hiso Health Information Standards Organisation
PAEREWA PĀRONGO HAUORA

Te Whatu Ora
Health New Zealand

Oral Health Data Standard

HISO 10059:2023

Released 2023

Te Kāwanatanga o Aotearoa
New Zealand Government

Citation: Te Whatu Ora – Health New Zealand. 2023. *HISO 10059 Oral Health Data Standard*. Wellington: Te Whatu Ora – Health New Zealand.

Published September 2023 by Te Whatu Ora – Health New Zealand
PO Box 793, Wellington 6140, New Zealand

ISBN 978-1-99-106749-4 (online)

Te Whatu Ora
Health New Zealand

This document is available at **tewhatuora.govt.nz**

Contents

1 Purpose

The **Electronic Oral Health Record programme** aims to improve the collection, access and reporting of oral health information to better meet the needs of public oral health service providers and the populations they serve. The programme will support improved equity of service access and outcomes, including for Māori and Pacific populations, and support clinical safety. The **Tier 2 Te Whatu Ora Oral Health Specifications** define these oral health services.

This standard defines administrative and clinical data elements and service codes that constitute a minimum dataset for Community Oral Health Services (COHS), Māori Oral Health Services[1] and Hospital Dental Services (HDS).

The first edition of this standard was published in 2021 and set the direction towards standardising capture and coding of core data elements for public oral health services. This second edition seeks to address integration, data quality and implementation issues for the intended shift towards a single, coherent national oral health information system (OHIS). Additionally, the update reflects the new operating environment following the 2022 health reforms, the disestablishment of district health boards and creation of Te Whatu Ora and Te Aka Whai Ora.

[1] A Māori Oral Health Service sits within a Hauora Māori Partner (a primary care provider belonging to an iwi organisation)

2 Scope

This standard sets out the minimum data set required to cover administrative, demographic and clinical information in relation to oral health services. Such information is collected, updated and maintained through primary and public health oral health information systems including those that support COHS and HDS.

Through Te Whatu Ora, New Zealand is a member of **SNOMED International**. The majority of public oral health services currently use a set of procedure codes derived from the **Australian Schedule of Dental Services and Glossary (ASDSG), 12th Edition.** SNOMED CT codes have been incorporated into this standard where it has been practical to do so. There is a longer-term intent to move to SNOMED CT codes for all oral health clinical information. The intent is to revisit the use of SNOMED CT in two years, if the standard is not updated sooner.

3 Background

In late 2017, inconsistencies in data collection were observed to be a barrier to the integration and interoperability of oral health information with other health records and systems. Data inconsistencies increase the costs of information system administration, end-user support and reporting development. In 2021 we published HISO 10059:2021 Oral Health Data Standard to incrementally apply a national data and code set standard for public oral health services to district systems and processes.

This standard has been revised and refined to reflect oral health services as part of the new national public health service created in July 2022 and the potential to consolidate these services onto a single national Oral Health Information System.

Our standard is designed to promote the consistent recording of oral health information that will be comparable across oral health services. This is a pre-requisite to a range of positive oral health outcomes, such as understanding and being able to address inequities in service delivery and outcomes.

3.1 Legislation and regulations

The following Acts of Parliament and Regulations are relevant to this standard. Complying with this Standard includes compliance with each of these

- Health Act 1956
- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
- Health Information Privacy Code 2020
- Health Practitioners Competence Assurance Act 2003
- Health (Retention of Health Information) Regulations 1996.
- New Zealand Public Health and Disability Act 2000
- Privacy Act 2020
- Public Records Act 2005
- Te Pae Ora (Healthy Futures) Act 2022

3.2 Supporting Te Pae Tata | Interim New Zealand Health Plan 2022

Te Pae Tata | interim New Zealand Health Plan 2022 (Te Pae Tata) sets out the first two years of action for Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority as healthcare is transformed in Aotearoa New Zealand. Te Pae Tata outlines the first steps to build the foundations of a sustainable affordable and unified health system that better serves all of Aotearoa's people and communities.

One of Te Pae Tata's priorities is to develop greater use of digital services to provide more care in homes and communities. High quality and consistent oral health information that can be shared between community and hospital providers will support the seamless provision of care and improve health outcomes.

4 Data elements

The data elements in the standard describe patient demographic and course of care information. Each course of care delivered to a patient is represented by at least one or more entries as necessary to provide a clear record of that course of care.

4.1.1 Data element template

Data element specifications are presented in the following templated form based on publicly available standard **ISO/IEC 11179 Information Technology – Metadata Registries (MDR)**.

Name	Data element name
Definition	A statement that expresses the essential nature of the data element
Source standards	Established standards or guidelines pertaining to the data element
Value domain	The named, enumerated or bounded set of valid values or codes that are acceptable for the data element Each coded data element has a specified code set The value domain may simply be a data type, with or without bound constraints
Data type	Data type and precision associated with the value domain: • Boolean • String • Date • Date/time • Integer • Decimal
Layout	The formatted arrangement of characters with 'A' for alpha, N for numeric and X for alphanumeric, eg, X(50) for a 50-character alphanumeric string NNN for a 3-digit number
Obligation	Indicates if the data element is mandatory, recommended, optional or conditional

	A recommended data element is not a mandatory requirement Conditional means use of the data element depends on the context
Guide for use	Additional guidance to inform the use of the data element, including verification rules

4.1.2 Clinical terminology standard

Most coded data elements use by default the SNOMED CT terminology for clinical information. The concepts making up each value domain are denoted by preferred term. Further details for a term can be found by entering the SNOMED CT code in the **SNOMED CT Concept Lookup** tool.

Some data elements are restricted to a definite set of SNOMED CT concepts, while others are more open-ended and allow the user to select from a wider set of concepts, usually within a certain hierarchy or sub-hierarchy – eg, the set of all disease concepts. See the **SNOMED CT Search and Data Entry Guide** for a guide to building a user-friendly search across the terminology.

The **SNOMED CT NZ Edition**, incorporating the SNOMED CT International Edition and released in April and October every year, is the standard distribution.

Where a data element in this standard uses SNOMED CT, the display is to show the agreed SNOMED concept term or synonym to the user and record the correct SNOMED CT identifier. Active SNOMED CT concepts must be selected when determining values for data elements.

4.1.3 Character sets

Text data elements must accommodate macrons for te reo Māori and diacritic characters for other commonly used languages. By default, this means using the Unicode Basic Latin, Latin-1 Supplement and Latin Extended A character sets.

ISO/IEC 10646:2017 Information technology – Universal Coded Character Set (UCS) is the recognised standard. UTF-8 is the recommended character encoding.

Alphabetic and alphanumeric codes and identifiers are restricted to printable Basic Latin characters.

5 Patient information

This section includes reference to data elements that are already defined and specified in other HISO standards. The format and values for each of these elements are to be obtained from the referenced HISO standard.

5.1 Identity information

The following table lists patient identity data elements, the content and format definitions of which are set out in HISO 10046 Consumer Health Identity Standard and the HISO 10094:2022 Māori Descent and Iwi Affiliation Data Protocols (see section: Error! Reference source not found. Error! Reference source not found.). This information is available to registered health care providers and includes demographic and other generic information. The information is mandatory except for the collection of iwi affiliation information, which is optional.

Consumer Health Identity Standard data elements:

- NHI number/identifier
- Date of birth
- Gender
- Ethnicity
- Date of death (mandatory only if patient is deceased)
- Language

Māori Descent and Iwi Affiliation Data Protocols data elements:

- Iwi Affiliation

5.2 Patient enrolment record

Community Oral Health Services are usually the primary provider of oral health services for pre-school and primary school-aged children and also for some adolescents. Enrolment in the service implies an expectation of a future service, and that services maintain patient enrolment records so they can (re)call an enrolled patient for a service. Monitoring an enrolled population, planning future service needs and recalling patients for services over a calendar year requires the capture of time-sensitive data. Oral health administrators require data that enables them to manage patient enrolment, reconcile school rolls and easily identify who in the eligible population is enrolled.

Service managers and clinicians need to understand why patients leave a service or become overdue for services, and the impact this may have on a patient's continuity of care. Equity of service access and oral health outcomes are understood from patient enrolment elements described in the following section. Data elements that constitute the patient enrolment record represent the current known enrolment status of the patient.

With the move to a national information system for administration of public oral health, having a single patient record per individual is an opportunity to simplify patient record management. However, this single patient record will be shared by all services (COHS and HDS in all districts), meaning that it should not be 'inactivated' if needed by another service. Therefore, patient record inactivation is limited to merging of duplicates, recording death of a patient, and deactivating test records.

Management of 'Service' or 'Programme' enrolment is recorded via patient enrolment records for COHS (see sections **5.2.5 - 5.2.7)**, and via recall, waitlist and referral records for HDS.

5.2.1 Activity status

Error! Reference source not found. Error! Reference source not found.

5.2.3 Patient record inactive reason

5.2.4 Public oral health service patient enrolment status

5.2.5 Primary oral health service the patient is enrolled in

5.2.6 Patient enrolment termination date

5.2.7 Patient enrolment termination reason

5.2.8 Error! Reference source not found.

5.2.9 School year level

5.2.10 School decile rating

5.2.11 School equity index rating

5.2.12 Water fluoridation status – education facility

5.2.13 Water fluoridation status – patient's home address

5.2.14 Earliest enrolment date for under-18 primary oral health service provider

5.2.15 Under-18 oral health service programme enrolment pathway

5.2.1 Activity status

While historically some services have recorded patients as inactive if enrolment terminates, this should now be recorded via **Patient enrolment termination**. The patient record shouldn't be inactivated unless the Patient is deceased, or the record is known to be a duplicate requiring a merge.

Name	Current patient activity situation
Definition	An indicator that the patient is currently receiving or is eligible to receive services from a service provider.
Source standards	
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)
Obligation	Mandatory
Guide for use	Activity status is: • about the patient in the Oral Health Information System (not about the service provider or funder) • established without reference to eligibility for service.

