**Introduction**

This glossary includes terms used by National Collections. Some of the terms may not be currently used in the national collections, however, have been included for completeness.

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| **ACCD** |
| The Australian Consortium for Classification Development (ACCD) was responsible for the development of the classification ICD-10-AM/ACHI/ACS Ninth Edition, Tenth Edition and Eleventh Edition and AR-DRG v8.0, v9.0 and v10 under the contract of the Independent Health and Aged Care Pricing Authority (IHACPA). |
| **ACHI** |
| The Australian Classification of Health Interventions (ACHI) is the Australian national standard for intervention clinical coding. ACHI classifies interventions performed in public and private hospitals.  The procedure codes in ACHI are numeric only. ACHI contains codes for surgical operations and medical procedures, and includes codes for allied health interventions, dental services and other interventions performed outside the operating theatre. |
| **Acute Admission (AC)** |
| An acute admission is an unplanned admission on the day of presentation at the admitting healthcare facility. Admission may be to an Emergency Department (ED), Acute Assessment (AAU) or Short Stay Unit (SSU) or may be from the Emergency or Outpatient Departments of the healthcare facility or a transfer from another facility. If a patient is admitted to ED/AAU/SSU or is admitted from ED to an inpatient ward, the event start datetime will be the datetime assessment/treatment commenced in ED/AAU/SSU (in the NNPAC national collection this is datetime of first contact). Procedures carried out in ED meeting the criteria for clinical coding are to be coded as part of the episode of admitted patient care (inpatient event). |
| **Additional Diagnosis (Adx)** |
| 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. |
| **Admission** |
| The documentation process, which may include entry to the NHI, by which a person becomes a resident in a healthcare facility. For the purposes of the national collections, healthcare users who receive assessment and/or treatment for three hours or more, or who have a general anaesthetic are to be admitted. This also applies to healthcare users of Emergency Departments (ED).  When calculating the three hours, exclude waiting time in a waiting room, exclude triage and use only the duration of assessment/treatment. If part of the assessment/treatment includes observation, then this time contributes to the three hours. ‘Assessment/treatment’ is clinical assessment, treatment, therapy, advice, diagnostic or investigatory procedures from a nurse (excluding triage nurse), nurse practitioner, clinician or other health professional. Start time for an inpatient admission should be the same as the NNPAC datetime of first contact in ED. |
| **Admitted Patient** |
| A person who undergoes a hospital’s admission process to receive treatment and/or care.  This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person’s home (for hospital-in-the-home patients). |
| **AHB** |
| Area Health Board (AHB). AHBs were health funding bodies until 1 July 1993. They were replaced with four Regional Health Authorities (RHA). |
| **Arranged Admission (AA)** |
| An 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 the admission was necessary, or ­the admission relates to normal maternity cases of 37 to 42 weeks gestation delivered during the event. These maternity patients will have been booked into the admitting facility. |
| **Attendance** |
| An encounter where the healthcare user goes to the healthcare provider and leaves within three hours of the start of the consultation. |
| **Bed equivalent** |
| The term ‘bed equivalent’ includes the categories beds, cots/bassinets, incubators, and special day­ patient chairs that can accommodate a patient after admission to a healthcare facility. |
| **Boarder** |
| A boarder is a person who is receiving food and/or accommodation but for whom the hospital does not accept the responsibility for treatment and/or care. This excludes all babies born in hospital.  A hospital may register and admit a boarder; however, boarder events are not required to be reported to the NMDS. |
| **Casemix** |
| Refers to the mix of cases treated within a hospital or other healthcare service. A casemix classification would categorise the patient care episodes into clinically meaningful groups and is based on those patient attributes that best explain the cost of care. |
| **CHE** |
| Crown Health Enterprise (CHE). This term was used to refer to hospitals from 1 July 1993 to 31 December 1997, first under Regional Health Authorities, and then under the Transitional Health Authority (THA). |
| **CodefinderTM** |
