

PRIMHED Data Set

HISO 10023.2

To be used in conjunction with:
HISO 10023.1 – Integrated Mental Health Data Process Standard
and HISO 10023.3 – PRIMHED Code Set

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Related Documents

NZS/AS

AS/NZS 7799.2 Information security management. Part 2: Specification for information security management systems. (This standard was redesignated from AS/NZS 4444.2:2000.)

ISO

ISO/IEC 17799 Information Technology – Code of practice for information security management. (This standard supersedes AS/NZS 4444.1:1999.)

ISO/IEC 11179 ISO Standard 11179-3 Information technology – specification and standardization of data elements. Part 3: Basic attributes of data elements, 1994.

Other standards

HL7 V2.4 Health Level Seven Standard Version 2.4. Ann Arbor: Health Level Seven Inc., 2001.

HISO Ministry of Health. Ethnicity Data Protocols for the Health and Disability Sector. Wellington: Ministry of Health, 2004.

HISO 10005 Health Practitioner Index Data Set.

HISO 10006 Health Practitioner Index Common Code Set.

HISO Referrals and Discharges Data Set

HISO Referrals and Discharges Common Code Set.

Other publications

NZSCC99 Statistics New Zealand Country Code List.

HNBC HealthNet/BC Provider Data Standards, Version 1.0.

NHDD National Health Data Committee. National Health Data Dictionary, Version 12.0. Canberra: Australian Institute of Health and Welfare, 2003.

New Zealand legislation

Alcoholism and Drug Addiction Act 1966

Criminal Procedure (Mentally Impaired Persons) Act 2003

Health Act 1956

Health Practitioners Competence Assurance Act, 2003

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

Mental Health (Compulsory Assessment and Treatment) Act 1992

Parole Act 2002

1 INTRODUCTION

This document defines the data to be provided in the national integrated mental health data set (PRIMHED). The PRIMHED (Programme for the Integration of Mental Health Data) data set represents the entire set of data elements that will be collected and stored. The data combines information from the providers' patient management systems for mental health services activity (via the MHINC module) and mental health services assessments/outcome (via the MH-SMART module) into a single extract for a new mental health national system/collection. Provision has been made for the collection of the Health Practitioner Index Common Person Number (HPI-CPN) and ECT and 'Seclusion' information in this document.

This document also defines the elements of the data set in detail, providing an overview of each grouping of data elements (e.g. name elements), as well as:

- (a) a definition of each individual data element;
- (b) attributes of each element, such as the maximum length of the field, the type of data it holds, the data domain (free text, code table, etc) and layout;
- (c) information about the source of the defined element attributes; and
- (d) information such as guides for use, rules for verifying data in the element and comment about methods of collection of the data, where appropriate.

This document does not provide a technical specification for creating these data elements in a database system. It remains silent on issues such as table structures, key fields and relationships between data elements. It does not provide a full and comprehensive list of all fields required to represent the data according to the definitions provided; in other words, other fields may be necessary to ensure the data is properly validated and presented.

The definitions of elements of the data set provide a standard way of representing this data for the health sector. HISO's intention is to develop standards for health data for use across the health sector, not just in dealings between the Ministry of Health and other health entities. With increasing use of health information systems, establishing an accepted protocol for communication will facilitate rapid and accurate sharing of health information. Standardising data removes the need for complex translation and manipulation programmes.

In developing the standard, care has been taken to keep the definitions simple, while ensuring that they allow for appropriate representation of the data elements. For the most part, health data is held in a similar way by various health entities (e.g. sex, date of birth). One exception to this is the way that name and address data is held. For this reason, HISO has chosen to use an international standard for names and addresses (eXtensible Name and Address Language, or xNAL), which has been adopted as part of the e-Government Interoperability Framework (e-GIF). For more information, please go to <http://www.e-government.govt.nz/docs/e-gif-v-2-1/index.html>

1.1 The purpose of the PRIMHED

The overarching purpose of the PRIMHED process is to define the collection of minimally-required core data elements for an integrated mental health and addiction services national collection. The PRIMHED project's purpose also is to provide:

- (e) secure information access and reporting through consistent use of benchmarking, standards and key performance indicators, to underpin decision support and policy development.
- (f) data about the value of mental health services to support workforce development activities, including cultural relevance; to enhance the mental health knowledge base and to improve health outcomes for consumers.

1.2 The requirement for standards

The PRIMHED will provide an integrated collection of service and outcome information for consumers within the mental health service.

The MHINC/MH-SMART feasibility project examined the issues that surrounded the integration of two quite different data collections. The sector recognised the value of the MHINC data collection; however it was also felt that with the introduction of MH-SMART there was an opportunity to address some of the underlying actual and perceived issues with MHINC. The sector recognised the difficulties that would be created – and the associated costs of – having two distinct national collections. It was recommended that a single national collection be established, hence the creation of the PRIMHED project.

Most mental health services within New Zealand are structured in a manner that has been developed to suit the local environment. The same is true for the information systems present within these organisations. There is a plethora of differing systems throughout the country, recording and reporting on consumer admissions, discharges and activity. Even when the same system is in use in two organisations, it has often be implemented in quite different ways. The introduction of MH-SMART has introduced some system standards around outcome measurement in the collection of information.

As the PRIMHED system will be a new collection, it is appropriate that it is established based on solid standards that have been developed and endorsed by representatives from the sector.

As part of the MH-SMART implementation, organisations will need to modify the content and the structure of the files that are reported through to the national collection housed by NZHIS. Organisations should benefit substantially from the existence of a data standard for core information prior to commencing this work.

1.3 Collection of Data

Initially, data will be collected from DHBs. This will be expanded out to the NGO sector as the NGO sector develops capability. The MHIRS project will assist the NGO sector in their ability to capture and report information electronically.

2 DETAILS OF THE DATA STANDARD

2.1 Data standard type

This section describes the proposed data standards for both the records and the attributes required for the collection. This data standard reflects a logical view of the data. It does not necessarily represent the physical implementation of the data.

Every entity will require the following additional audit attributes to enable the re-creation of a record at a point in time and attribute the data to someone:

- (a) create data source organisation ID;
- (b) individual user ID; and
- (c) create and expiry date and time.

2.2 Data element structure

Each data element has been defined according to a set of metadata components that are based on ISO Standard 11179, *Information technology – Specification and standardization of data elements*, (1999). Most components (i.e. definition, data type, representational form, data domain, etc) describe essential features of the structure of a data element. Some components, such as collection methods and comments describe additional, non-essential features and may be left blank where appropriate. The metadata components of each data element are:

Component	Description
Definition	A statement that expresses the essential nature of the data element and its differentiation from all other data elements.
Source standards	Details of established data definitions or guidelines for data elements that have been cited in this standard.
Data type	Alphanumeric (X), Alphabetic (A), Numeric (N, numbers including decimals), Boolean (Y/N or checkbox on/off).
Date data structure	Century (C), Year (Y), Month (M) and Day (D). Full date representation is CCYYMMDD.
Time data structure	Hour (H), Minute (M). Time is recorded using the 24 hour clock, HHMM.
Representational class	For A, N & X, use code, free text or identifier. For date use full, partial or both date types. Does not apply to Boolean types.
Field size	Maximum number of characters that may be recorded in the field.
Representational layout	The arrangement of characters in the data element. For example, 'A(50)' means up to fifty alphabetic characters; 'NNAAAA' means numeric, numeric, alpha, alpha, alpha, alpha. Does not apply to Boolean types.
Data domain	The valid values or codes that are acceptable for the data element. The data elements contained in this standard are dates, free text or coded. For each data element that is coded, a code value is provided in the 'PRIMHED Code Set', as well as a description and an explanation of the code value. The valid values or codes contained in this standard are principally New Zealand values, although, in certain cases, international codes are used. Free text fields also allow international data to be received and stored.
Guide for use	Additional guidance to inform the use of the data element.
Verification rules	Quality control mechanisms that preclude non-valid codes from the data element.

