity signed	N/A ED event only	No	Yes
Patient in ED receives treatment >3hrs self discharges without indemnity signed	ES	Yes	Only for counting purposes – PUC Edxx001A
Patient in ED receives treatment <3hrs self discharges with indemnity signed	N/A ED event only	No	Yes
Patient in ED receives treatment >3hrs self discharges with indemnity signed	EI	Yes	Only for counting purposes – PUC Edxx001A
Patient in ED receives treatment <3hrs and dies	ED	Yes	Only for counting purposes – PUC Edxx001A
Patient in ED receives treatment >3hrs and dies	ED	Yes	Only for counting purposes – PUC Edxx001A
Patient in ED receives treatment <3hrs transferred (discharged) to another facility	N/A ED event only	No	Yes
Patient in ED receives treatment >3hrs transferred (discharged) to another facility	ET	Yes	Only for counting purposes – PUC Edxx001A
Neonatal or burns patient receives treatment <3hrs transferred (discharged) to another facility	N/A ED event only	No	Yes
Neonatal or burns patient receives treatment >3hrs transferred (discharged) to another facility	EA	Yes	Only for counting purposes – PUC Edxx001A
Patient in ED receives treatment <3hrs admitted to inpatient ward or straight to Operating Theatre	N/A - admit as inpatient	Yes Inpatient event	Only for counting purposes – PUC Edxx001A
Patient in ED receives treatment >3hrs admitted to inpatient ward or straight to Operating Theatre	N/A - admit as inpatient	Yes Inpatient event	Only for counting purposes – PUC Edxx001A
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	N/A - admit as inpatient	Yes Inpatient event	Only for counting purposes – PUC Edxx001A
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	N/A - admit as inpatient	Yes Inpatient event	Only for counting purposes – PUC Edxx001A
Patient transfers from smaller hospital to ED at your bigger hospital, receives treatment <3hrs and is then transferred (discharged) back to smaller hospital	N/A ED event only	No	Yes
Patient transfers from smaller hospital to ED at your bigger hospital, receives treatment >3hrs and is then transferred (discharged) back to smaller hospital	ET	Yes	Only for counting purposes – PUC Edxx001A

EMERGENCY DEPARTMENT SCENARIOS	EVENT END TYPE	NMDS REPORTING	NNPAC REPORTING
Obstetric patient in ED receives treatment (for non obstetric problem) <3hrs and then is admitted to inpatient obstetric ward for observation of pregnancy	N/A ED event only	No	Yes
Obstetric patient in ED receives treatment (for non obstetric problem) >3hrs and then is admitted to inpatient obstetric ward for observation of pregnancy	DW [Note 1]	Yes	Only for counting purposes – PUC Edxx001A
Obstetric patient in ED receives treatment (for obstetric or non obstetric problem) <3hrs transferred (discharged) to another facility	N/A ED event only	No	Yes
Obstetric patient in ED receives treatment (for obstetric or non obstetric problem) >3hrs transferred (discharged) to another facility	ET	Yes	Only for counting purposes – PUC Edxx001A
Obstetric inpatient sustains an in hospital injury/accident transferred to ED and receives treatment (for non obstetric problem) <3hrs then transferred back to inpatient obstetric ward	N/A ED event only	No	Yes
Obstetric inpatient sustains an in hospital injury/accident transferred to ED and receives treatment (for non obstetric problem) >3hrs then transferred back to inpatient obstetric ward	DW [Note 1]	Yes	Only for counting purposes – PUC Edxx001A
Mental health patient in ED receives treatment (for an acute condition eg, self harm) <3hrs transferred (discharged) to psychiatric unit (within same facility)	N/A ED event only	No	Yes
Mental health patient in ED receives treatment (for an acute condition eg, self harm) >3hrs transferred (discharged) to psychiatric unit (within same facility)	DW [Note 1]	Yes	Only for counting purposes – PUC Edxx001A
Mental health patient in ED receives treatment (for an acute condition eg, self harm) <3hrs transferred (discharged) to psychiatric unit (another facility)	N/A ED event only	No	Yes
Mental health patient in ED receives treatment (for an acute condition eg, self harm) >3hrs transferred (discharged) to psychiatric unit (another facility)	ET	Yes	Only for counting purposes – PUC Edxx001A
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	N/A ED event only	No	Yes
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	DW [Note 1]	Yes	Only for counting purposes – PUC Edxx001A
Home hospital inpatient transferred to ED receives treatment <3hrs and is then transferred (discharged) back to home hospital services	N/A ED event only	No	Yes
Home hospital inpatient transferred to ED receives treatment >3hrs and is then transferred (discharged) back to home hospital services	ET	Yes	Only for counting purposes – PUC Edxx001A

Event End Type Codes - Mapping to Separation Mode

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

3M Codefinder™ Separation Mode Codes and Descriptions

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