| The 3MTM CodefinderTM Software is an application that assists in the clinical coding process.  The software replaces the task of searching for ICD-10-AM/ACHI codes in the hard copy coding books with computerised prompts that aid in the decision-making process. The Codefinder software contains the same information used in the hard copy coding books to ensure that terminology, rules and codes are applied consistently.  The software does not identify the relevant information in the patient’s clinical record; this is the responsibility of a clinical coder. The Codefinder software also contains diagnosis related grouping, editing and data quality functions. |
| **Community Client** |
| A person receiving healthcare assistance outside of a healthcare facility. |
| **Community Patient** |
| A healthcare user who receives treatment, therapy, advice or diagnostic services outside of a healthcare facility, eg, those in the care of a community mental health team. |
| **Community Support** |
| A community client (not a resident in a healthcare facility) who receives assistance only with the normal activities of daily living, or visits for monitoring purposes only where there is no active treatment or clinical intervention, eg, those receiving:   * nappy/linen service * meals on wheels * home care * attendant care * home help * hygiene and dressing assistance * visits from a DHB well elderly visitor * accredited visitors * befriending schemes.   Community support clients are healthcare non­users. |
| **Day Case Patient** |
| A person admitted for healthcare with a length of stay three hours or more but less than one day (ie, not overnight), regardless of intent. Day case events will have the same event start and end date. See also ‘Admission’ and ‘Intended day case’.  This term is synonymous with ‘same day patient’ and ‘short stay event’. |
| **DHB** |
| District Health Board (DHB). Previously there were 21 DHB health funding bodies, which were introduced 1 January 2001. As of 1 May 2010 there were 20 DHBs, as Otago and Southland DHBs merged and were known as Southern DHB.  DHBs were disestablished under the Health Reform with their functions merged into Te Whatu Ora – Health New Zealand (HNZ) 1 July 2022. |
| **Did Not Attend (DNA)** |
| A person is classified as DNA if they did not attend the outpatient clinic appointment and there was no communication before the appointment. If there was communication, this is deemed to be a cancellation. |
| **Did Not Wait (DNW)** |
| Did not wait is used in ED where the person is triaged but did not wait for treatment. It is also used for outpatient services where the person arrives but does not wait to receive service. |
| **Discharge** |
| A healthcare user physically leaves a healthcare facility or the process of documentation that changes the status of an admitted healthcare user, eg, statistical discharge.  See NMDS event end datetime and event end type code. |
| **Domiciliary Service** |
| A domiciliary service is aimed at the treatment of healthcare users in the community in their home. This sub-categorisation of community service is no longer in common usage. |
| **DRG Classification** |
| Diagnosis Related Groups (DRGs) are a patient classification system used to structure episodes of care into groups that are clinically similar both in terms of patient characteristics and health interventions, and that are therefore anticipated to consume comparable levels of hospital resources. DRGs are calculated by National Collections as part of the NMDS load process. DRGs are not reported to the National Minimum Data Set (NMDS) by hospitals. The DRG classifications from v11.0 are defined and developed by IHACPA. |
| **Elective Admission** |
| A planned (booked) admission where the admission date is seven or more days after the date the decision was made by the specialist that the admission was necessary. |
| **Episode of Care/Event** |
| A phase of treatment defined according to the acuity of the patient: acute, non-acute (arranged/elective). Patients may have more than one episode of care in the period from admission to discharge, for example in one hospitalisation there may have been an acute episode of care for a fractured neck of femur, followed by a rehabilitation episode of care.  This term is synonymous with ‘event’. |
| **First Specialist Assessment (FSA)** |
| The first assessment by a registered medical practitioner of registrar level or above, or a registered nurse practitioner for a particular referral (or, with a self-referral, for a discrete episode). The healthcare user receives treatment, therapy, advice, diagnostic or investigatory procedures within three hours of the start of the consultation. The service is provided in a ward and/or designated outpatient clinic or by telehealth. Excludes Emergency Department and outpatient attendances for preadmission assessment/screening. |
| **Follow ­Up Attendance** |
| A follow up attendance is a subsequent patient consultation with a registered medical practitioner of registrar level or above, or a registered nurse practitioner, for the same condition in the same specialty. The patient receives treatment, therapy, advice, diagnostic or investigatory procedures, is not admitted, does not receive a general anaesthetic and the specialist’s intent is that they will finish the consultation within three hours. |