5.2.2 Patient record inactive date

Name	Date the patient activity ceased
Definition	The date the patient's record in the Oral Health Information System was made inactive.
Source standards	
Value domain	Date

Data type	Date
Layout	YYYYMMDD
Obligation	Mandatory on a response of 1 – Yes to section **5.2.1 Activity status**
Guide for use	When a response of 1 – Yes is recorded to section **5.2.1 Activity status** and an inactive date is not known, the date the patient's demographic record was last updated can be entered

5.2.3 Patient record inactive reason

Name	Reason the patient record was inactivated
Definition	The reason the patient's record status was inactivated.
Source standards	
Value domain	**Agreed term** / **Code** Archived / 1 Deceased / 2 Duplicate record merged / 3 Duplicate record awaiting merge / 4 Test patient / 5
Data type	Integer
Layout	NN
Obligation	Mandatory on a response to section Error! Reference source not found. Error! Reference source not found.
Guide for use	Archived – don't use until archiving processes & criteria are defined. Retention of Patient Records must be according to the **Dental Council Practice Standard for Patient Records**: Standard 11 Retention of patient records. Standard 11 is a requirement of the Health (Retention of Health Information) Regulations 1996 and also corresponds to Rule 9 of the Health Information Privacy Code 2020.

	Duplicate record awaiting merge – use only if delays in system record merging are expected. Note that recording termination of a patient's enrolment with a 'service' is through patient enrolment termination for COHS, and via recall, waitlist and referral records for HDS. So, reasons for inactivating a patient's record are limited to only those values above.

5.2.4 Public oral health service patient enrolment status

Name	Public oral health enrolment status
Definition	An indicator of the patient's current enrolment status with: a) COHS, or b) HDS for patient's seen under the Combined Dental Agreement.
Source standards	
Value domain	1 – Yes, enrolled 0 – No, not enrolled
Data type	Boolean
Layout	N(1,0)
Obligation	Mandatory
Guide for use	Default is '0 – No, not enrolled'

5.2.5 Primary oral health service the patient is enrolled in

Name	Enrolled patient service type
Definition	The service the patient is currently enrolled in (as the primary oral health service provider).
Source standards	

Value domain	<table><tr><th>Agreed term</th><th>Code</th></tr><tr><td>COHS</td><td>COHS</td></tr><tr><td>Oral health service for adolescents</td><td>OHSA</td></tr><tr><td>Emergency/temporary care because usual provider not available</td><td>ECDA</td></tr><tr><td>Special dental services</td><td>SDS</td></tr><tr><td>Other dental programmes</td><td>OTH</td></tr></table>
Data type	String
Layout	AAAA
Obligation	Optional
Guide for use	As an interim, this standard has focussed on programmes that provide primary oral health services to the under 18-year age group. OTH is a code to recognise any other publicly funded primary oral health programmes. Future versions of this standard will focus on standardisation of HDS services codes.

5.2.6 Patient enrolment termination date

Name	Patient enrolment termination date
Definition	The date a patient's enrolment is ended.
Source standards	
Value domain	Date
Data type	Date
Layout	YYYYMMDD
Obligation	Mandatory on a response of 0 – No to section **5.2.4 Public oral health service patient enrolment status**
Guide for use	Te Whatu Ora are considering defining a population enrolment approach in the Service specification. This guidance will reference that if or when it changes.

5.2.7 Patient enrolment termination reason

Patient enrolment is terminated when a patient is no longer within the criteria of the service (eg, COHS). Te Whatu Ora (TWO) are considering defining a population enrolment approach in the Service specification, at which time relevant guidance here will be updated to reference it. Note this section's values echo those in **7.9 Recall inactive/cancellation reason**. Ideally many of recall cancellations and their reasons will be auto-filled when the equivalent enrolment termination is recorded.

Name	Enrolment termination reason
Definition	The reason recorded in the Oral Health Information System that a patient's enrolment has been terminated.
Source standards	
Value domain	

Agreed term	Code
Entered in error	1
Left service catchment area	2
Moved overseas (confirmed)	3
Non-responder – assumed overseas	4
Non-responder – contacted	5
Non-responder – uncontactable	6
Not eligible	7
Patient deceased	8
Patient declined (following informed consent)	9
Transferred to Combined Dental Agreement	10
Transferred to private provider (opted out of publicly funded service)	12
Transfer to Special Dental Service Provider (under CDA)	13

Data type	Integer
Layout	NN

<table>
<tr><td>Obligation</td><td>Mandatory on a response of 0 – No to section 5.2.4 Public oral health service patient enrolment status</td></tr>
<tr><td>Guide for use</td><td>
<table>
<tr><th>Agreed term</th><th>Details</th></tr>
<tr><td>Entered in error</td><td></td></tr>
<tr><td>Left service catchment area</td><td>Not to be used unless Te Whatu Ora decide the receiving area will create a new enrolment record as part of transfer (ie, Enrolment record doesn’t just have a District identifier change made).</td></tr>
<tr><td>Moved overseas (confirmed)</td><td>Use when the service has confirmed the patient has moved overseas.</td></tr>
<tr><td>Non-responder – assumed overseas</td><td>Leaving New Zealand is a legitimate reason for exiting COHS enrolment. Use when ALL efforts at contact have been made, including data mining other services, BUT there are likely but unconfirmed indications the patient has moved overseas.</td></tr>
<tr><td>Non-responder - contacted</td><td>TWO/MH are considering defining a population enrolment approach in the Service specification. The ‘Non-responder – contacted’ Enrolment termination reason would not be allowed under this population enrolment approach.</td></tr>
<tr><td>Non-responder – uncontactable</td><td>TWO/MH are considering defining a population enrolment approach in the Service specification. This Enrolment termination reason would not be allowed under this population enrolment approach.</td></tr>
</table>
</td></tr>
</table>

	Not eligible	'Not eligible' probably isn't necessary as an Enrolment termination, unless a provider *chooses* to enrol patients only eligible for Acute or ACC funded care. These could be handled using Recalls instead and this probably would result in less confusion about entitlement.
	Patient deceased	
	Patient declined (following informed consent)	Use when patient's decision is for enrolment entirely, but they aren't transferring to a private provider.
	Transferred to Combined Dental Agreement	Ideally, for Districts where all patients age out after Year 8 (or similar), recording of bulk transfer to CDA will be automated. However, this reason would also cover older (or younger) than Y8 patients transferring. Note that patients transferring to a Special Dental Service Provider under the CDA should be recorded under Transfer to Special Dental Service Provider (under CDA) instead.
	Transferred to Private Provider (opted out of publicly funded service)	
	Transfer to Special Dental Service Provider (under CDA)	Patients transferring to the CDA under Special Dental Service providers should be recorded under this category only if it is necessary for the patient to be released from the COHS to a

		Special Dental Service provider.

Retention of patient records must be according to the **Dental Council Practice Standard for Patient Records**: Standard 11 Retention of patient records. Standard 11 is a requirement of the Health (Retention of Health Information) Regulations 1996 and also corresponds to Rule 9 of the Health Information Privacy Code 2020.

5.2.8 Current education facility

The collection of current education facility data supports school roll reconciliation with those in the Oral Health Information System. It helps administrators to identify patients who are no longer active in the service or who have moved to a different education facility within the last 12 months. Current education facility may be an early childhood education centre, day care facility, home schooling, tertiary education facility or tertiary training programme provider.

Name	Educational facility number
Definition	The education facility the patient is currently enrolled at.
Source standards	
Value domain	See Error! Reference source not found.
Data type	String
Layout	X(5)
Obligation	Mandatory on a response to section **5.2.5 Primary oral health service the patient is enrolled in**. Optional for other patients.
Guide for use	

5.2.9 School year level

This records the child's school year level at the education facility they currently attend (as defined by the Ministry of Education). School year level is used to manage transitions, such as when children at the end of school year 8 transition to the Combined Dental Agreement and are enrolled with a community service provider.

Name	Year of schooling
Definition	The child's school year level.
Source standards	
Value domain	0 – 13 99 (preschool)
Data type	Integer
Layout	NN
Obligation	Mandatory on a relevant response to section **5.2.8** Error! Reference source not found.. Otherwise, conditional.
Guide for use	There are around 13 years in the New Zealand school system, which begins at primary school. Primary school covers years 0 to 8 if the school is a 'full' primary school, or years 0 to 6 if it's a 'contributing' primary school.

5.2.10 School decile rating

The Ministry of Education has replaced the school decile rating system with the Equity Index system from 2023. This section is retained for transitional purposes while the Equity Index system is implemented into contracts and systems.

While school decile can be derived from the government list of New Zealand schools, not all schools are listed. A school's decile rating reflects the percentage of its students that live in low socioeconomic or poorer communities.

Name	School decile number
Definition	The decile score of the school attended by the patient.
Source standards	See Error! Reference source not found.
Value domain	1 – 10
Data type	Integer
Layout	NN
Obligation	Mandatory on a response other than 9999x to section **5.2.8** Error! Reference source not found.

Guide for use	Rating is on a scale of 1 – 10. Lower decile schools (those with a decile rating of 1–3) have more students living in poorer communities.

5.2.11 School equity index rating

The Ministry of Education published the Equity Index (EQI) in January 2023 to replace the decile rating. The EQI estimates the extent to which student face socio-economic barriers to achievement at school and is a much more accurate measure than the decile rating.

Name	School equity index value
Definition	The equity index value of the school attended by the patient.
Source standards	**EQI numbers**
Value domain	Valid EQI number
Data type	Integer
Layout	NNN
Obligation	Mandatory on a response to **5.2.8** Error! Reference source not found. that includes a New Zealand School identifier.
Guide for use	Rating is on a scale of 344-569. A higher EQI number indicates a school has students facing more or greater socio-economic barriers.

5.2.12 Water fluoridation status – education facility

This is required for children enrolled from birth to the end of school year 8, unless the child is transferred to a provider delivering services under the Combined Dental Agreement or the HDS.

Name	Education facility fluoride status
Definition	The water fluoridation status operating at the child's current education facility.
Source standards	
Value domain	**Agreed term** / **Code** Not recorded / 0

	<table><tr><td>Fluoride</td><td>1</td></tr><tr><td>Non-fluoride</td><td>2</td></tr></table>
Data type	Integer
Layout	N
Obligation	Mandatory for those enrolled from birth to the end of school year 8 and are attending an educational facility. **Not required** if the child is transferred to a provider delivering services under the Combined Dental Agreement or the HDS.
Guide for use	The water fluoridation status of children attending school is derived from the fluoridation status of water delivered to the school or early childhood facility the child attends. If the child is home-schooled, the fluoridation status of water delivered to the child's residential address should be reported under section **5.2.13 Water fluoridation status – patient's home address**

5.2.13 Water fluoridation status – patient's home address

Name	Patient home fluoride status
Definition	An indicator to capture the water fluoridation status operating at the patient's home address.
Source standards	
Value domain	<table><tr><th>Agreed term</th><th>Code</th></tr><tr><td>Not recorded</td><td>0</td></tr><tr><td>Fluoride</td><td>1</td></tr><tr><td>Non-fluoride</td><td>2</td></tr></table>
Data type	Integer
Layout	N

Obligation	Optional for children enrolled from birth to the end of school year 8. The obligation will be set to mandatory once a suitable systematic collection mechanism is established.
Guide for use	If the child is pre-school age or home-schooled, the fluoridation status of the child's residential address should be reported.