3 PERSON IDENTIFIER DETAILS

This section of the standard describes the data elements commonly used to identify individuals. These data elements are generally regarded as core data elements for unambiguous identification of individuals. In this standard a person will either be identified as a 'Healthcare Worker' ('Health Care Provider'/'Health Practitioner'/'Clinician') or a 'Health Consumer' ('Patient'/'Consumer'/'Healthcare User') for PRIMHED in the identification of individuals.

3.1 Healthcare Worker CPN Identifier

The 'Healthcare Worker CPN' is a unique lifetime identifier for all New Zealand, which takes precedence over all other identifiers, for workers providing health care services.

This section does not include:

- (a) Healthcare worker name(s), date of birth, gender and title details, which are covered in the HISO *HPI Data Set 10005* and HISO *HPI Code Set 10006*.
- (b) 'Organisation', 'Facility' and 'Team' details, which are covered in Section 4.

3.1.1 Data requirements

A healthcare worker will be identified with the use of a HPI Common Person Number (HPI CPN). Refer HISO *HPI Data Set 10005* and HISO *HPI Code Set 10006*.

The HPI system will maintain the person data history of information for each healthcare worker, e.g. name changes.

The PRIMHED system will maintain the mental services information provided by healthcare workers.

3.1.2 Data record Healthcare Worker CPN (HPI CPN)

The data element for a 'Healthcare Worker CPN' is:

(a) Healthcare Worker CPN (HPI Common Person Number or HPI CPN)

3.1.3 Healthcare Worker CPN (HPI CPN)

A unique lifetime identifier for an individual healthcare worker, which takes precedence over all other provider, practitioner and clinician identifiers and is sourced from the Health Practitioner Index (HPI).

Definition:	A unique lifetime identifier for practitioners and health workers which takes precedence over all other identifiers for the person across the HPI.		
Source standards:	HISO <i>10005 HPI Data Set</i> .		
Data type:	Alphanumeric	Representational class:	Identifier
Field size:	Max: 6	Representational layout:	NNXXXX
Data domain:			
Guide for use:	HPI system-generated two numeric (the second of which is a check digit) plus four alphabetic characters.		
Verification rules:	The CPN includes a check digit in the second position. Modulus 11 Check Digit Algorithm. The person (Healthcare Provider) must be registered on the HPI before use.		

3.2 Health Consumer NHI Identifier

A unique lifetime identifier for all New Zealand, which takes precedence over all other identifiers, for consumers of health care services in New Zealand.

This section does not include:

Health consumer name(s), date of birth, gender, title, address and ethnicity details, which are covered in the NHI data set and NHI code set.

3.2.1 Data requirements

- (a) where the person is a consumer, the National Health Identifier (NHI) will be used
- (b) the NHI system will maintain the person data history of information for each health consumer, e.g. name changes.
- (c) the PRIMHED system will maintain the mental services information for each health consumer.

3.2.2 Data Record Health Consumer NHI

The data elements for the Health Consumer NHI are:

(a) Health Consumer NHI <ul style="list-style-type: none"> i. Master NHI (aka Master HCU ID) ii. Secondary NHI (aka Event HCU ID)

3.2.3 Health Consumer National Health Identifier (NHI)

3.2.3.1 Master NHI

The primary unique lifetime identifier for a healthcare consumer.

Definition:	The primary unique lifetime identifier for all New Zealand that takes precedence over all other identifiers for consumers of health care services.		
Source standards:			
Data type:	Alphanumeric	Representational class:	Identifier
Field size:	Max: 7	Representational layout:	AAANNNN
Data domain:			
Guide for use:	<p>The NHI number is also known as National Health Index number, Healthcare User Identifier (HCU ID), NMPI Number, Hospital Number, Consumer Number.</p> <p>Where duplicate records for a consumer are merged, one of the NHI numbers will be deemed to be the Master NHI and the others become Secondary NHIs (Event HCU IDs).</p> <p>See Secondary NHI explanatory notes below for further information.</p>		
Verification rules:	<p>The NHI includes a check digit in the seventh position.</p> <p>Modulus 11 Check Digit Algorithm.</p> <p>The person must be registered on the NHI before use.</p>		

3.2.3.2 Secondary NHI

A duplicate unique lifetime identifier that has been merged to the 'Master NHI' for a healthcare consumer.

Definition:	A duplicate unique lifetime identifier for all New Zealand that has been merged to the Master HCU ID or primary unique lifetime identifier for consumers of health care services.		
Source standards:			
Data type:	Alphanumeric	Representational class:	Identifier
Field size:	Max: 7	Representational layout:	AAANNNN
Data domain:			

Guide for use:	Where duplicate records for a consumer are merged, one of the NHI numbers will be deemed to be the Master NHI (Master HCU ID) and the others become Secondary NHI numbers (Event HCU IDs).
Verification rules:	The NHI includes a check digit in the seventh position. Modulus 11 Check Digit Algorithm. The person must be registered on the NHI before use. Can be the same as the Master HCU ID, where the secondary NHI and Master NHI are not merged.

4 ORGANISATION AND TEAM DETAILS

4.1 Organisation (formerly known as Agency)

An organisation is the entity that provides services of interest to, or is involved in, the business of the health care service provision. There may be a hierarchical (parent-child) relationship between organisations.

Within the context of the PRIMHED this means any organisation that provides health care to consumers of mental health services.

This section does not include:

- (a) address details. Refer HISO *HPI Data Set 10005* and HISO *HPI Code Set 10006*; or
- (b) electronic communication details. Refer HISO *HPI Data Set 10005* and HISO *HPI Code Set 10006*.

Both address and electronic communication details are provided for in the collection of organisation data in the HPI.

4.1.1 Data requirements

- (a) the Organisation Identifier (Health Practitioner Index) will be used to define the organisation providing service; or
- (b) the agency code will be used as a secondary reference (in the Health Practitioner Index) to define the organisation providing the service (refer NZHIS Agency Table).

4.1.2 Data record Organisation

The data elements for 'Organisation' are:

(a) Organisation Identifier i. Organisation Identifier ii. Organisation Identifier Check Digit	(b) Agency Code
--	-----------------

Refer to the HPI standard ("*HISO 10005*" and "*HISO 10006*") for the complete standard for 'Organisation'.

4.1.3 Organisation Identifier

Definition:	A unique lifetime identifier for an organisation assigned by the data source.		
Source standards:			
Data type:	Alphanumeric	Representational class:	Identifier
Field size:	Max: 6	Representational layout:	GXXNNN
Data domain:			
Guide for use:	G is a constant prefix. X is either an alpha or a numeric. The Organisation Identifier is assigned by the HPI system at the time that the organisation record in the HPI is created.		
Verification rules:	1. the organisation must be registered on the HPI before use. 2. must be a valid identifier in the HPI system organisation file.		

4.1.4 Organisation Identifier Check Digit

Definition:	The Organisation Identifier Check Digit is used to validate data entry of Organisation Identifiers.		
Source standards:			
Data type:	Alphabetic	Representational class:	Text

Field size:	Max: 1	Representational layout:	A
Data domain:			
Guide for use:	A Modulus 11 check digit routine is run over the 6 characters of the organisation identifier to produce the Organisation Identifier Check Digit.		
Verification rules:	Modulus 11 Check Digit Algorithm.		

4.1.5 Agency Code

A character or string of characters historically assigned to an organisation by NZHIS and replaced by an HPI 'Organisation Identifier'.