| **Forensic Psychiatry** |
| Forensic psychiatry is that branch of psychiatry which requires special knowledge and training in the law as it relates to the mental state of the offender (or alleged offender), and training in the assessment, treatment and care of persons who have offended or who are alleged to have offended or appear likely to do so because of their psychiatric condition. |
| **Grouper** |
| The grouper is specially designed computer software that assigns patient episodes of care to DRGs using diagnosis (ICD-10-AM) and procedure (ACHI) codes and other specific attributes such as age, sex, length of stay and event end type. External cause codes are not used by the grouper. The grouper uses up to 30 diagnoses and up to 30 procedures in its calculations. It is recommended that hospitals prioritise diagnoses and procedure codes within the current coding standards and guidelines in order to present the grouper with the most serious diagnoses and procedures. |
| **Health Agency Facility** |
| A place that may be permanent, temporary or mobile (excluding supervised hostels, halfway houses and staff residences), which people attend or are resident in, for the primary purpose of receiving healthcare or disability support services (i.e., would not be resident if no need for healthcare). |
| **Healthcare User (HCU)** |
| A person booked to receive or receiving healthcare resulting from direct contact with a healthcare provider where the healthcare results in the use of resources associated with observation, assessment, diagnosis, consultation, rehabilitation or treatment.  This term is synonymous with ‘patient’. |
| **Healthcare Non­user** |
| A person in contact with a health service but not booked to receive or receiving healthcare. |
| **HFA** |
| Health Funding Authority (HFA). The HFA was the health funding body from 1 January 1998 to 12 December 2000. It was replaced with the District Health Boards. |
| **HHS** |
| Hospitals and Health Services (HHS). This term was used to refer to hospitals from 1 January 1998 to 12 December 2000, under Health Funding Authorities. |
| **ICD-10-AM** |
| The *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification* (ICD-10-AM) is based on the World Health Organization (WHO) disease publication ICD-10. ICD-10-AM enables the translation of diagnoses, injuries and other health related problems from clinical concepts into an alphanumeric code, which permits easy storage, retrieval and analysis of data. |
| **IHACPA** |
| ​The Independent Health and Aged Care Pricing Authority's (IHACPA) primary function is to enable activity based funding for Australian public hospital services.  IHACPA is also responsible for developing national classifications for healthcare and other services delivered by public hospitals and as required, resolving disputes on cost-shifting and cross-border issues. |
| **Intended Day Case (ID)** |
| An admission where the intent of the episode of care will be a same day event ie, event start and end date are the same. Intended day case events used to be identified by the event type of ID. The event type (ID) was retired for all event records reported with an event end date on or after 1 July 2013, as it was no longer used by the DRG grouper software logic. |
| **Inpatient (IP)** |
| A patient admitted for healthcare. Includes same day (events.  Includes patients who are transferred from another healthcare facility, and or interdepartmental transfers (statistical discharge between specific health specialities) within the same facility. For event records reported with an event end date before 1 July 2013 the definition of ‘inpatient’ included ‘where the intention at admission was that it would not be a same day event’. |
| **Inpatient Length of Stay** |
| The time in days between admission to hospital ‘X’ and discharge, death or transfer from hospital ‘X’, minus leave days from hospital ‘X’. Counts are at midnight. |
| **Leave** |
| The planned absence of an inpatient from the healthcare facility to which they were most recently admitted. Leave is counted only where that patient is absent at midnight and has a planned return within three nights of going on leave, for the continuation of their treatment or care. 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. Where there is more than one period of leave during an episode, accumulated leave days should be reported. This definition does not cover sectioned Mental Health Service patients whose leave definitions are included in the Mental Health (Compulsory Assessment and Treatment) Act 1992. |
| **Leave Days** |
| 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 and 14 days (midnights) for informal psychiatric patients. If after three days for non-­psychiatric hospital inpatients or 14 days for informal psychiatric inpatients the patient has not returned to care, discharge is effective on the date of leaving hospital. This period of leave is not to be reported in the event leave day’s field. Where there is more than one period of leave during an episode, accumulated leave days should be reported.  For formal patients the duration of their leave is variable and is determined by the legislation they are under. |