5.2.14 Earliest enrolment date for under-18 primary oral health service provider

The earliest enrolment date may differ from the date the patient is initially registered in the Oral Health Information System. Some oral health services register a patient at birth to indicate that the parent/guardian may want to use the service at some point in the future.

Name	Earliest patient enrolment date
Definition	The date the patient first enrolled in the under 18–oral health services programme
Source standards	
Value domain	Date
Data type	Date
Layout	YYYYMMDD
Obligation	Mandatory if the patient is under 18 years of age
Guide for use	If enrolment date is not recorded in the Oral Health Information System, the patient may not be included in Service enrolment statistics reporting
Validation rules	Valid date that is: a) greater than or equal to both 1 January 2001 and the patient's date of birth (section **5.1 5.1 Identity** information 5.2 Patient enrolment record 5.3 Service coordination data

	b) Identity information), and c) less than or equal to the current date

5.2.15 Under-18 oral health service programme enrolment pathway

Some regions have a multi-enrolment/registration process at birth, while others use an oral health coordinator who attends maternity clinics to enrol new-borns. In the case of relief of pain or when a patient moves into a district, enrolment may be self-referred (initiated by the patient, parent or guardian contacting the service) or by an external organisation/referrer.

Name	Source of enrolment
Definition	How the patient came to be enrolled in the under–18 oral health service programme
Source standards	
Value domain	**Agreed term** / **SCTID** Birth notification / 312486000 Referral from another provider / 3457005 Self-referral / 306098008 Identified by reconciliation of educational institution information / 301621000210105
Data type	Integer
Layout	N(18)
Obligation	Optional if the patient is under 18 years of age
Guide for use	

5.3 Service coordination data

Service co–ordination data enables an oral health service provider to understand the patient's clinic location and provider preferences, and to be aware of a patient's needs in respect of appointment planning and support when receiving a service. Collection of this data supports the analysis of service throughput.

Data elements:

5.3.1 Provider information

5.3.2 Special assistance requirement(s)

5.3.3 Siblings/household members enrolled in service

5.3.4 Attendance coordination alert indicator

5.3.1 Provider information

This section specifies information available to registered health care providers that should only be obtained from the HPI system. The format and description of the information is documented in Error! Reference source not found.. The information is mandatory.

Required data elements:

- Patient preferred oral health practitioner – the **Common person number**
- Current patient service – the **Organisation identifier**

Name	HPI - ORG
Definition	A unique 8-character ID assigned by the HPI system to an individual organisation
Source standards	
Value domain	
Data type	String
Layout	GXXNNN-C
Obligation	Mandatory
Guide for use	Only the HPI system generates an HPI organisation identification (HPI ORG ID). This ID is not re-used once assigned. Where more than one HPI ORG exists for an organisation, one is declared ‘live’ and all other HPI ORG IDs are made ‘dormant’ and attached to the live record. The HPI ORG ID is the primary key for organisation records. A Modulus 11 check digit routine is run over the organisation identifier to produce the organisation identifier check digit

Verification rules	G is a constant prefix. X is either an alphabetic or a numeric. N is a numeric C is the Check Digit established using the Modulus 11 system.

- Facility identifier Patient preferred clinic location – the **Facility identifier**

5.3.2 Special assistance requirement(s)

Patient special assistance terms and codes are used to enable the service to understand how a patient's special needs impact the support they need to receive a service.

Name	Special needs specification
Definition	Identification of the type of service support the patient needs or relies on attending an appointment.
Source standards	
Value domain	**Agreed term** / **SCTID** Interpreter / 315593009 Hoist / 228614007 Extra time / 171661000210103 Appointment assistance (attendant) / 715930009 Wheelchair / 105503008 Guide dog *(SNOMED CT preferred term is 'Dependence on seeing eye dog')* / 105506000 Pre-requirement for antibiotics / 422181004 Advice about medication dosage / 768729006 Cultural support / 301631000210107

Data type	Integer
Layout	N(18)
Obligation	Optional
Guide for use	Up to ten instances of support requirement may be recorded. Where 'Interpreter' is selected, record the language (see section **5.1 5.1 Identity** information 5.2 Patient enrolment record 5.3 Service coordination data Identity information)

5.3.3 Siblings/household members enrolled in service

Name	Enrolled family members
Definition	An indicator that the patient has siblings/household members enrolled in the service.
Source standards	
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)
Obligation	Optional
Guide for use	For use when coordinating family appointments. This data item should be system derived from having family members linked together in the system.

5.3.4 Attendance coordination alert indicator

Name	Coordination need advisory
Definition	An indicator that the patient may require special liaison to co-ordinate appointment times.
Source standards	
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)
Obligation	Optional
Guide for use	To be used to identify patients who may require special liaison to identify suitable times for appointments

6 Clinician information

The consistent collection of information about the oral health clinical workforce will improve understanding of how the workforce is being used (such as the incidence of preventive work), and whether professional development is needed.

6.1 Provider information

This section specifies information available to registered health care providers that should only be obtained from the HPI system The format and description of the information is documented in Error! Reference source not found.. The information is mandatory except for the collection of facility information, which is optional.

Required data elements:

- Oral health practitioner – the Common person number (CPN)
- Referred from organisation – the Organisation identifier

Name	HPI - CPN
Definition	A unique six-character identifier assigned by the HPI system to an individual person
Source standards	
Value domain	Valid CPN only
Data type	String
Layout	NCAAAA
Obligation	Mandatory, except for registrars (students) and dental assistants
Guide for use	Only the HPI system generates a new unique CPN which is the primary key for person records. This CPN is not re-used once assigned.

	Where more than one CPN exists for a single person, one CPN is declared ‘live’ and all other CPNs are made ‘dormant’ and attached to the live record. The CPN is the primary key for person records. A Modulus 11 routine is used to produce the identifier check digit Registrars (students), and dental assistants aren't currently covered by the HPI-CPN, and therefore it's not possible to record a CPN for them. Instead, currently these groups record their identity in the Oral Health Information System using identities assigned locally in Te Whatu Ora Districts. The intent of current work is for both these groups to eventually be able to record a unique identifier for themselves via the HPI-CPN mechanism. Once this (or similar) is possible the obligation will be updated.
Verification rules	N – is a number excluding number zero “0” A – is an alpha character excluding letter ‘I’ or ‘O’ C – is a check digit number in the second position calculated using check digit Modulus 11.

- Organisation identifierReferred from facility – the Facility identifier

Name	HPI - ORG
Definition	A unique 8-character ID assigned by the HPI system to an individual organisation
Source standards	
Value domain	
Data type	String
Layout	GXXNNN-C
Obligation	Mandatory

Guide for use	Only the HPI system generates an HPI organisation identification (HPI ORG ID). This ID is not re-used once assigned. Where more than one HPI ORG exists for an organisation, one is declared 'live' and all other HPI ORG IDs are made 'dormant' and attached to the live record. The HPI ORG ID is the primary key for organisation records. A Modulus 11 check digit routine is run over the organisation identifier to produce the organisation identifier check digit
Verification rules	G is a constant prefix. X is either an alphabetic or a numeric. N is a numeric C is the Check Digit established using the Modulus 11 system.

6.2 Facility identifierProvider occupation code

Name	The occupation of the provider
Definition	A code representing the role or occupation of a health care provider/worker.
Source standards	
Value domain	See Error! Reference source not found.
Data type	Integer
Layout	N(18)
Obligation	Mandatory
Guide for use	Occupation is not to be confused with scope of practice (as applied to a practitioner under the Health Practitioners Competence Assurance Act 2003).

	An oral health care provider may have one or more professional occupations. The code used should be the most appropriate description of the professional occupation of the health care provider working with the patient and for the oral health service. **Note:** The fields ‘HPI Scope of practice’ and ‘ANZSCO Number’ are provided as guidance only. The SNOMED CT identifier (SCTID) code is the value that will be recorded.

7 Patient recall detail

Patient recall details are a record of future service recommended by a provider based on individual clinical need. A recall record consists of a purpose and a recall due date. 'Recall risk' (and ‘recall period’) are also influenced by factors other than clinical examination, such as familial/sibling oral health history, history of oral health non-attendance/completion and the water fluoridation status of a patient's home environment.

Patients can be recalled for COH and/or HD services. Te Whatu Ora reports annually on the number of pre-school and primary (to school year 8) children who are overdue for examination. Patient recall records enable a service to identify that a patient is overdue (in arrears) for a service. The data elements in this section assist in consistent monitoring of patient recall details and identify patients who are not receiving the services a provider has recommended.

Data elements:

7.1 Patient recall purpose code

7.2 Recall due date

7.3 Recall risk

7.4 Recall period

7.5 Recall status

7.6 Recall is overdue

7.7 Recall active

7.8 Recall inactive/cancellation date

7.9 Recall inactive/cancellation reason

7.1 Patient recall purpose code

Districts currently use recalls that can specify the need to be examined by a clinician (eg, therapist review, hygienist) or the service to be provided (for example: annual assessment, fluoride application, oral medicine, oral surgery). This will change with the new national system to reflect recall purpose, and for COHS use, to distinguish routine examination recalls from other types, as these are core to active management and also track COHS exam recall management metrics. Provision is also made for a set of recall purpose codes for HDS, which would be filtered out for COHS use, but enabled for HDS use.

<table>
<tr><td>Name</td><td>Patient recall reason</td></tr>
<tr><td>Definition</td><td>A code for the purpose of the patient’s recall.</td></tr>
<tr><td>Source standards</td><td></td></tr>
<tr><td>Value domain</td><td>
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>COHS use:</td><td>-</td></tr>
<tr><td>Routine oral examination</td><td>51733004</td></tr>
<tr><td>Fluoride application</td><td>68071007</td></tr>
<tr><td>High risk caries</td><td>426482000</td></tr>
<tr><td>HDS use:</td><td>-</td></tr>
<tr><td>Values for HDS use to be agreed by HDS in a future update.</td><td>-</td></tr>
</table>
</td></tr>
<tr><td>Data type</td><td>Integer</td></tr>
<tr><td>Layout</td><td>N(18)</td></tr>
<tr><td>Obligation</td><td>Mandatory</td></tr>
<tr><td>Guide for use</td><td>A patient may have one or more recalls concurrently with different services, ie, COHS and HDS.