Definition:	A code that uniquely identifies an agency. An agency is the historical or legacy systems terminology for an organisation, institution or group of institutions that contracts directly with the principal health services purchaser to deliver healthcare services to the community.		
Source standards:			
Data type:	Alphanumeric	Representational class:	Identifier
Field size:	Max: 4	Representational layout:	XXXX
Data domain:			
Guide for use:	<p>The agency code is assigned by NZHIS and is historically used to identify an organisation, institution or group of institutions in NZHIS legacy systems (NMDS, NBRS, MHINC et al).</p> <p>The agency code will be used as a secondary reference identifier only. The agency code will be mapped to its replacement HPI Organisation Identifier to populate the PRIMHED Organisation Identifier data element, where the team/provider's systems are not able to use HPI Organisation Identifiers.</p>		
Verification rules:	Must be a valid code set value from NMDS, NBRS and MHINC that has been mapped to its replacement HPI Organisation Identifier.		

4.2 Team

A team consist of a person or functionally discrete grouping of people providing mental health and addiction services. These codes are maintained by NZHIS.

This section does not include:

- (a) 'Organisation Identifier'(s), which are identified in Section 4.1;

4.2.1 Data requirements

- (a) each team will have a single unique 'Team Code' to identify the record.
- (b) the team record will identify the team type, service setting and demographics.
- (c) team records will be maintained by NZHIS.
- (d) the PRIMHED will retain a history of team information.

4.2.2 Data record Team

The data elements for 'Team' are:

(a) Team Code (Identifier)	(f) Team Target Population
(b) Team Name	(g) Facility Identifier
(c) Team Type	(h) Facility Identifier Check Digit
(d) Team Setting	(i) Team – Other Detail
(e) Team Service Type	(i) Team Open Date
	(ii) Team Close Date

4.2.3 Team Code

Definition:	A code, which uniquely identifies a healthcare team assigned by NZHIS. A person or functionally discrete grouping of people based in a particular location, providing mental health care to a consumer group in either an inpatient or community setting. Uniquely linked to provider's Organisation and Facility Identifiers.		
Source standards:			
Data type:	Alphanumeric	Representational class:	Code (Identifier)
Field size:	Max: 6	Representational layout:	XXXXXX
Data domain:	Refer to Section 2.1 'Team Code' code set.		
Guide for use:	The Team Code is assigned by NZHIS. This code has a minimum of four digits with a maximum of 6.		
Verification rules:	<ol style="list-style-type: none"> 1. must be a valid identifier code in the Team Code ID Table that has been assigned by NZHIS. 2. must be a minimum of 4 characters and a maximum of 6 characters. 3. must have valid HPI Organisation and Facility Identifiers assigned in the Team table. 4. at least one code required. 5. code must be valid for the date open and close range the team is applied to. 		

4.2.4 Team Name

Definition:	The name by which the Team is known.		
Source standards:	xNAL – OrganisationName.		
Data type:	Alphanumeric	Representational class:	Free text
Field size:	Max: 255	Representational layout:	X(255)
Data domain:			
Guide for use:	Generally, the complete team name should be used to avoid any ambiguity in identification. However, in certain circumstances (e.g. internal use), a short name (i.e. an abbreviated name by which the team is known) may be used.		
Verification rules:			

4.2.5 Team Type

Definition:	A code that categorises the primary function of the healthcare Team.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Numeric	Representational class:	Code
Field size:	Max: 4	Representational layout:	NNNN
Data domain:	Refer to Section 2.2 'Team Type' code set.		
Guide for use:	Use the most specific code available. Codes for inpatient and community teams should only be used when there is no other code applicable.		
Verification rules:	Valid code set value only.		

4.2.6 Team Setting

Definition:	A code that categorises the setting of the healthcare team.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alpha	Representational class:	Code
Field size:	Max: 1	Representational layout:	A
Data domain:	Refer to Section 2.3 'Team Setting' code set.		
Guide for use:	Use the most specific code available.		
Verification rules:	Valid code set value only.		

4.2.7 Team Service Type(s)

Definition:	A code that categorises whether the team is a designated cultural service healthcare team.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alpha	Representational class:	Code
Field size:	Max: 2	Representational layout:	AA
Data domain:	Refer to Section 2.4 'Team Service Type' code set.		
Guide for use:	Use the most specific code available.		

Verification rules:	Valid code set value only.
----------------------------	----------------------------

4.2.8 Team Target Population

Definition:	A code that categorises the age group or target population group that the healthcare team provides service to.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Numeric	Representational class:	Code
Field size:	Max: 1	Representational layout:	N
Data domain:	Refer to Section 2.5 'Team Target Population' code set.		
Guide for use:	Use the most specific code available.		
Verification rules:	Valid code set value only.		

4.2.9 Facility Identifier

Definition:	A unique lifetime identifier for a facility assigned by the data source.		
Source standards:			
Data type:	Alphanumeric	Representational class:	Identifier
Field size:	Max: 6	Representational layout:	FXXNNN
Data domain:			
Guide for use:	F is a constant prefix. X is either an alpha or a numeric. The Facility Identifier is assigned by the HPI system at the time that the facility record in the HPI is created.		
Verification rules:	<ol style="list-style-type: none"> 1. the facility must be registered on the HPI before use. 2. must be a valid identifier in the HPI system facility file. 		

4.2.10 Facility Identifier Check Digit

Definition:	<p>The Facility Identifier Check Digit is used to validate data entry of facility identifiers.</p> <p>A Modulus 11 check digit routine is run over the six characters of the facility identifier to produce the Facility Identifier Check Digit.</p>		
Source standards:			
Data type:	Alphabetic	Representational class:	Text
Field size:	Max: 1	Representational layout:	A
Data domain:			
Guide for use:			
Verification rules:	Modulus 11 Check Digit Algorithm, refer Appendix A.		

4.2.11 Team – Other Detail

4.2.11.1 Team Open Date

Definition:	The date on which the Team began its operation.		
Source standards:	HL7 v2.4 DT – date.		
Data type:	Date	Representational class:	Full or partial date
Field size:	Max: 8	Representational layout:	CCYYMMDD
Data domain:	Valid date or year.		
Guide for use:	Enter the full date including year, month and day. If the establishment date is not known, provision should be made to collect age data (in years) and a year of establishment is to be derived from the age (i.e. CCYY).		
Verification rules:	This field must: <ul style="list-style-type: none"> 1. be less than or equal to the date of record creation; and 2. be a valid date or year. 		

4.2.11.2 Team Close Date

Definition:	The date on which the Team ceased its operation.		
Source standards:	HL7 v2.4 DT – date.		
Data type:	Date	Representational class:	Full or partial date
Field size:	Max: 8	Representational layout:	CCYYMMDD
Data domain:	Valid date or year.		
Guide for use:	Enter the full date including year, month and day.		
Verification rules:	This field must: <ul style="list-style-type: none"> 1. be less than or equal to the date of record creation; and 2. be greater than or equal to Team Open Date; and 3. be a valid date or year. 		

5 LEGAL STATUS DETAILS

5.1 Legal Status

Information that describes a consumer's legal status under the appropriate section of the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Alcoholism and Drug Addiction Act 1996, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, or the Criminal Procedure (Mentally Impaired Persons) Act 2003.

5.1.1 Data requirements

- (a) consumers may have more than one legal status current at any one time;
- (b) 'Legal Status' records will be maintained by the organisation responsible for the consumer's care under the compulsory treatment order;
- (c) the PRIMHED will retain a history of a consumer's legal status;
- (d) Directors of Area Mental Health Services (DAMHS) are responsible for recording legal status data.

This section does not include:

- (a) 'Organisation Identifiers' for the DAMHS office and the mental health service providers, which are identified in Section 4.1; or
- (b) 'Healthcare Worker' CPN', which is covered in Section 3.1; or
- (c) 'Consumer Identifier' (NHI), which is covered in Section 3.2.3.