| **Long Stay** |
| A healthcare user who has received continuous inpatient care, regardless of periods of leave and location, for a period as specified by the requirement of the service or data user. |
| **Mass Contacts** |
| Healthcare non­users whose only contact with the health service is through health promotion or screening campaigns. |
| **Measures** |
| These are cumulative stays that are incremented at midnight:   1. Unoccupied bed equivalent days per period 2. Occupied bed equivalent days per period 3. Resourced bed equivalent days per period.   Percentage occupancy = (occupied bed nights per period/resourced bed nights per period) x 100.  Turnover rate = (admissions/number of days in period)/resourced bed nights per period.  Turnover interval = unoccupied bed nights per period/ (admissions x number of days in period).  Five-­day wards need to be handled carefully. They have five resourced bed nights per week but only four bed-­equivalent days, as they are counted at midnight. The denominator used should be four resourced bed nights rather than five; otherwise 100 percent occupancy would not be possible. |
| **Mental Health First Admissions** |
| A person admitted for the first time with a mental illness. |
| **Mental Health Readmissions** |
| A person admitted for subsequent treatment of a mental illness. |
| **NBRS** |
| The National Booking Reporting System (NBRS) is a national collection that contains information by health speciality and booking status on how many patients are waiting for elective surgery, and how long they have had to wait for before receiving treatment. |
| **NCAMP** |
| The National Collections Annual Maintenance Project (NCAMP) is an annual project in order for Te Whatu Ora – Health New Zealand to meet its statutory obligation of delivering information from the national collections. NCAMP requires hospitals to initiate changes to their patient management systems (PMSs). |
| **NCCC** |
| National Casemix and Classification Centre (NCCC), University of Wollongong, Australia.  The NCCC was responsible for the development of the Australian Refined Diagnosis Related Group (AR-DRG) Classification System that consists of:   * The *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification* (ICD-10-AM), Eighth Edition * The *Australian Classification of Health Interventions* (ACHI), Eighth Edition * *Australian Coding Standards* (ACS), Eighth Edition * The Australian Refined Diagnosis Related Groups (AR-DRG) classification AR-DRG v7.0. |
| **NCCH** |
| National Centre for Classification in Health (NCCH), Sydney University, Australia. NCCH was the service provider for the ICD-9-CM-A and ICD-10-AM classifications (1st to 7th Editions) up until 30 June 2010. The NCCH was responsible for the development of the Australian Refined Diagnosis Related Groups (AR-DRG) Classification Systems from 1 July 2013 to 2018. |
| **NCR** |
| National Collections and Reporting (NCR) was a group within Data and Digital (D&D), Te Whatu Ora – Health New Zealand. National Collections and Reporting was changed to National Collections as part the D&D restructure in 2023. The National Collections group manage the national collections, reporting systems and provide access to information and coded clinical data. |
| **New Zealand Health Information Services (NZHIS)** |
| New Zealand Health Information Service was a group within the Ministry of Health responsible for the collection and dissemination of health­ related data. NZHIS was disestablished in 2008. |
| **NHI** |
| The National Health Index (NHI) is a unique number that is assigned to each person who receives healthcare in New Zealand. The NHI is an index of identity information associated with that unique number. The Health Information Privacy Code places restrictions on the creation and use of unique identifiers such as the NHI number. |
| **NMDS** |
| The National Minimum Dataset (NMDS) is a national collection of public and private hospital discharge information, including clinical information for inpatient and day patients. It also includes aged care and hospice records along with those for maternity services.  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. |
| **NNPAC** |
| The National Non-Admitted Patient Collection (NNPAC) is a national collection of non-admitted (outpatient and emergency department) activity, which was introduced 1 July 2006. The NNPAC information includes event-based purchase units that relate to medical and surgical outpatient events and emergency department events. From July 2020 clinical information has been reported for ED attendances. From July 2023 procedure information has been reported for five purchase unit codes. |
| **Occupied Bed Equivalent** |
| A resourced bed equivalent that is assigned to an admitted patient who is not on leave. |
| **Old Long Stay** |