Recall purpose codes and terms should be specific to services/oral health programmes and should not refer to the role of the service provider.

‘Routine oral examination’ Recalls are core to tracking COHS recall management metrics.</td></tr>
</table>

7.2 Recall due date

Name	Date recall due
Definition	The date by which the expected service associated with a recall is due to be completed.
Source standards	
Value domain	Date
Data type	Date

Layout	YYYYMMDD
Obligation	Mandatory
Guide for use	

7.3 Recall risk

Name	Recall associated risk
Definition	The risk associated with the recall purpose identifier (as documented in section **7.1 Patient recall purpose code**).
Source standards	
Value domain	**Agreed term** / **SCTID** None (not specified) / 260413007 Low / 609400006 Moderate / 609401005 High / 609402003 Very high / 609403008
Data type	Integer
Layout	N(18)
Obligation	Mandatory
Guide for use	This list reflects the recall categories currently available in oral health information systems. The recognition of recall risks in this standard supports the development of business rules and recall workflow management guidelines that will support the development of nationally consistent reporting queries.

7.4 Recall period

Te Whatu Ora service standards require enrolled children to be recalled at regular intervals depending on their risk of oral health disease.

Name	Recall time period
Definition	The time interval (in months), between the last examination/service and the recommended future service.
Source standards	
Value domain	Integers greater than zero
Data type	Integer
Layout	NN
Obligation	Mandatory
Guide for use	

7.5 Recall status

Name	Recall workflow status
Definition	The current workflow status of a patient's recall.
Source standards	
Value domain	

Agreed term	Code
Awaiting consent	7
Booked	9
Cancelled	4
Contacted	2
Completed	3
Due	8
Purged	5
Under treatment	6

Data type	Integer

Layout	N
Obligation	Optional
Guide for use	The status reflects the current auditable recall workflow in oral health information systems. The recognition of status in this standard supports the development of business rules and recall workflow management guidelines that will support the development of nationally consistent reporting queries.

7.6 Recall is overdue

Name	Overdue recall flag
Definition	An indicator that a recall is currently overdue (sometimes referred to as being ‘in arrears’).
Source standards	
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)
Obligation	Mandatory on a response of 1 – Yes to section **5.2.4 Public oral health service patient enrolment status**
Guide for use	This is a reporting indicator and may not be captured in oral health information systems.

7.7 Recall active

Name	Current recall status
Definition	An indicator that the recall is currently active (not cancelled).
Source standards	
Value domain	1 – Yes 0 – No

Data type	Boolean
Layout	N(1,0)
Obligation	Mandatory
Guide for use	This is a reporting indicator and may not be captured in oral health information systems.

7.8 Recall inactive/cancellation date

Name	Recall closure date
Definition	The date a recall was made inactive or cancelled.
Source standards	
Value domain	Date
Data type	Date
Layout	YYYYMMDD
Obligation	Mandatory on a response of 0 – No to section **7.7 Recall active**
Guide for use	

7.9 Recall inactive/cancellation reason

Recalls may be made inactive or cancelled because the service is unable to contact the patient or at the patient's request. However, every effort to contact patients should be made, including data mining other services. Te Whatu Ora are considering defining a population enrolment approach in the Service specification. See the guidance below each category. The guidance will be refined if a population enrolment approach is accepted.

Name	Recall closure reason
Definition	The reason recorded in the Oral Health Information System that a recall has been cancelled or made inactive.
Source standards	
Value domain	**Agreed term** / **Code** Entered in error / 1

	<table><tr><td>Left service catchment area</td><td>2</td></tr><tr><td>Moved overseas (confirmed)</td><td>3</td></tr><tr><td>Non-responder – assumed overseas</td><td>4</td></tr><tr><td>Non-responder – contacted</td><td>5</td></tr><tr><td>Non-responder – uncontactable</td><td>6</td></tr><tr><td>Not eligible for recall</td><td>7</td></tr><tr><td>Patient deceased</td><td>8</td></tr><tr><td>Patient declined (following informed consent)</td><td>9</td></tr><tr><td>Transferred to Combined Dental Agreement</td><td>10</td></tr><tr><td>Transfer to HDS</td><td>11</td></tr><tr><td>Transferred to private provider (opted out of publicly funded service)</td><td>12</td></tr><tr><td>Transfer to Special Dental Service Provider (under CDA)</td><td>13</td></tr><tr><td>Discharged from HDS (to referrer) – [HDS use only]</td><td>14</td></tr><tr><td>Single course of care – [HDS use only]</td><td>15</td></tr></table>
Data type	Integer
Layout	NN
Obligation	Mandatory on a response of 0 – No to section **7.7 Recall active**
Guide for use	<table><tr><th>TERM</th><th>NOTES</th></tr><tr><td>Entered in error</td><td></td></tr><tr><td>Left service catchment area</td><td>Not to be used if we decide the receiving area will pick up the active recall as part of transfer.</td></tr></table>

	Instead, the recall should be left active.
Moved overseas (confirmed)	Use when the service has confirmed the patient has moved overseas. Ideally recording this Recall cancellation reason will be automated when the Enrolment is terminated with the same reason.
Non-responder – assumed overseas	Leaving New Zealand is a legitimate reason for exiting COHS enrolment. Use when ALL efforts at contact have been made, including data mining other services, BUT there are likely but unconfirmed indications the patient has moved overseas. Ideally recording this Recall cancellation reason will be automated when the Enrolment is terminated with the same reason.
Non-responder - contacted	TWO are considering defining a population enrolment approach in the Service specification. The 'Non-responder – contacted' Recall cancellation reason would be allowable under this approach, but continued active management is encouraged.
Non-responder – uncontactable	TWO are considering defining a population enrolment approach in the Service specification. This Recall cancellation reason would be allowable under this approach, but continued active management is encouraged.

Not eligible for recall	Use where patient isn't eligible beyond a single course of care – eg, ineligible for enrolment, but eligible for acute care.
Patient deceased	Ideally recording this Recall cancellation reason will be automated when the Enrolment is terminated, or the Patient record inactivated with the same reason.
Patient declined (following informed consent)	This may relate to a particular treatment, or enrolment in the service entirely. IF just a particular treatment, a new exam recall record should be recorded if there isn't one active.
Transferred to Combined Dental Agreement	Ideally, for Districts where all patients age out after Year 8 (or similar), recording of bulk transfer to CDA will be automated. However, this reason would also cover older (or younger) than Y8 patients transferring. Note that patients transferring to a Special Dental Service Provider under the CDA should be recorded under that category instead.
Transfer to HDS	Use when a patient is referred to an HDS, to inactivate their current (COHS) recall until their referral completes – but only if this is necessary. The referral process will handle the actual referral. This just inactivates the recall if needed, .

	Transferred to Private Provider (opted out of publicly funded service)	Ideally recording this Recall cancellation reason will be automated when the Enrolment is terminated with the same reason.
	Transfer to Special Dental Service Provider (under CDA)	Patients transferring to the CDA under Special Dental Service Providers should be recorded under this category if their recalls should stop while under SDS Provider care.
	Discharged from HDS (to referrer)	[HDS use only]. Use when the patient has been referred to the HDS by another oral health provider who will continue their care after discharge.
	Single Course of Care	[HDS use only] Use when a patient received a single course of care, AND wasn't referred by their 'normal' oral health care provider. If they were referred by their 'normal' oral health provider, use 'Discharged from HDS [to referrer]' instead.

8 Incoming referral information

A referral is a transfer of some or all of the responsibility for the care of a patient for a particular purpose. Incoming referrals are received from private dentists or general practitioners (GPs), other oral health service providers and clinicians from other specialties. Oral health referrals may be recorded in one or more district information systems – particularly during the transition to a single national public Oral Health Information System. Information collected about referrals for oral health service delivery should be aligned with **National Patient Flow** data collection.

An ’internal’ referral is one made within the national public Oral Health Information System. For example, between a District COHS and a District HDS where both are served by the same system. This section indicates the relevance of each data element for ‘internal’ referrals under ’Guide for use’

Collecting consistent referral information will enable understanding of what is driving the demand for specialist oral health services; whether patients are waiting for oral health services in order to receive other specialist treatment; service wait times; and the reasons patients are removed from hospital waiting lists. Referrers do not always know the status of patients they have referred for specialist services; some of the data elements described in this section are concerned with keeping referrers informed about the service delivery status of patients they have referred.

8.1 Referral details duplicated in districts' clinical workstations

Name	Referral duplication flag
Definition	An indicator that a referral is recorded in a public hospital clinical workstation.
Source standards	
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)
Obligation	Optional
Guide for use	Not needed for an internal referral as the incoming referral record is already in the system.

8.2 Source of referral

Name	Referral source
Definition	A code categorising the source of referral
Source standards	
Value domain	

Agreed term	SCTID
Community dental practitioner • Community oral health practitioner, or • COHS clinician	301641000210104
General medical practitioner	309014007
General dental practitioner	301651000210101
Emergency department (own District)	301661000210103

	Emergency department (other District)	301671000210109
	Dental specialist (own District)	301681000210106
	Dental specialist (other District)	301691000210108
	Specialist (own District)	2031000124104
	Specialist (other District)	301741000210106
	Well Child Tamariki Ora Programme	301701000210108
	School nurse	301771000210101
	School teacher	301751000210109
	Social worker	185365002
	Public health nurse	301731000210103
	Nurse practitioner	301721000210100
	Self	1991000124105
	Other agency	309015008
	Aged residential care facility	719023008
	Youth justice facility	301781000210104
	Allied health practitioner	306056005
	Lead maternity carer	301711000210105
	Other health worker	301821000210106
Data type	Integer	
Layout	N(18)	
Obligation	Optional	
Guide for use	For internal referrals the referral source is limited to: • Community dental practitioner • General dental practitioner • Dental specialist (own/other district) Referral source cannot always be clearly differentiated (for example, where a GP has a primary care practice but	

	attends a patient who lives in a residential care facility). District services can opt to implement a reduced list or use local codes that are mapped to these sources. This list may be extended in the future.