5.1.2 Data Record Legal Status

The data elements for 'Legal Status' are:

(a) Legal Status ID	(c) Legal Status Start Date/Time
(b) Legal Status Code	(d) Legal Status End Date/Time

5.1.3 Legal Status ID

Definition:	An identifier for the corresponding record stored within the health provider's system.		
Source standards:			
Data type:	Alphanumeric	Representational class:	Free text
Field size:	Max: 20	Representational layout:	XX(20)
Data domain:			
Guide for use:	This is used by some organisations as a reference field for checking data quality. It allows providers to link to their patient management systems.		
Verification rules:	Optional.		

5.1.4 Legal Status Code

Definition:	Code describing a consumer's legal status under the appropriate section of the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Alcoholism and Drug Addiction Act 1966, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, or the Criminal Procedure (Mentally Impaired Persons) Act 2003.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphabetic	Representational class:	Code
Field size:	Max: 2	Representational layout:	AA
Data domain:	Refer to Section 3.1 'Legal Status Code' code set.		
Guide for use:	This is required to be submitted by the assigning organisation when Legal Status is other than voluntary		
Verification rules:	<ol style="list-style-type: none"> 1. at least one code required; 2. valid code set value only; 3. code must be valid for the date range the legal status is applied to; 4. must be valid for the applicable Legal Status Code commencement and conclusion dates within the Legal Status Code table. 		

5.1.5 Legal Status Start Date/Time

5.1.5.1 Legal Status Start Date

Definition:	The date the legal status came into effect.		
Source standards:	HL7 v2.4 DT – date.		
Data type:	Date	Representational class:	Full date
Field size:	Max: 8	Representational layout:	CCYYMMDD
Data domain:	Valid date or year.		
Guide for use:	<p>Enter the full date and time including year, month and day.</p> <p>If the legal status start date is not known, provision should be made to collect age data (in years) and a year the legal status started is to be derived from the age (i.e. CCYY).</p>		
Verification rules:	<p>This field must:</p> <ol style="list-style-type: none"> 1. be less than or equal to the date of record creation; 2. be a valid date or year; 3. be greater than the consumer's date of birth; 4. be less than the consumer's date of death, if the consumer is deceased; 5. be less than or equal to the Legal Status End Date; 6. be on or after the Legal Status Code commencement date in the Legal Status code set table; 7. be on or before the Legal Status Code conclusion date in the Legal Status Code set table. 		

5.1.5.2 Legal Status Start Time

Definition:	The time the legal status came into effect.		
Source standards:	HL7 v2.4 TM – time.		
Data type:	Time	Representational class:	Full time
Field size:	Max: 4	Representational layout:	HHMM
Data domain:	Valid time.		
Guide for use:	<p>Enter the time in hours and minutes.</p> <p>Time is to be recorded using the 24 hour clock.</p> <p>If time is not known, enter '0000'.</p>		
Verification rules:	<p>This field must:</p> <ol style="list-style-type: none"> 1. be a valid time; 2. when combined with the Legal Status start date, be less than or equal to the Legal Status end date and time. 		

5.1.6 Legal Status End Date/Time

5.1.6.1 Legal Status End Date

Definition:	The date the legal status code ceased to apply, or the consumer is discharged (if voluntary code) from the service.		
Source standards:	HL7 v2.4 DT – date.		
Data type:	Date	Representational class:	Full date
Field size:	Max: 8	Representational layout:	CCYYMMDD
Data domain:	Valid date or year.		
Guide for use:	Enter the full date including year, month and day.		
Verification rules:	<p>This field must:</p> <ol style="list-style-type: none"> 1. be less than or equal to the date of record creation; 2. be a valid date or year; 3. be greater than or equal to the legal status start date; 4. be less than or equal to the consumer's date of death, if the consumer is deceased; 5. be on or after the Legal Status Code commencement date in the Legal Status Code set table; 6. be on or before the Legal Status Code conclusion date in the Legal Status Code set table. 		

5.1.6.2 Legal Status End Time

Definition:	The time the legal status code ceased to apply, or the consumer is discharged (if voluntary code) from the service.		
Source standards:	HL7 v2.4 TM – time.		
Data type:	Time	Representational class:	Full time
Field size:	Max: 4	Representational layout:	HHMM
Data domain:	Valid time.		
Guide for use:	<p>Enter the time in hours and minutes.</p> <p>Time is to be recorded using the 24 hour clock.</p> <p>If Time is not known, enter '0000'.</p>		
Verification rules:	<p>This field must:</p> <ol style="list-style-type: none"> 1. be a valid time; 2. when combined with the Legal Status end date, be greater than or equal to the Legal Status start date and time. 		

6 ACTIVITY DETAILS

6.1 Activity

Activity describes the types of activities, the location of activity, and the team that provided the activity.

6.1.1 Data Requirements

- (a) there can be none or multiple activity records per 'Referral Identifier', per 'Team', per 'Facility', per 'Organisation', for the same consumer.
- (b) the referral record is the parent record for all activity records.

This section does not include:

- (a) 'Organisation Identifiers', which are identified in Section 4.1; or
- (b) 'Team Codes', which are identified in Section 4.2; or
- (c) 'Healthcare Worker' CPN, which is covered in Section 3.1; or
- (d) 'Consumer Identifier' (NHI), which is covered in Section 3.2.3; or
- (e) 'Referral Identifier', which is covered in Section 8.1.3; or
- (f) 'Coding Information', which is covered in Section 7.1; or
- (g) 'Collection Occasion' and 'Outcomes' information, covered in Section 9.

6.1.2 Data Record Activity

The data elements for 'Activity' are:

(a) Activity ID	(d) Activity Start Date/Time
(b) Activity Type	(e) Activity End Date/Time
(c) Activity Setting	

6.1.3 Activity ID

Definition:	An identifier for the corresponding record stored within the health provider's system.		
Source standards:			
Data type:	Alphanumeric	Representational class:	Free text
Field size:	Max: 20	Representational layout:	XX(20)
Data domain:			
Guide for use:	An Identifier used to enable organisations to reference records in the national collection against those held in their local systems.		
Verification rules:			

6.1.4 Activity Type

Definition:	A code that classifies the type of healthcare activity provided to the consumer.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphanumeric	Representational class:	Code
Field size:	Max: 3	Representational layout:	ANN
Data domain:	Refer to Section 4.1 'Activity Type'.		
Guide for use:	<p>Activity Type is a code that is used to classify the type of healthcare activity provided to the consumer.</p> <p>Each consumer's attendance at a day programme is only counted once in any one day.</p> <p>Only one code should be recorded per team per contact.</p>		
Verification rules:	Must be a valid code in the Activity Type code set table.		

6.1.5 Activity Setting

Definition:	The Activity Setting indicates the type of physical setting or contact channel that the activity was provided in.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphanumeric	Representational class:	Code
Field size:	Max: 2	Representational layout:	XX
Data domain:	Refer to Section 4.2 'Activity Setting' code set.		
Guide for use:	Describes the type of service setting the consumer was accessing service in.		
Verification rules:	Valid code set value only.		

6.1.6 Activity Start Date/Time

6.1.6.1 Activity Start Date

Definition:	The date the consumer commenced accessing this mental health activity.		
Source standards:	HL7 v2.4 DT – date.		
Data type:	Date	Representational class:	Full date
Field size:	Max: 8	Representational layout:	CCYYMMDD
Data domain:	Valid date or year.		
Guide for use:	<p>Enter the full date including year, month and day.</p> <p>Where the consumer is an inpatient this is the date of admission, where they are an outpatient or community consumer, this is the date that they accessed a service, i.e. a consumer attending a community programme three days per week, would have a service start date on each day they attended the programme.</p>		
Verification rules:	<p>This field must:</p> <ol style="list-style-type: none"> 1. be less than or equal to the Activity End Date; 2. be greater than or equal to the referral date; 3. be greater than the consumer's date of birth and less than or equal to their date of death, if the consumer is deceased; and 4. be a valid date; 5. be between the Referral Start Date and Referral End Date. 		