| A client who has achieved old long stay status as at July 1991. This status results from continuous residence in a psychiatric hospital since 1 April 1975, except for periods of absence of less than one year. |
| **Outpatient (OP)** |
| An outpatient is a person who receives a pre­admission assessment, a diagnostic procedure, treatment, therapy, advice at a healthcare facility or via telehealth, and who is not admitted, and the specialist’s intent is that they will leave that facility within three hours from the start of the consultation. When a person receives a general anaesthetic they are deemed not to be an outpatient. See ‘Follow-up attendance’. |
| **Outpatient Clinic** |
| A scheduled administrative arrangement enabling an outpatient (person) to receive the attention of a healthcare provider. The holding of a clinic provides the opportunity for consultation, investigation and minor treatment with a person attending in person or virtually by prior arrangement. The clinic may be held on or off the hospital site. See ‘Follow-up attendance’. |
| **Patient** |
| This term is synonymous with ‘healthcare user’. |
| **PAS** |
| A facility’s local Patient Administration System (PAS). |
| **PMS** |
| A facility’s local Patient Management System (PMS). |
| **PRIMHD** |
| The Programme for the Integration of Mental Health Data (PRIMHD) creates a single national mental health information collection of service activity and outcomes data from across New Zealand’s mental health sector. Public hospitals and Non-Governmental Organisations (NGOs) electronically report their activity and outcomes data to national collections. |
| **Principal Diagnosis (Pdx)** |
| The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care in hospital (or attendance at the healthcare facility). The phrase ’after study’ in the definition means evaluation of findings to establish the condition that was chiefly responsible for occasioning 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.  Reference: Australian Coding Standards (ACS), Twelfth Edition, IHACPA 2022 |
| **Procedure** |
| A discrete therapeutic or diagnostic intervention. |
| **Recurrent Care Patient** |
| A person who attends as a same day patient but where the intention is for recurring day therapy, eg, renal dialysis, chemotherapy, geriatric, paediatric care. |
| **Recurrent ­Care Psychiatry** |
| A person who attends at a same day/recurrent­ care facility, staffed by a mental health service (excluding substance abuse and forensic services), for a period of more than three hours and less than one day, including treatment/education/promotion services. |
| **Referral** |
| Referral is a request for the shifting of clinical responsibility. The actual transfer of responsibility is recorded by (usually) a change from one status to another or a change of responsible clinician. The request may precede the assumption of responsibility by some time, the difference being the waiting time. |
| **Rehabilitation** |
| Intensive therapy and skill retraining required, after an acute treatment period, to permit an independent or semi-independent existence outside the hospital environment. |
| **Resourced Bed Equivalent** |
| A bed equivalent that is resourced to accommodate an admitted patient. Resources must include staff, linen, etc. The old term ‘commissioned bed’ corresponds with the term ‘resourced bed’. |
| **Respite/Crisis Care** |
| A short ­term admission, usually in order to give a carer respite from the provision of care. |
| **RHA** |
| Regional Health Authority. The four RHAs were the health funding bodies from 1 July 1993 to 1 July 1997. They were replaced with a single Transitional Health Authority. |
| **Short Stay Event** |
| A person admitted for healthcare where a length of stay will be three hours or more but less than one day, regardless of intent. Short stay events will have the same event start and end date. See also ‘Admission’ and ‘Intended day case’. This term is synonymous with ‘day case patient’ or ‘same day event’. |
| **THA** |
| Transitional Health Authority. The THA was the single health funding body from 1 July 1997 to 31 December 1997. It was replaced with the Health Funding Authority. |
| **Total Attendances** |
| The sum of first and follow-up attendances. |
| **Transfer** |
| The physical movement of a healthcare user within a healthcare facility not involving a change of healthcare status. The transfer of responsibility is signalled when a referral is accepted. |
| **Underlying Cause of Death** |
| The underlying cause of death is defined by the World Health Organization (WHO) as:   1. “the disease or injury which initiated the train of morbid events leading directly to death   or   1. the circumstances of the accident or violence which produced the fatal injury.” |
| **Unoccupied Bed Equivalent** |
| A resourced bed equivalent that is not an occupied bed equivalent.  The old term ‘commissioned bed’ corresponds with the term ‘resourced bed’. |
| **Visit** |
| An encounter where the healthcare provider goes to the healthcare user. |