8.3 Service prioritisation decision

Name	Service prioritisation decision
Definition	The referral prioritisation decision
Source standards	Te Whatu Ora – National Collections – **National Patient Flow – see section 12.20.**
Value domain	**Agreed term** / **Code** Accepted / A Declined / D Transferred / T Not decided / N
Data type	String
Layout	A
Obligation	Mandatory
Guide for use	Required also for internal referrals

8.4 Reason referral declined

Name	Declined referral reason
Definition	The reason why the service declined a referral
Source standards	Te Whatu Ora – National Collections – **National Patient Flow section 12.21 (refer to the note in the Guide for Use below)**
Value domain	**Agreed term** / **Code** Insufficient information / 03

	<table><tr><td>Service not required</td><td>04</td></tr><tr><td>Access criteria not met</td><td>05</td></tr><tr><td>Not eligible</td><td>06</td></tr><tr><td>Transferred to another service</td><td>07</td></tr><tr><td>Patient not medically fit for service</td><td>09</td></tr><tr><td>Service/sub-specialty not offered by district</td><td>10</td></tr><tr><td>Treatment provided elsewhere</td><td>11</td></tr></table>
Data type	Integer
Layout	NN
Obligation	Mandatory on a response of **Declined** to section **8.3 Service prioritisation decision** (includes internal referrals)
Guide for use	The reason a referral has been declined may be defined by the clinician (when prioritising the referral) or by the service). Note: Codes 10 and 11 are not part of the National Patient Flow source standard. They are additional codes for this standard only.

8.5 Referrer notification indicator

Name	Referral notification flag
Definition	An indication that the referrer has been notified of the service prioritisation decision.
Source standards	
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)

Obligation	Optional
Guide for use	For internal referrals the OHIS should derive this indicator. For non-internal referrals, recording is manual. Default is 0 – No

8.6 Treatment plan linked to referral

Linking treatment plans to a referral will enable services to better understand patients' end-to-end health care journey.

Name	Treatment plan link flag
Definition	An indication that the treatment plan has been linked to the referral.
Source standards	
Value domain	1 – Yes (active) 0 – No (inactive)
Data type	Boolean
Layout	N(1,0)
Obligation	Mandatory
Guide for use	This is always derived from the existence or otherwise of the linking action Required also for internal referrals. There may be one or multiple treatment plans linked/associated with the referral.

8.7 Receiving other services from a non-dental service provider

Name	Other services flag
Definition	An indication that the patient is currently receiving other (non-dental) specialty services (in a hospital or community delivery setting).

Source standards	
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)
Obligation	Optional
Guide for use	May also be relevant for an internal referral. This field can be used to indicate service inter-dependencies (eg, where oral health services are required before the patient can receive other planned care).

8.8 Dental waiting list indicator

This dental wait list indicator, when combined with section **8.7 Receiving other services from a non-dental service provider,** helps oral health services to understand how many dental wait-listed patients are also on other specialty waiting lists where dental services are a dependency of other treatment.

Name	Wait list flag
Definition	An indicator that a patient has a wait-listed dental procedure
Source standards	
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)
Obligation	Optional
Guide for use	May also be relevant for an internal referral.

8.9 Hospital waiting list removal reason

<table>
<tr><td>Name</td><td>Wait list removal reason (for an exception)</td></tr>
<tr><td>Definition</td><td>The reason the patient’s procedure has been cancelled and removed from the hospital waiting list.</td></tr>
<tr><td>Source standards</td><td>Te Whatu Ora – National Collections – <u>National Patient Flow section 12.14.</u></td></tr>
<tr><td>Value domain</td><td>
<table>
<tr><th>Agreed term</th><th>Code</th></tr>
<tr><td>Patient not available (suspended)</td><td>1</td></tr>
<tr><td>Patient decision not to proceed</td><td>3</td></tr>
<tr><td>Patient deceased</td><td>4</td></tr>
<tr><td>Patient treated elsewhere</td><td>5</td></tr>
<tr><td>Entered on list in error</td><td>6</td></tr>
<tr><td>Patient received services acutely</td><td>7</td></tr>
<tr><td>Patient ineligible for publicly funded care</td><td>8</td></tr>
<tr><td>Patient referred to another District for care</td><td>9</td></tr>
<tr><td>Patient medically unfit (cancelled)</td><td>10</td></tr>
<tr><td>Patient medically unfit (suspended)</td><td>11</td></tr>
<tr><td>Patient did not attend booking (suspended)</td><td>14</td></tr>
</table>
</td></tr>
<tr><td>Data type</td><td>Integer</td></tr>
<tr><td>Layout</td><td>NN</td></tr>
<tr><td>Obligation</td><td>Mandatory</td></tr>
<tr><td>Guide for use</td><td>Required also for internal referrals</td></tr>
</table>

8.10 Incoming referral cancellation reason

Name	Incoming referral closure reason
Definition	The reason the patient's referral has been cancelled.
Source standards	Te Whatu Ora – National Collections – **National Patient Flow section 12.14**
Value domain	

Agreed term	Code
Patient not available (suspended)	1
Patient decision not to proceed	3
Patient deceased	4
Patient treated elsewhere	5
Entered on list in error	6
Patient received services acutely	7
Patient ineligible for publicly funded care	8
Patient referred to another District for care	9
Patient medically unfit (cancelled)	10
Patient medically unfit (suspended)	11
Patient did not attend booking (suspended)	14

Data type	Integer
Layout	NN
Obligation	Mandatory
Guide for use	Required also for internal referrals

8.11 Referrer notified removed from waiting list

Name	Referrer notification flag

Definition	An indicator that the referrer has been advised the patient has been removed from the hospital waiting list
Source standards	
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)
Obligation	Optional
Guide for use	Relevant also for internal referrals but should be derived.

9 Outgoing referral information

Outgoing referral information describes a referral that is made from a service to another service (such as a referral made from a COHS to an HDS). The data elements described in this section enable the service to track the progress of patients who are referred out of their service (where information is provided by the referred–to service).

'Internal' outgoing referral information is the same, but the service receiving the referral is also within the national public Oral Health Information System. This section indicates the relevance of each data element for 'internal' referrals under 'Guide for use'.

9.1 External service referral prioritisation decision

Name	External service referral prioritisation status
Definition	The way in which the external service has advised they have prioritised the outgoing referral.
Source standards	Te Whatu Ora – National Collections – **National Patient Flow – see section 12.20**
Value domain	**Agreed term** / **Code** Accepted / A Declined / D Transferred / T Not decided / N
Data type	String
Layout	A

Obligation	Optional
Guide for use	For internal referrals, this information should be available within the OHIS (section **8.3 Service prioritisation decision**) and does not need duplication.

9.2 Public Oral Health waiting list

Name	Wait listed flag
Definition	An indication that the patient is wait listed for the service
Source standards	
Value domain	**Agreed term** / **Code** Yes / 1 No / 2 Unknown / 3
Data type	Integer
Layout	N
Obligation	Optional
Guide for use	For internal referrals, this information should be available within the OHIS (section **8.8 Dental waiting list indicator**) and does not need duplication.

9.3 Referral discharge summary received

Name	Discharge summary date
Definition	The date an outgoing referral discharge summary was received.
Source standards	
Value domain	Date
Data type	Date
Layout	YYYYMMDD

Obligation	Optional
Guide for use	For incoming referrals, this information should be available within the OHIS from the incoming referral discharge summary and does not need duplication.

10 Consent

Consent recognises the terms, rules and conditions related to the authorisation or restrictions of service delivery. Every informed consent process is different, and every interaction (including any attempts to engage) with a patient, parent, legal guardian or family member by any form of communication is part of the informed consent process. Written clinical notes about the nature of the conversation a service provider had with the patient/guardian are always required.

The data elements in this section record screening or treatment consent. Consent can be one-off, given until advised differently, or expires on a specified date. Service providers can obtain examination and preventive services consent at the time of enrolment/registration with a service. Treatment consent tends to be recorded in a specific treatment plan. Recognition of the type of consent obtained not only comprises essential clinical record–keeping but also supports decision-making by appointment administrators.

Consent is not a ‘tick-box’ exercise; the onus is on the clinician treating the patient to know what the patient or their guardian has consented to. Providers must be able to identify those patients for whom treatment has not yet gone ahead because consent has not been obtained.

Note: At time of publication, a review of consent data is underway by Te Whatu Ora. This standard will be updated to reflect any relevant changes from the review.

10.1 Category code

Name	Service category
Definition	A category code that classifies the service context for consent
Source standards	
Value domain	**Agreed term** / **Code** COHS / 1 HDS / 2 Adolescent services (Combined Dental Agreement) / 3 Special dental services (Combined Dental Agreement) / 4
Data type	Integer
Layout	N
Obligation	Optional
Guide for use	The type of consent may vary according to whether the service is the patient's primary or secondary dental service provider. Recognising that implementation for Māori Oral Health Services may require additional categories, these category codes may be adjusted in future.

10.2 Scope of consent

A description of the activity/scope of consent that has been collected in advance for the patient (also known as screening consent).

Name	Scope of consent
Definition	The scope of activity for which consent is covered.
Source standards	
Value domain	**Agreed term** / **SCTID**

	<table><tr><td>Regular dental checks</td><td>34043003</td></tr><tr><td>Cleaning and scaling *(SNOMED CT preferred term is 'Dental scaling and polishing')*</td><td>234696006</td></tr><tr><td>Dental X-rays</td><td>22891007</td></tr><tr><td>Fluoride varnish</td><td>313042009</td></tr><tr><td>Fissure sealants/protection</td><td>234713009</td></tr><tr><td>Restoration of tooth</td><td>173307000</td></tr><tr><td>Tooth extraction</td><td>55162003</td></tr><tr><td>Sedation and anaesthesia</td><td>410011004</td></tr></table>
Data type	Integer
Layout	N(18)
Obligation	Optional
Guide for use	

10.3 Treatment on hold due to consent

Name	Treatment on hold flag
Definition	An indicator that treatment cannot proceed because the service has been unable to obtain consent.
Source standards	
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)
Obligation	Optional
Guide for use	

10.4 Examination and preventive services consent type

<table>
<tr><td>Name</td><td>Consent type</td></tr>
<tr><td>Definition</td><td>The type of consent given for examination and preventive services; recognition of this consent supports appointment administration.</td></tr>
<tr><td>Source standards</td><td></td></tr>
<tr><td>Value domain</td><td>
<table>
<tr><th>Agreed term</th><th>Code</th></tr>
<tr><td>Examinations – full</td><td>1</td></tr>
<tr><td>Examinations – refused</td><td>2</td></tr>
<tr><td>Examinations – partial</td><td>3</td></tr>
<tr><td>Preventive – full</td><td>4</td></tr>
<tr><td>Preventive – refused</td><td>5</td></tr>
<tr><td>Preventive – partial</td><td>6</td></tr>
</table>
</td></tr>
<tr><td>Data type</td><td>Integer</td></tr>
<tr><td>Layout</td><td>N</td></tr>
<tr><td>Obligation</td><td>Optional</td></tr>
<tr><td>Guide for use</td><td>The Examination and preventive services consent type is to be derived from 10.2 Scope of consent as follows:

[Examinations – full] = (regular dental checks) + (dental x-rays)

[Examinations – refused]

[Examinations – partial] = (regular dental checks) only

[Preventive – full] = (cleaning and scaling) + (fluoride varnish) + (fissure sealants/protection)

[Preventive – refused]</td></tr>
</table>

	[Preventive – partial] = any (but not all) of (cleaning and scaling) +/- (fluoride varnish) +/- (fissure sealants/protection) However, details of consent should always be written in the patient's clinical notes so consent can be appropriately respected and referenced. This is particularly important where consent is partial or conditional – eg, 'the parent is generally happy for fluoride varnish, but would prefer to be asked each time'.