6.1.6.2 Activity Start Time

Definition:	The time the consumer commenced accessing this mental health activity.		
Source standards:	HL7 v2.4 TM – time.		
Data type:	Time	Representational class:	Full time
Field size:	Max: 4	Representational layout:	HHMM
Data domain:	Valid time.		
Guide for use:	<p>Enter the time in hours and minutes.</p> <p>Time is to be recorded using the 24 hour clock.</p> <p>If Time is not known, enter '0000'.</p>		
Verification rules:	This field must be a valid time.		

6.1.7 Activity End Date/Time

6.1.7.1 Activity End Date

Definition:	The date the consumer ceased receiving this mental health activity.		
Source standards:	HL7 v2.4 DT – date.		
Data type:	Date	Representational class:	Full date
Field size:	Max: 8	Representational layout:	CCYYMMDD
Data domain:	Valid date or year.		
Guide for use:	Enter the full date including year, month and day. For non inpatient services, service start and end date will normally be the same day.		
Verification rules:	This field must: <ol style="list-style-type: none"> 1. be greater than or equal to the Activity Start Date; 2. be greater than the consumer's date of birth and less than or equal to their date of death, , if the consumer is deceased; 3. be a valid date 4. be between the Referral Start Date and Referral End Date 		

6.1.7.2 Activity End Time

Definition:	The time the consumer ceased receiving this mental health activity.		
Source standards:	HL7 v2.4 TM – time.		
Data type:	Time	Representational class:	Full time
Field size:	Max: 4	Representational layout:	HHMM
Data domain:	Valid time.		
Guide for use:	Enter the time in hours and minutes. Time is to be recorded using the 24 hour clock. If time is not known, enter '0000'.		
Verification rules:	This field must: <ol style="list-style-type: none"> 1. be a valid time; 2. when combined with Activity End Date, must be greater than or equal to Activity Start Date and Time. 		

7 CLASSIFICATION DETAILS

7.1 Classification Coding

Details describing the diagnosis and/or issue codes assigned to a consumer by a healthcare organisation's team. This section does not include:

- (a) 'Organisation Identifiers', which are identified in Section 4.1; or
- (b) 'Team Codes', which are identified in Section 4.2; or
- (c) 'Consumer Identifier' (NHI), which is covered in Section 3.2.3; or
- (d) 'Referral Identifier', which is included in Section 8; or

7.1.1 Data requirements

- (a) there can be multiple coding records per 'Referral Identifier' per 'Organisation'.
- (b) NGOs are required to submit coding records.

7.1.2 Data record Classification Coding

The data elements for 'Classification Coding' are:

(a) Diagnosis Coding	(b) Issues Coding
i. Classification Code ID	i. Classification Code ID
ii. Clinical Coding System ID	ii. Issue Coding System ID
iii. Diagnosis Type	iii. Issue Type
iv. Clinical Code	iv. Issue Code
v. Clinical Code Start Date/Time	v. Issue Code Start Date/Time
vi. Clinical Code End Date/Time	vi. Issue Code End Date/Time

7.1.3 Coding Systems

The current coding systems that must be – or are intended to be – used in PRIMHED are:

- ICD-9-CM 2nd Edition – Australian version of the International Classification of Diseases, 9th Revision, Clinical Modification.
- ICD-10-AM 1st Edition – The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 1st Edition.
- ICD-10-AM 2nd Edition – The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 2nd Edition.
- ICD-10-AM 3rd Edition – The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 3rd Edition.
- ICD 10-AM 6th Edition, The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 6th Edition (from 2008).
- SNOMED CT (Systematized Nomenclature of Medicine – Clinical Terms), a comprehensive clinical terminology, owned, maintained, and distributed by the international Health Terminology Development Organisation (IHTSDO) (future availability/use to be advised).
- DSM-IV – Diagnostic and Statistical Manual of Mental Health Disorders, 4th Edition.

7.1.4 Diagnosis Coding

7.1.4.1 Classification Code ID

Definition:	An identifier for the corresponding record stored within the health provider's system.		
Source standards:			
Data type:	Alphanumeric	Representational class:	Free Text
Field size:	Max: 20	Representational layout:	XX(20)
Data domain:			
Guide for use:	An Identifier used to enable organisations to reference records in the national collection against those held in their local systems.		
Verification rules:			

7.1.4.2 Clinical Code Value

Definition:	A code used to classify the condition or issue.		
Source standards:	Must be a valid code in one of the specified clinical coding systems, as listed in Section 7.1.3 'Clinical Coding Systems'; HISO 10023.3 PRIMHED Code Set.		
Data type:	Alphanumeric	Representational class:	Code
Field size:	Max: 8	Representational layout:	XXXXXXXX
Data domain:			
Guide for use:	This comes from one of several clinical coding systems, as listed in Section 7.1.3 'Clinical Coding Systems'.		
Verification rules:	This field must: <ol style="list-style-type: none"> 1. must be a valid code value in the specified coding system. 2. must form part of a valid combination of Coding System Type and Code Value and Code Type. 		

7.1.4.3 Clinical Coding System ID.

Definition:	A code identifying the clinical coding system used for diagnosis and procedures.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphanumeric	Representational Class:	Code
Field size:	Max: 2	Representational layout:	XX
Data domain:	Refer to Section 5.1 'Clinical Coding System ID' code set.		
Guide for use:	This allows for mapping of codes to other clinical coding systems. The identifier used is the same as used for the National Minimum Dataset (NMDS).		
Verification rules:	This field must: <ol style="list-style-type: none"> 1. be a valid code in the Coding System Type code set table. 2. form part of a valid combination of Clinical Coding System ID and Clinical Code Value and Diagnosis Type. 		

7.1.4.4 *Diagnosis Type*

Definition:	A code that groups clinical codes or indicates the priority of a diagnosis.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphabetic	Representational class:	Code
Field size:	Max: 1	Representational layout:	A
Data domain:	Refer to Section 5.2 'Diagnosis Code Type' code set.		
Guide for use:			
Verification rules:	This field must: <ol style="list-style-type: none"> 1. be a valid code in the Diagnosis Code Type code set table. 2. form part of a valid combination of Clinical Coding System ID and Clinical Code Value and Diagnosis Type. 		

7.1.4.5 *Diagnosis Start Date*

Definition:	The date the clinical condition was identified.		
Source standards:	HL7 v2.4 DT – date.		
Data type:	Date	Representational class:	Full date
Field size:	Max: 8	Representational layout:	CCYYMMDD
Data domain:	Valid date or year.		
Guide for use:	Enter the full date including year, month and day.		
Verification rules:	This field must: <ol style="list-style-type: none"> 1. be less than or equal to the Diagnosis End Date; 2. be between the Referral Start Date and Referral End Date; 3. be greater than the consumer's date of birth and less than or equal to their date of death, if the consumer is deceased; 4. be a valid date. 		

7.1.4.6 *Diagnosis Start Time*

Definition:	The time the clinical condition was identified.		
Source standards:	HL7 v2.4 TM – time.		
Data type:	Time	Representational class:	Full time
Field size:	Max: 4	Representational layout:	HHMM
Data domain:	Valid time.		
Guide for use:	Enter the time in hours and minutes. Time is to be recorded using the 24 hour clock. If time is not known, enter '0000'.		
Verification rules:	This field must be a valid time.		

7.1.4.7 *Diagnosis End Date*

Definition:	The date the clinical condition ceased to apply.		
Source standards:	HL7 v2.4 DT – date.		
Data type:	Date	Representational class:	Full date

Field size:	Max: 8	Representational layout:	CCYYMMDD
Data domain:	Valid date or year.		
Guide for use:	Enter the full date including year, month and day.		
Verification rules:	This field must: <ol style="list-style-type: none"> 1. be greater than or equal to the Diagnosis Code Start Date; 2. be between the Referral Start Date and Referral End Date 3. be greater than the consumer's date of birth and less than or equal to their date of death, if the consumer is deceased. 4. be a valid date. 		

7.1.4.8 *Diagnosis End Time*

Definition:	The time the clinical condition ceased to apply.		
Source standards:	HL7 v2.4 TM – time.		
Data type:	Time	Representational class:	Full time
Field size:	Max: 4	Representational layout:	HHMM
Data domain:	Valid time.		
Guide for use:	Enter the time in hours and minutes. Time is to be recorded using the 24 hour clock. If time is not known, enter '0000'.		
Verification rules:	This field must: <ol style="list-style-type: none"> 1. be a valid time; 2. when combined with activity end date, must be greater than or equal to activity start date and time. 		

7.1.4.9 *Classification Code ID*

Definition:	An identifier for the corresponding record stored within the health provider's system.		
Source standards:			
Data type:	Alphanumeric	Representational class:	Free text
Field size:	Max: 20	Representational layout:	XX(20)
Data domain:			
Guide for use:	An Identifier used to enable organisations to reference records in the national collection against those held in their local systems.		
Verification rules:			

7.1.4.10 Issue Code Value

Definition:	A code used to classify the condition or issue.		
Source standards:	Must be a valid code in one of the issue coding systems, to be defined for future use.		
Data type:	Alphanumeric	Representational class:	Code
Field size:	Max: 8	Representational layout:	XXXXXXXX
Data domain:			
Guide for use:	This comes from one of issue coding systems, to be defined for future use		
Verification rules:	This field must: <ol style="list-style-type: none"> 1. be a valid code value in the specified coding system. 2. form part of a valid combination of Issue Coding System ID and Issue Code Value and Issue Type. 		

7.1.5 Issue Coding System ID.

Definition:	A code indicating the Issue Coding System(s) being used.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphanumeric	Representational class:	Code
Field size:	Max: 2	Representational layout:	XX
Data domain:	Refer to Section 5.3 'Coding System Type' code set.		
Guide for use:			
Verification rules:	This field must: <ol style="list-style-type: none"> 1. be a valid code in the Coding System Type code set table. 2. form part of a valid combination of Issue Coding System ID and Issue Code Value and Issue Type. 		

7.1.6 Issue Type

Definition:	A code that groups issue codes or indicates the priority of an issue.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphabetic	Representational class:	Code
Field size:	Max: 1	Representational layout:	A
Data domain:	Refer to Section 5.4 'Issue Code Type' code set.		
Guide for use:			
Verification rules:	This field must: <ol style="list-style-type: none"> 1. be a valid code in the Issue Code Type code set table. 2. form part of a valid combination of Issue Coding System ID and Issue Code Value and Issue Type. 		

7.1.7 Issue Code Start Date/Time

7.1.7.1 Issue Code Start Date

Definition:	The date the clinical condition or issue was identified.		
Source standards:	HL7 v2.4 DT – date.		
Data type:	Date	Representational class:	Full date
Field size:	Max: 8	Representational layout:	CCYYMMDD
Data domain:	Valid date or year.		
Guide for use:	Enter the full date including year, month and day.		
Verification rules:	<p>This field must:</p> <ol style="list-style-type: none"> 1. be less than or equal to the Issue Code End Date; 2. be between the Referral Start Date and Referral End Date; 3. be greater than the consumer's date of birth and less than or equal to their date of death, if the consumer is deceased; 4. be a valid date. 		

7.1.7.2 Issue Code Start Time

Definition:	The Time the clinical condition or issue was identified.		
Source standards:	HL7 v2.4 TM – time.		
Data type:	Time	Representational class:	Full time
Field size:	Max: 4	Representational layout:	HHMM
Data domain:	Valid time.		
Guide for use:	<p>Enter the time in hours and minutes.</p> <p>Time is to be recorded using the 24 hour clock.</p> <p>If Time is not known, enter '0000'.</p>		
Verification rules:	This field must be a valid time.		

7.1.8 Issue Code End Date/Time

7.1.8.1 Issue Code End Date

Definition:	The date the clinical condition or issue ceased to apply.		
Source standards:	HL7 v2.4 DT – date.		
Data type:	Date	Representational class:	Full date
Field size:	Max: 8	Representational layout:	CCYYMMDD
Data domain:	Valid date or year.		
Guide for use:	Enter the full date including year, month and day.		
Verification rules:	<p>This field must:</p> <ol style="list-style-type: none"> 1. be greater than or equal to the Issue Code Start Date; 2. be between the Referral Start Date and Referral End Date 3. be greater than the consumer’s date of birth and less than or equal to heir date of death, if the consumer is deceased. 4. be a valid date. 		

7.1.8.2 Issue Code End Time

Definition:	The time the clinical condition or issue ceased to apply.		
Source standards:	HL7 v2.4 TM – time.		
Data type:	Time	Representational class:	Full time
Field size:	Max: 4	Representational layout:	HHMM
Data domain:	Valid time.		
Guide for use:	<p>Enter the time in hours and minutes.</p> <p>Time is to be recorded using the 24 hour clock.</p> <p>If Time is not known, enter ‘0000’.</p>		
Verification rules:	<p>This field must:</p> <ol style="list-style-type: none"> 1. be a valid time; 2. when combined with Activity End Date, must be greater than or equal to Activity Start Date and Time. 		

8 REFERRAL AND DISCHARGE DETAILS

8.1 Referral Discharge

A referral is a specific request from one healthcare team/provider to another, for advice about, or treatment of, a consumer¹. Mental health and addiction services referrals can also be received directly from the consumer or the consumer's family/whānau/significant other (self or relative referral), or via another agency. Referral includes internal referrals between teams.

A referral ends when the consumer is discharged from the 'referred to' health care team/provider with no expectation by that healthcare team/provider of direct involvement in ongoing care.²

This section does not include:

- (a) 'Organisation Identifiers', which are identified in Section 4.1; or
- (b) 'Team Codes', which are identified in Section 4.2; or
- (c) 'Healthcare Worker' CPN, which is covered in Section 3.1; or
- (d) 'Consumer Identifier' (NHI), which is covered in Section 3.2.3; or
- (e) processes related to the electronic transfer of Referral, Status and Discharge (RSD) information are contained within the *Referral, Status and Discharge Business Process Standard* (HDZ 10011/PPC).

8.1.1 Data requirements

- (a) each referral will have a single unique identifier and record.
- (b) referral transfer records will use the parent referral identifier to indicate the master or primary service provider.
- (c) there will be one discharge record only per referral identifier per organisation.
- (d) secondary teams can only discharge the consumer back to the master or primary service provider.
- (e) only the master or primary service provider that has created the parent referral identifier can discharge the consumer out of service, thus indicating the closure of the episode.

8.1.2 Data record Referral Discharge

The data elements for 'Referral Discharge' are:

- | | |
|-------------------------|--|
| (a) Referral Identifier | (d) Referral End Code |
| (b) Referral From | (e) Referral Start Date and Time |
| (c) Referral To | (f) Referral/Discharge End Date and Time |

¹ HISO *Referrals, Status and Discharges Business Process Standard* (HDZ 10011/PPC), p. 10.

² HISO *Referrals, Status and Discharges Business Process Standard* (HDZ 10011/PPC), p. 12.

8.1.3 Referral Identifier

Definition:	An Identifier that links a variety of activity, including diagnosis and outcome measurements together for one episode.		
Source standards:			
Data type:	Alphanumeric	Representational class:	Free text
Field size:	Max: 20	Representational layout:	XX(20)
Data domain:			
Guide for use:	An Identifier generated by the source organisation using the Organisation Identifier, Organisation Identifier Check Digit and up to seven additional free text characters that uniquely identify the referral.		
Verification rules:	A Referral Identifier can have only one consumer per organisation. The Identifier is assigned by the Data Source.		