10.5 Treatment consent type

Name	Consent type
Definition	The type of treatment consent given
Source standards	
Value domain	<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Full consent to treat</td><td>408835000</td></tr><tr><td>Declined consent to treat</td><td>737038009</td></tr><tr><td>Partial consent to treat</td><td>301871000210105</td></tr><tr><td>Not given: providing acute emergency care</td><td>301851000210102</td></tr></table>
Data type	Integer
Layout	N(18)
Obligation	Optional
Guide for use	Details of consent should always be written in the patient's clinical notes so consent can be appropriately respected and referenced. This is particularly important where consent is partial or conditional.

10.6 Status of examination or treatment consent

A patient may have multiple consent records. This data element recognises that the time interval for consent may have expired and needs to be renewed.

Name	Consent status
Definition	The current status of examination or treatment consent
Source standards	
Value domain	<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Active</td><td>55561003</td></tr><tr><td>Inactive</td><td>73425007</td></tr><tr><td>Entered in error</td><td>723510000</td></tr></table>
Data type	Integer
Layout	N(18)
Obligation	Optional
Guide for use	

10.7 Consent effective to date

A patient may have multiple records associated with their scope of consent.

Name	Date consent effective to
Definition	The date the consent expired
Source standards	
Value domain	Date
Data type	Date
Layout	YYYYMMDD
Obligation	Mandatory on a response of ‘Inactive’ or ‘Entered in error’ to section **10.6 Status of examination or treatment consent**

Guide for use	Consent is valid from when it is given to when it is withdrawn, and should be checked continually

10.8 Consent form

Name	Form of consent
Definition	They way in which consent was obtained
Source standards	
Value domain	**Agreed term** / **Code** Verbal / 1 Handwritten / 2 Electronically written / 3 Online health record / 4 Authority to treat without consent / 5 Treatment provided as emergency / 6
Data type	Integer
Layout	N
Obligation	Optional
Guide for use	Details of consent should be written in the patient's clinical notes.

10.9 Consent source

Name	Consent source
Definition	The person who gave consent
Source standards	
Value domain	**Agreed term** / **SCTID** Patient / 116154003 Legal guardian / 58626002

<table>
<tr><td></td><td><table>
<tr><td>Treatment without consent</td><td>303291000210106</td></tr>
<tr><td>Emergency treatment

(Dentist)</td><td>106289002</td></tr>
<tr><td>Enduring power of attorney</td><td>303341000210108</td></tr>
<tr><td>Other consent source</td><td>125676002</td></tr>
</table></td></tr>
<tr><td>Data type</td><td>Integer</td></tr>
<tr><td>Layout</td><td>N(18)</td></tr>
<tr><td>Obligation</td><td>Optional</td></tr>
<tr><td>Guide for use</td><td>“Other consent source” recognises circumstances not otherwise foreseen – such as for example where court action taken in the best interests of a child results in temporary power of attorney (or similar) being assigned to a clinician, organisation, or other entity.

Note that for “Treatment without consent” and “Emergency treatment”, the person giving consent is effectively the responsible clinician under <u>Right 7(4)(a) of the Health & Disability Code</u> (Treatment without consent), or <u>Clause 3 of the Health & Disability Code</u> (Emergency treatment).</td></tr>
</table>

11 Appointment information

Appointment information combined with patient demographics and service delivery information enables the service to understand how barriers to access impact population oral health.

The data elements and codes in this section will enable oral health administrators and clinicians to manage appointments, efficiently plan ahead, understand how many clinics and appointments are cancelled due to staff shortages and illnesses, and follow up high–needs patients who do not attend examinations and treatments.

The data elements in this section are not exhaustive and are likely to be the focus of a future version of this standard. For example, information on appointment service provider is also collected, but is likely to be text rather than the HPI CPN.

11.1 Appointment date/time

Name	Appointment date/time
Definition	The date and time of the patient's appointment.
Source standards	
Value domain	Date and time
Data type	Date/time
Layout	YYYYMMDD HH:MM
Obligation	Mandatory
Guide for use	The 24-hour clock time format is to be used.

11.2 Appointment length

Name	Appointment period
Definition	The allocated length of time of the booking in minutes.
Source standards	
Value domain	An integer greater than zero
Data type	Integer
Layout	NNN
Obligation	Mandatory
Guide for use	

11.3 New patient indicator

The new patient appointment indicator is set when a patient attends their first appointment. The indicator alerts providers that additional administration and attention is required on this visit.

Name	New patient flag
Definition	An indicator that the appointment is for a new patient.
Source standards	
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)
Obligation	Mandatory
Guide for use	

11.4 Date appointment cancelled

Name	Date appointment cancelled
Definition	The date on which a booking was cancelled.

Source standards	
Value domain	Date
Data type	Date
Layout	YYYYMMDD
Obligation	Conditional
Guide for use	

11.5 Reason appointment cancelled

Name	Reason appointment cancelled
Definition	The reason an appointment was cancelled.
Source standards	
Value domain	<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Patient unavailable</td><td>398090008</td></tr><tr><td>Staff sickness</td><td>405536006</td></tr><tr><td>Transport problems</td><td>266934004</td></tr><tr><td>Late arrival</td><td>185328004</td></tr><tr><td>Clinician unavailable</td><td>303301000210105</td></tr><tr><td>Facility unavailable</td><td>303311000210107</td></tr><tr><td>Administration error</td><td>723510000</td></tr><tr><td>Appointment no longer required</td><td>410529002</td></tr></table>
Data type	Integer
Layout	N(18)
Obligation	Mandatory on a valid date recorded in section **11.4 Date appointment cancelled** <table><tr><td>**Name**</td><td>New patient flag</td></tr><tr><td>**Definition**</td><td>An indicator that the appointment is for a new patient.</td></tr></table>

	Source standards |
	Value domain | 1 – Yes 0 – No
	Data type | Boolean
	Layout | N(1,0)
	Obligation | Mandatory
	Guide for use |
	Date appointment cancelled**.**
Guide for use	

11.6 Appointment status

Name	Appointment status
Definition	The status of a patient's appointment according to the Oral Health Information System workflow
Source standards	
Value domain	**Agreed term** | **SCTID** Booked | 385650005 Attended *(SNOMED CT preferred term is 'Seen in establishment')* | 410542002 Did not attend | 281399006 Cancelled | 89925002 Rescheduled | 703465008
Data type	Integer
Layout	N(18)
Obligation	Mandatory
Guide for use	

11.7 Number of reminders

Name	Reminder sequence number
Definition	The number of times a patient is reminded about the appointment
Source standards	
Value domain	Integer of zero or greater
Data type	Integer
Layout	NN
Obligation	Optional
Guide for use	

11.8 Appointment location

This section specifies location information available to registered health care providers that should only be obtained from the HPI system. The format and description of the information is documented in Error! Reference source not found.. The information is mandatory.

Required data element:
Facility code – the Facility identifier

Guide for use:
Each fixed clinic facility and location routinely visited by a mobile dental unit for both examination and treatment will need to be registered in the HPI Facility table to comply with this recording requirement.

Mobile dental unit sites where only examination (screening) or preventive services are provided also need their locations recorded. Further consideration is needed to determine whether this is their location of service, or their hub location where treatment will later be provided. This detail will be included in a future update.

The purpose behind this is to support district level forward service planning with location-based information to understand and plan for their changing demand and access patterns. This will also better support understanding of access and equity issues.

12 Course of care summary details

An oral health course of care (treatment plan) may include examinations, diagnoses, procedures, recording of notes and treatment consent. It may span one or more appointments. A course of care may be marked as completed and may involve invoicing.

The data elements defined in this section relate to information about the patient's planned and actual service (including service location, and whether treatment approval is required) and service completion status. Consistent recording of these details will enable service managers to understand how their service is performing in real time.

The course of care summary details record is also likely to include data elements defined elsewhere (such as the service provider/funder described in section **5.2.5 Primary oral health service the patient is enrolled in**).

12.1 Course of care/treatment plan unique identifier

12.2 Date examination / treatment course of care started

12.3 Date examination / treatment course of care completed

12.4 Number of service items in examination/treatment course of care

12.5 Course of care payor (programme or contract funder)

12.6 Course of care/treatment approval required

12.7 Course of care/treatment approval received

12.1 Course of care/treatment plan unique identifier

Name	Unique course of care treatment identifier
Definition	The unique identifier for an examination and treatment plan for a course of care
Source standards	
Value domain	
Data type	String

Layout	X(11)
Obligation	Mandatory for each course of care/treatment plan, and for each element forming the course of care/plan (effected by linking all elements into their plan).
Guide for use	The course of care may span multiple appointment dates, locations (facilities) and service providers. The identifier is unique to the Oral Health Information System.

12.2 Date examination / treatment course of care started

Name	Treatment start date
Definition	The date the examination and/or treatment course of care is planned to start.
Source standards	
Value domain	Full date
Data type	Date
Layout	YYYYMMDD
Obligation	Conditional
Guide for use	This date will be the earliest (minimum) 'Treatment planned date' for the examination and treatment course of care uniquely identified in section **12.1 Course of care/treatment plan unique identifier**.

12.3 Date examination / treatment course of care completed

Name	Treatment completed date
Definition	The date the examination and/or treatment course of care plan was completed.
Source standards	

Value domain	Full date
Data type	Date
Layout	YYYYMMDD
Obligation	Mandatory on completion of treatment
Guide for use	This is conditional on the service/treatment course of care being completed. It records the date at which the identified course of care specified in section **12.1 Course of care/treatment plan unique identifier** is completed. If treatment is not yet completed (or recorded) then this element may be left blank
Verification rules	Valid date that is: a) greater than or equal to the date in section **12.2 Date examination / treatment course of care started**, and b) less than or equal to the current date.