8.1.4 Referral From

Definition:	The source from where the healthcare user, consumer, or recipient was referred for the beginning of this episode of care.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphabetic	Representational class:	Code
Field size:	Max: 2	Representational layout:	AA(2)
Data domain:	Refer to Section 6.1 'Referral From' code set.		
Guide for use:	Describes the groups of services or people who are referral sources.		
Verification rules:	Valid code set value only. Must have only one per referral record. Must be supplied with the Referral Start Date.		

8.1.5 Referral To

Definition:	The destination to where the healthcare user, consumer, recipient was referred when discharged from this episode of care.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphabetic	Representational class:	Code
Field size:	Max: 2	Representational layout:	AA(2)
Data domain:	Refer to Section 6.2 'Referral To' code set.		
Guide for use:	Describes the groups of services or people who are referral destinations.		
Verification rules:	Valid code set value only. Must have one only per referral. Must be supplied with the Referral End Date. Has conditional validation where data is mandatory when discharging the Consumer.		

8.1.6 Referral End Code

Definition:	A code that describes why the consumer was discharged from the healthcare team.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alpha	Representational class:	Code
Field size:	Max: 2	Representational layout:	AA
Data domain:	Refer to Section 6.3 'Referral End Type'.		
Guide for use:	<p>A code that identifies whether this is a Discharge or a Discharge Referral (refer HISO RSD documentation).</p> <p>A Discharge Referral within the hospital environment occurs when a consumer is discharged from one service, period of care, or location within the hospital and referred for further treatment as either an inpatient, outpatient within the same or different service or facility.³</p>		
Verification rules:	<p>Valid code set value only.</p> <p>If this field is populated, Referral Discharge End Date must be populated.</p>		

8.1.7 Referral Start Date and Time

8.1.7.1 Referral Start Date

Definition:	The date on which the referral was received.		
Source standards:	HL7 v2.4 DT – date.		
Data type:	Date		Full or partial date
Field size:	Max: 8		CCYYMMDD
Data domain:	Valid date or year.		
Guide for use:	<p>Enter the full date including year, month and day.</p> <p>If the referral date is not known, provision should be made to estimate the referral date. It is envisaged that only consumers who have been in the care of the mental health service for many years will have partial dates.</p>		
Verification rules:	<p>This field must:</p> <ol style="list-style-type: none"> 1. be less than or equal to the date of record creation; 2. be greater than the consumer's date of birth; 3. be less than the consumer's date of death, if the consumer is deceased; 4. be a valid date or year; 5. be less than or equal to the Referral End Date; 6. be on or after the Team Code Open Date in the Team table; 7. be on or before the Team Code Close Date in the Team table. 		

8.1.7.2 Referral Start Time

Definition:	The time on which the referral was received.		
Source standards:	HL7 v2.4 TM – time.		

³ HISO Referrals, Status and Discharges Business Process Standard (HDZ 10011/PPC), p. 15.

Data type:	Time	Representational class:	Full time
Field size:	Max: 4	Representational layout:	HHMM
Data domain:	Valid time.		
Guide for use:	<p>Enter the time in hours and minutes.</p> <p>Time is to be recorded using the 24 hour clock.</p> <p>If Time is not known, enter '0000'.</p>		
Verification rules:	<p>This field must:</p> <ol style="list-style-type: none"> 1. be a valid time; 2. when combined with referral date, must be less than or equal to Referral End Date and Time. 		

8.1.8 Referral/Discharge End Date and Time

8.1.8.1 Referral End Date

Definition:	The date that all contact between the consumer and the mental health team ends.		
Source standards:	HL7 v2.4 DT – date.		
Data type:	Date	Representational class:	Full date
Field size:	Max: 8	Representational layout:	CCYYMMDD
Data domain:	Valid date or year.		
Guide for use:	Enter the full date including year, month and day. If the consumer returns from leave and is discharged on the same day, the discharge date is the day they returned. If they do not return, the discharge date is the date that they went on leave.		
Verification rules:	<p>This field must:</p> <ol style="list-style-type: none"> 1. be less than or equal to the date of record creation; 2. be greater than or equal to the referral start date; 3. be greater than the consumer's date of birth; 4. be a valid date; 5. be on or after the Team Code Open Date in the Team table; 6. be on or before the Team Code Close Date in the Team table. <p>If Referral End Code is populated, this field is mandatory.</p>		

8.1.8.2 Referral End Time

Definition:	The time that all contact between the consumer and the mental health team ends.		
Source standards:	HL7 v2.4 TM – time.		
Data type:	Time	Representational Class:	Full Time
Field size:	Max: 4	Representational layout:	HHMM
Data domain:	Valid time.		
Guide for use:	Enter the time in hours and minutes. Time is to be recorded using the 24 hour clock. If Time is not known, enter '0000'.		
Verification rules:	<p>This field must:</p> <ol style="list-style-type: none"> 1. be a valid time; 2. when combined with Referral End Date, must be greater than or equal to Referral Start Date and Time. 		

9 COLLECTION OCCASION AND OUTCOME TOOL DETAILS

9.1 Collection Occasion

A 'Collection Occasion' is an occasion when standard measures for outcomes evaluation and casemix classification, together with other associated data items are required to be ascertained and collected in accordance with a standard protocol. Three principal 'Collection Occasions' are identified: 'Admission', 'Review', and 'Discharge'.

This section does not include:

- (a) 'Organisation Identifiers', which are identified in Section 4.1; or
- (b) 'Team Codes', which are identified in Section 4.2; or
- (c) 'Healthcare Worker'CPN, which is covered in Section 3.1; or
- (d) 'Consumer Identifier' (NHI), which is covered in Section 3.2.3.

9.1.1 Data requirements

The 'Collection Occasion Identifier' will be composed of the 'Referral Identifier' and the 'Collection Occasion Identifier'. This combination must be unique per organisation.

9.1.2 Data record Collection Occasion

The data elements for 'Collection Occasion' are:

(a) Collection Identifier	(d) Outcomes Episode ID
(b) Reason for Collection	(e) Protocol Version
(c) Collection Occasion Date	(f) Focus of Care

9.1.3 Collection Occasion Identifier

Definition:	A unique system-generated numeric identifier for each Collection Occasion within a particular Outcomes Episode of Care. Serves as the primary key for all collection occasion records and links to Outcome Tool and Outcome Item tables.		
Source standards:			
Data type:	Alphanumeric	Representational class:	Identifier
Field size:	Max: 20	Representational layout:	XX(20)
Data domain:	Auto number.		
Guide for use:	Unique number for each collection occasion at health agency level.		
Verification rules:	Must be the correct numerical sequence, in ascending order, from the previous Collection Identifier.		

9.1.4 Reason for Collection

Definition:	The reason for the collection of the standard measures and individual data items on the identified Collection Occasion.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphanumeric	Representational class:	Code
Field size:	4	Representational layout:	AANN

Data domain:	Refer to Section 7.1 'Reason for Collection' code set.
Guide for use:	The reason for the collection of the standard measures and individual data items on the identified Collection Occasion.
Verification rules:	Must be a valid code in the Reason For Collection code set.

9.1.5 Collection Occasion Date

Definition:	The date on which the collection of the outcome measure(s) was commenced.		
Source standards:	HL7 v2.4 DT – date.		
Data type:	Date	Representational class:	Full date
Field size:	Max: 8	Representational layout:	CCYYMMDD
Data domain:	Valid date or year.		
Guide for use:	<p>Enter the full date including year, month and day.</p> <p>For data collected at <i>admission</i> into an outcomes episode of care, the Collection Occasion date is the Admission Date. For data collected at <i>review</i> during an extended outcomes episode of care, it is the review date on which the data was collected. For data collected at <i>discharge</i> from an outcomes episode of care, the Collection Occasion date is the discharge date, i.e. the date of discharge in inpatient mental health service settings, or the date of last contact in community mental health service settings.</p> <p>The collection date is the reference date for all reports and statistical analyses of the data collected at any given Collection Occasion.</p>		
Verification rules:	Must be less than or equal to the date of record creation and a valid date or year.		