12.4 Number of service items in examination/treatment course of care

Name	Number of service items
Definition	The number of service items in an oral health examination/treatment course of care.
Source standards	
Value domain	1-99
Data type	Integer
Layout	NN
Obligation	Mandatory and based on the response to section **12.1 Course of care/treatment plan unique identifier**

Guide for use	The number of service items in an examination/treatment course of care can change over time as the course of care progresses. See section **13.1 Service code** for service items definition.

12.5 Course of care payor (programme or contract funder)

Name	Treatment funder code
Definition	The course of care programme or funder.
Source standards	
Value domain	<table><tr><th>Agreed term</th><th>Code</th></tr><tr><td>Community oral health services</td><td>COHS</td></tr><tr><td>Oral health service for adolescents</td><td>OHSA</td></tr><tr><td>Oral health services (Combined Dental Agreement - emergency/temporary enrolment)</td><td>ECDA</td></tr><tr><td>Special dental services</td><td>SDS</td></tr><tr><td>ACC funded programme</td><td>ACC</td></tr><tr><td>EDS (Emergency Dental Service)</td><td>EDS</td></tr><tr><td>Community Service Card funded</td><td>CSC</td></tr><tr><td>Other dental programmes</td><td>OTH</td></tr></table>
Data type	String
Layout	AAAA
Obligation	Mandatory
Guide for use	There are multiple local and regional publicly funded programmes in operation. ‘OTH’ is a code to signify that there is not yet a national code to recognise the patient’s enrolment in a particular dental programme.

	The data domain for this data element is expected to be expanded as national codes are introduced and need to be recognised.

12.6 Course of care/treatment approval required

Name	Required treatment approval flag
Definition	An indicator that prior approval is required before treatment can proceed
Source standards	
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)
Obligation	Mandatory on completion of treatment
Guide for use	

12.7 Course of care/treatment approval received

Name	Treatment received flag
Definition	An indicator that prior approval has been received for treatment to proceed.
Source standards	
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)

<table>
<tr><td>Obligation</td><td>Mandatory on a response of 1 – Yes to section 12.6 Course of care/treatment approval required

<table>
<tr><td>Name</td><td>Treatment funder code</td></tr>
<tr><td>Definition</td><td>The course of care programme or funder.</td></tr>
<tr><td>Source standards</td><td></td></tr>
<tr><td>Value domain</td><td>
<table>
<tr><th>Agreed term</th><th>Code</th></tr>
<tr><td>Community oral health services</td><td>COHS</td></tr>
<tr><td>Oral health service for adolescents</td><td>OHSA</td></tr>
<tr><td>Oral health services (Combined Dental Agreement - emergency/temporary enrolment)</td><td>ECDA</td></tr>
<tr><td>Special dental services</td><td>SDS</td></tr>
<tr><td>ACC funded programme</td><td>ACC</td></tr>
<tr><td>EDS (Emergency Dental Service)</td><td>EDS</td></tr>
<tr><td>Community Service Card funded</td><td>CSC</td></tr>
<tr><td>Other dental programmes</td><td>OTH</td></tr>
</table>
</td></tr>
<tr><td>Data type</td><td>String</td></tr>
<tr><td>Layout</td><td>AAAA</td></tr>
<tr><td>Obligation</td><td>Mandatory</td></tr>
<tr><td>Guide for use</td><td>There are multiple local and regional publicly funded programmes in operation. ‘OTH’ is a code to signify that there is not yet a national code to recognise the patient’s enrolment in a particular dental programme.

The data domain for this data element is expected to be expanded as national codes are introduced and need to be recognised.</td></tr>
</table>

Course of care/treatment approval required</td></tr>
<tr><td>Guide for use</td><td></td></tr>
</table>

13 Service details

The data elements in this section support service delivery benchmarking and will enable stakeholders to recognise how the non-delivery of services (such as bite–wing X-rays) impacts on patient health outcomes. Service details support an understanding of how many treatments are repeated and diagnosis changes (which may indicate workforce training and professional development needs).

The data elements in this section are not exhaustive and are likely to be the focus of a future version of this standard. For example, information on service provider and role may also be collected, but at this time, is likely to be in the form of text rather than HPI identifiers.

The following table details the services provided in the uniquely identified course of care described in section **12.1 Course of care/treatment plan unique identifier**.

13.1 Service code

Oral health services want to be able to better understand:

- the incidence of certain types of work (such as preventative work)
- the relationship between services, oral health outcomes, and
- patient quality of life (in respect of pain).

The use of a nationally consistent set of oral health service procedure codes supports clinical audit.

Name	Planned or provided oral health procedure service code

Definition	The oral health service (e.g., examination, diagnosis, treatment or procedure) that is planned or provided in a course of care.
Source standards	See Error! Reference source not found.
Value domain	Select and capture the appropriate ASDSG/NZ Extension Code from the source standard
Data type	Integer
Layout	X(18)
Obligation	Conditional on Australian Dental Association code being appropriate for the planned or provided service
Guide for use	Historically there has been variation in use of codes and terms. Services use procedure codes defined by the Australian Dental Association or ACC, and codes in the Combined Dental Agreement, and local/custom codes. The intent of this Standard is for Community Oral Health Services to continue to use the Australian Dental Association code-set, though to increasingly adopt SNOMED CT terminology. Adopting SNOMED CT has a range of benefits and opportunities around integrating with other parts of the health sector which use SNOMED CT, as well as national and international comparability of information. There is therefore a longer-term intent that oral health services adopt SNOMED Clinical Terminology.

13.2 Planned and actual treatment plan service provider

This section specifies service treatment provider information available to registered health care providers that should only be obtained from the HPI system. The format and description of the information is documented in Error! Reference source not found.. The information is mandatory.

Required data elements:

- Planned treatment provider person – the Common Person number

- Actual treatment provider person – the Common Person number
- Referred from facility – the Facility identifier

13.3 Examination/treatment location

This section specifies service treatment location information available to registered health care providers that should only be obtained from the HPI system. The format and description of the information is documented in Error! Reference source not found.. The information is mandatory.

Required data element:

- Treatment facility code – the Facility identifier

Name	HPI - ORG
Definition	A unique 8-character ID assigned by the HPI system to an individual organisation
Source standards	
Value domain	
Data type	String
Layout	GXXNNN-C
Obligation	Mandatory
Guide for use	Only the HPI system generates an HPI organisation identification (HPI ORG ID). This ID is not re-used once assigned. Where more than one HPI ORG exists for an organisation, one is declared ‘live’ and all other HPI ORG IDs are made ‘dormant’ and attached to the live record. The HPI ORG ID is the primary key for organisation records. A Modulus 11 check digit routine is run over the organisation identifier to produce the organisation identifier check digit
Verification rules	G is a constant prefix. X is either an alphabetic or a numeric.

	N is a numeric C is the Check Digit established using the Modulus 11 system.

13.4 Facility identifierTooth number

Name	Tooth identification number
Definition	The tooth number that the service code refers to identified by a two-digit numbering system that refers to the quadrant of the mouth and number of the tooth.
Source standards	Fédération Dentaire Internationale (FDI), also known as ISO 3950 notation. See **https://www.iso.org/standard/68292.html**
Value domain	11-85
Data type	Integer
Layout	NN
Obligation	Optional
Guide for use	Supernumerary teeth are extra teeth that are not in the numbering system, but still have treatment. They are described as ‘Supernumerary’ in written notes and charted between whichever tooth numbers they appear between. The FDI has no convention for recording supernumerary teeth. This Standard is to be updated once consensus is reached on supernumerary teeth annotation.

13.5 Surface

Name	Tooth surface
Definition	The tooth surface(s) associated with a diagnosis, examination, or treatment service code.
Source standards	

Value domain	<table><tr><th>Agreed term</th><th>Code</th></tr><tr><td>Occlusal</td><td>83473006</td></tr><tr><td>Mesial</td><td>8483002</td></tr><tr><td>Buccal</td><td>245648002</td></tr><tr><td>Distal</td><td>90933009</td></tr><tr><td>Lingual</td><td>72203008</td></tr><tr><td>Labial</td><td>245647007</td></tr><tr><td>Palatal</td><td>245650005</td></tr></table>
Data type	Integer
Layout	N(18
Obligation	Optional
Guide for use	

13.6 Completion of service

Name	Service complete
Definition	An indicator that the treatment plan for the patient has been completed.
Source standards	
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)
Obligation	Mandatory
Guide for use	

13.7 Radiographs linked to service record

Name	Radiograph link flag

Definition	An indication that radiographs are linked to this service record
Source standards	Oral health intraoral images to be captured with DICOM metadata (CID 4018 Primary Anatomic Structure for Intra-oral Radiography) and include the DICOM metadata in integration.
Value domain	1 – Yes 0 – No
Data type	Boolean
Layout	N(1,0)
Obligation	Mandatory if available
Guide for use	Default is 0 – No. The process for recording that radiographs are linked to a service record (whether manual or automated) is to be described in an implementation/user guide.

14 Decayed, missing, and filled teeth

Decayed, missing and filled teeth (dmft/DMFT) is an index of the dental caries experience of the patient determined by counting the number of decayed (d), missing (m), and filled (f) teeth (t). Lower case letters denote primary teeth (dmft) and upper-case letters (DMFT) denote permanent teeth.

The index is calculated following an oral health examination and is typically used to benchmark the oral health status of two age groups:

- dmft for patients with primary teeth
- dmft/DMFT for patients with primary and permanent teeth

The Oral Health Information System needs to enable the reporting of dmft/DMFT index to show the Service and other health and social services (such as those operated by Well Child Tamariki Ora and Oranga Tamariki) have made an impact on the outcome of protecting and promoting good health and independence through providing effective publicly funded child oral health programmes. dmft/DMFT data, itemised by ethnicity and fluoridation status, enables the service to identify and target the populations in their district where children's oral health status is poorest.

14.1 Facility where dmft/DMFT recorded

This section specifies service location information available to registered health care providers that should only be obtained from the HPI system. The format and description of the information is documented in Error! Reference source not found.. The information is mandatory.

Required data element:

- Facility information – the Facility identifier

Name	HPI - ORG
Definition	A unique 8-character ID assigned by the HPI system to an individual organisation
Source standards	
Value domain	
Data type	String
Layout	GXXNNN-C
Obligation	Mandatory
Guide for use	Only the HPI system generates an HPI organisation identification (HPI ORG ID). This ID is not re-used once assigned. Where more than one HPI ORG exists for an organisation, one is declared ‘live’ and all other HPI ORG IDs are made ‘dormant’ and attached to the live record. The HPI ORG ID is the primary key for organisation records. A Modulus 11 check digit routine is run over the organisation identifier to produce the organisation identifier check digit
Verification rules	G is a constant prefix. X is either an alphabetic or a numeric. N is a numeric C is the Check Digit established using the Modulus 11 system.

14.2 Facility identifierSchool at time of dmft/DMFT examination

Name	dmft/DMFT education facility identifier

Definition	The school/education facility the patient attended at the time of the dmft/DMFT examination.
Source standards	
Value domain	see Error! Reference source not found.
Data type	Integer
Layout	N(5)
Obligation	Optional
Guide for use	

14.3 Education facility fluoride status at time of dmft/DMFT examination

Name	dmft/DMFT education facility fluoride status
Definition	The school/education facility water fluoridation status operating at the dmft/DMFT examination time.
Source standards	
Value domain	**Agreed term** / **Code** Not recorded / 0 Fluoride / 1 Non-fluoride / 2
Data type	Integer
Layout	N
Obligation	Optional
Guide for use	If the child is home-schooled, the fluoridation status at the child's residential address should be the same as that reported in section **5.2.13 Water fluoridation status – patient's home address**

14.4 Date of dmft/DMFT examination

Name	dmft/DMFT date
Definition	The date of the dmft/DMFT examination.
Source standards	
Value domain	Full date
Data type	Date
Layout	YYYYMMDD
Obligation	Mandatory
Guide for use	

14.5 Permanent teeth

Name	Permanent teeth information
Definition	Information in respect of permanent teeth when the dmft/DMFT examination was recorded.
Source standards	
Value domain	For each of the following categories, a number within the valid range is to be recorded.

Permanent teeth information	**Valid range**
Number of teeth present	0–32
Number of caries free teeth	0–32
Number of decayed teeth	0–32
Number of teeth with decayed surfaces	0–32
Number of missing teeth	0–32
Number of missing surfaces	0–99
Number of filled teeth	0–32
Number of filled surfaces	0–99

	Number of teeth with noncavitated carious lesions: 0–32 Number of teeth surfaces with noncavitated carious lesions: 0–99
Data type	Integer
Layout	NN
Obligation	Mandatory
Guide for use	Decay must be charted for all teeth regardless of mobility.
Verification rules	Valid integer for each and every permanent tooth category listed above.

14.6 Deciduous teeth

Name	Deciduous teeth information
Definition	Information in respect of deciduous teeth when the dmft/DMFT examination was recorded.
Source standards	
Value domain	For each of the following categories, a number within the valid range is to be recorded.

Deciduous teeth information	Valid range
Number of teeth present	0–20
Number of caries free teeth	0–20
Number of decayed teeth	0–20
Number of teeth with decayed surfaces	0–32
Number of missing teeth	0–20
Number of missing surfaces	0–99
Number of filled teeth	0–20
Number of filled surfaces	0–99
Number of teeth with noncavitated carious lesions	0–20

	Number of teeth surfaces with noncavitated carious lesions: 0–99
Data type	Integer
Layout	NN
Obligation	Mandatory
Guide for use	
Verification rules	Valid integer for each and every deciduous tooth category listed above.

14.7 Fissure protectants/sealants

Name	Number of fissures treated
Definition	Information in respect of fissure protectants/sealants when the dmft/DMFT examination was recorded.
Source standards	
Value domain	For each of the following categories, a number within the valid range is to be recorded. **Fissure sealants** — **Valid range** Number of teeth with fissure protectants/sealants: 0–32 Number of surfaces with fissure protectants/sealants: 0–99
Data type	Integer
Layout	NN
Obligation	Mandatory
Guide for use	Valid integer for each and every fissure protectants/sealants categories listed above.

15 Related specifications

The two current Health Provider Index (HPI) standards were published in 2008. While they can provide guidance on HPI values referred to in this Standard, they are not suitable for any other purpose. They are:

HISO 10005:2008 Health Practitioner Index (HPI) Data Set

HISO 10006:2008 Health Practitioner Index (HPI) Code Set

An update of these standards is currently underway and has been referred to in this document. A copy of the revised draft standard (HISO 10045 Health Provider Identity Standard) can be requested from standards@health.govt.nz.

The standards listed below have been used in the development of this standard. They may provide some further clarity, if required. Compliance with this standard also requires compliance with related supporting HISO standards.

HISO 10029:2022 Health Information Security Framework

HISO 10046 Consumer Health Identity Standard

HISO 10064:2017 Health Information Governance Guidelines

HISO 10094:2022 Māori Descent and Iwi Affiliation Data Protocols

Appendix A: School information

The collection of current education facility data supports the reconciliation of school and oral health information systems. This assists administrators to identify patients who are no longer active in the service or who have moved education facility within the last 12 months.

‘Current education facility’ comprises a range of venues, the sources of which are listed below.

Name	School or education facility identifier
Definition	An identifier for the school or other educational facility relevant to the particular element being recorded
Source standards	**New Zealand schools** **Early childhood services** **Tertiary institutes** **Secondary-tertiary programmes** **Equity Index information** **School and kura 2023 EQI numbers**
Value domain	Available codes are listed in the above links. In the event that a suitable and accurate code is not found, select one of the following: Not in school 99999 School unknown 99998 At work 99997 Tertiary education 99996 Other 99995
Data type	Integer
Layout	X(5)
Obligation	
Guide for use	The school or facility identifiers in the source standards should be used wherever possible. The source standards code set may be extended in the future to include education facilities known to oral health service providers. The process for adding an education facility not currently in the source standards will be described in an implementation guide.

Appendix B: Health Provider Index sourced information

The following three data elements set out the information that is to be held within the oral health system. The table identifies the requisite HPI field name and data format for a provider, organisation and facility.

See section Error! Reference source not found. Error! Reference source not found. to source the latest release of the standard.

Common person number

The Common Person Number (CPN) identifies an individual person. It takes precedence over all other health worker identifiers across the HPI.

Name	HPI - CPN
Definition	A unique six-character identifier assigned by the HPI system to an individual person
Source standards	
Value domain	Valid CPN only
Data type	String
Layout	NCAAAA
Obligation	Mandatory, except for registrars (students) and dental assistants
Guide for use	Only the HPI system generates a new unique CPN which is the primary key for person records. This CPN is not re-used once assigned. Where more than one CPN exists for a single person, one CPN is declared ‘live’ and all other CPNs are made ‘dormant’ and attached to the live record.

	The CPN is the primary key for person records. A Modulus 11 routine is used to produce the identifier check digit Registrars (students), and dental assistants aren't currently covered by the HPI-CPN, and therefore it's not possible to record a CPN for them. Instead, currently these groups record their identity in the Oral Health Information System using identities assigned locally in Te Whatu Ora Districts. The intent of current work is for both these groups to eventually be able to record a unique identifier for themselves via the HPI-CPN mechanism. Once this (or similar) is possible the obligation will be updated.
Verification rules	N – is a number excluding number zero “0” A – is an alpha character excluding letter ‘I’ or ‘O’ C – is a check digit number in the second position calculated using check digit Modulus 11.

Organisation identifier

Name	HPI - ORG
Definition	A unique 8-character ID assigned by the HPI system to an individual organisation
Source standards	
Value domain	
Data type	String
Layout	GXXNNN-C
Obligation	Mandatory
Guide for use	Only the HPI system generates an HPI organisation identification (HPI ORG ID). This ID is not re-used once assigned.

	Where more than one HPI ORG exists for an organisation, one is declared ‘live’ and all other HPI ORG IDs are made ‘dormant’ and attached to the live record. The HPI ORG ID is the primary key for organisation records. A Modulus 11 check digit routine is run over the organisation identifier to produce the organisation identifier check digit
Verification rules	G is a constant prefix. X is either an alphabetic or a numeric. N is a numeric C is the Check Digit established using the Modulus 11 system.

Facility identifier

Name	HPI-FAC
Definition	A unique 8-character identifier assigned by the HPI system to an individual facility
Source standards	
Value domain	Valid HPI Facility Identifier
Data type	String
Layout	FXXNNN-C
Obligation	Mandatory
Guide for use	Only the HPI System generates a new HPI FAC ID. They are not re-used once assigned. Where more than one FAC ID exists for a single facility, one FAC ID is declared ‘live’ and all others are made ‘dormant’ and attached to the live record. The HPI FAC ID is the primary key for facility records. A Modulus 11 check digit routine is run over the six characters of the facility identifier to produce the facility identifier check digit

Verification rules	F is a constant prefix – all facility identification numbers start with ‘F’. X is either an alphabetic or a numeric. N is a number C is the check digit established using the Modulus 11 system The Facility Identifier is assigned by the HPI system at the time that the facility record in the HPI is created.

Appendix C: Oral Health Occupation Codes

Agreed term	SCTID	HPI Scope of Practice Code	ANZSCO[2] number
Clinical dental technician	160008000	DECD	411212
Dental technician	160008000	DEDT	411213
Dental assistant	4162009	-	423211
Dental hygienist	26042002	DEDH	411211
Dental therapist	301911000210107	DEGD	411214
Endodontist	50149000	DEEN	252311
Dentist	106289002	DENT	252312
Oral and maxillofacial surgeon	49993003	DEOR	252311
Oral health therapist	301921000210102	DEOH	411214
Oral medicine dental specialist	1259964002	DEOM	252311
Oral pathologist	66476003	DEOP	252311
Oral surgeon	49993003	DEOS	252311
Orthodontic auxiliary	159035003	DEOA	411211
Orthodontist	37504001	DESP	252311
Paediatric dental specialist	90201008	DEPA	252311
Periodontist	37154003	DEPE	252311
Prosthodontist	68950000	DEPS	252311
Public health dental specialist	68867008	DEPH	252311

[2] ANZSCO: **Australian and New Zealand Standard Classification of Occupations Version 1.2**

Restorative dental specialist	309460000	DERE	252311
Special needs dental specialist	301901000210105	DESN	252311
Registrar	301931000210100	-	-

Appendix D: Oral health service code set

The Oral Health service code set in New Zealand is the **Australian Schedule of Dental Services and Glossary (ASDSG), Twelfth Edition.** The intention is to move to SNOMED CT for oral health diagnoses and procedures in the longer-term, so this will be revisited in two years if the standard isn't updated sooner. Future iterations of this standard will at least include a mapping of ASDSG codes (Twelfth and Thirteenth Editions) to the SNOMED CT codes.

SNOMED CT contains the following dentistry reference sets:

- **General dentistry diagnostic reference set**
- **Odontogram reference set**