9.1.6 Outcome Episode ID

Definition:	Unique identifier for each outcome episode at organisation level.		
Source standards:			
Data type:	Numeric	Representational class:	Identifier
Field size:	Max: 9	Representational layout:	NNNNNNNNN
Data domain:			
Guide for use:	The Episode Identifier is assigned by the MH-SMART system at the time that the episode record in the MH-SMART is created. It provides a link to build an outcomes episode from individual collection occasions.		
Verification rules:	Must be a valid identifier in MH-SMART before use.		

9.1.7 Protocol Version

Definition:	The version of the information collection protocol under which the data has been collected and submitted.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphanumeric	Representational class:	Code
Field size:	Max: 4	Representational layout:	NNNN

Data domain:	Refer to Section 7.2 'Protocol Version' code set.
Guide for use:	
Verification rules:	Must be a valid code.

9.1.8 *Focus of Care*

Definition:	The focus of care identifies the principal clinical intent of the care provided during the period of care preceding the collection occasion. It is a global clinical judgement based on the intensity and purpose of the services provided during the period of care.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphanumeric	Representational class:	Code
Field size:	4	Representational layout:	AANN
Data domain:	Refer to Section 7.3 'Focus of Care' code set.		
Guide for use:	It has implications for the kinds of outcomes that might be expected. Not used for HoNOSCA		
Verification rules:	Must be a valid code in the Focus Of Care code set.		

9.2 Outcome Tool

'Outcome Tool' includes data regarding the measures or instruments used to gather data about consumer outcomes. Currently, the HoNOS family of instruments (HoNOS, HoNOS65+, HoNOSCA, HoNOS-LD and HoNOS Secure) have been implemented. HoNOS was developed in the United Kingdom for use by clinicians in their routine clinical work to measure consumer outcomes. Future instruments could include a consumer measure, a cultural measure, an NGO measure and a functioning measure.

This section does not include:

- (a) 'Referral Identifier', which is included in Section 8;
- (b) 'Collection Occasion', which is included in Section 9.1.

9.2.1 Data requirements

The 'Collection Occasion' and 'Outcome Tool', along with its protocol, will determine which measures or items will be collected.

9.2.2 Data record Outcome Tool

The data elements for 'Outcome Tool' are:

(a) Outcome Tool Type and Version	(c) Collection Status
(b) Mode of Administration	(d) Completion Date

9.2.3 Outcome Tool Type and Version

Definition:	A code that identifies the Outcome Tool, and the Version of that tool, which is used for a particular outcome collection.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphanumeric	Representational class:	Code
Field size:	Max: 2	Representational layout:	AN
Data domain:	Refer to Section 7.4 'Outcome Tool Type' and 'Version' code set.		
Guide for use:			
Verification rules:	Must be a valid code.		

9.2.4 Mode of Administration

Definition:	The procedure or method used in the ascertainment and recording of the standard measure.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphanumeric	Representational class:	Code
Field size:	4	Representational layout:	AANN
Data domain:	Refer to Section 7.5 'Mode of Administration' code set.		
Guide for use:			
Verification rules:	Must be a valid code in the Mode Of Administration code set.		

9.2.5 Collection Status

Definition:	The completion status of the data recorded and, if missing data is recorded, the reason for the non-completion of the measure.
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Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphanumeric	Representational class:	Code
Field size:	4	Representational layout:	AANN
Data domain:	Refer to Section 7.6 'Collection Status' code set.		
Guide for use:	The status of the data recorded and if missing data is recorded, the reason for the non-completion of the measure.		
Verification rules:	Must be a valid code in the Collection Status code set.		

9.2.6 Completion Date

Definition:	The date of completion of the outcome measure collection.		
Source standards:	HL7 v2.4 DT – date.		
Data type:	Date	Representational class:	Full date
Field size:	Max: 8	Representational layout:	CCYYMMDD
Data domain:	Valid date or year.		
Guide for use:	Enter the full date including year, month and day that the item was scored/collected.		
Verification rules:	This field must: <ol style="list-style-type: none"> 1. be less than or equal to the date of record creation; and 2. be a valid date or year. 		

9.3 Outcome Item

HoNOS has a number of outcome items developed in the United Kingdom for use by clinicians in their routine clinical work to measure consumer outcomes. As well as individual outcome items, summary, subscale and total scores are included.

This section does not include:

- (a) 'Referral Identifier', which is included in Section 8; or
- (b) 'Collection Occasion', which is included in Section 9.1.

9.3.1 Data requirements

The 'Outcome Tool' along with its protocol will determine which items or measures will be collected.

9.3.2 Data record Outcome Item

The data elements for 'Outcome Item' are:

(a) Outcome Item Code	(b) Outcome Item Value
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9.3.3 Outcome Item Code

Definition:	An identifier that indicates the Outcome Item that is being measured.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphanumeric	Representational class:	Identifier
Field size:	Max: 3	Representational layout:	XXX
Data domain:	Refer to Section 7.7 'Outcome Item Number' code set. HoNOS, HoNOS65, HoNOSCA, HoNOS Secure, HoNOS LD Item numbers.		
Guide for use:			
Verification rules:	Must be a valid code in the Outcome Item code set. Must be a valid Outcome Item for the Outcome Tool and protocol that is being used.		

9.3.4 Outcome Item Value

Definition:	The value given to a particular outcome item code.		
Source standards:	HISO 10023.3 PRIMHED Common Code Set.		
Data type:	Alphanumeric	Data type:	Alphanumeric
Field size:	Max: 1	Field size:	Max: 1
Data domain:	Refer to Section 7.8 'Outcome Item Value' code set.		
Guide for use:			
Verification rules:	<ol style="list-style-type: none"> 1. Must be a valid code for the Outcome Item Value within the code set. 2. Outcome Item Code codes A-J, X and Z are only valid when the following "Outcome Item Value" codes are used: <ul style="list-style-type: none"> a. HoNOS: Outcome Item Value code 08a b. HoNOS 65+: Outcome Item Value code 08a 3. Outcome Item Code codes A-E, X and Z are only valid when HoNOS LD: Outcome Item Value code 03a is used 		

APPENDIX A GLOSSARY

The following definitions are integral to the understanding of this document.

Term	Definition
Admission/Admitted	In the case of mental health and addiction, this does not mean the admission of a consumer to a facility. It is where a consumer is accepted for treatment by a service, either by way of an inpatient admission, or with outpatient services.
CLIC	Client Information Collection database.
Consumer	A person who accesses publicly funded healthcare. This person may be referred to elsewhere as a 'Healthcare User', 'Client' or 'Patient'.
CPN	Common Person Number.
DAMHS	Director of Area Mental Health Services.
Data Element	An atomic piece of data, e.g. first name, last name etc.
Data Group	Group of data elements of related data, e.g. consumer identification, demographic data.
Data Set	Collection of data groups, used for specific purposes, e.g. referral data set, exit data set.
Data Source	An organisation (usually) or authorised person that supplies data about a practitioner, health worker, organisation or facility to the HPI.
DHB	District Health Board.
Exit	The relinquishing of consumer care/support in whole or in part by a healthcare provider or organisation. There are two common types of exit: <ul style="list-style-type: none"> (a) administrative; (b) clinical exit. <p>In other settings, 'Exit' may be referred to as 'Discharge'.</p>
Exit Referral	A referral occurring in the context of exit and comprising a referral with an attached exit summary.
Exit Summary	A collection of information, reported by a provider or organisation, about events at the point of exit.
Facility	A single physical location from which health goods and/or services are provided.
Health Practitioner Index (HPI)	A centrally managed utility that is used to collect and distribute practitioner, health worker, organisation and facility data. The HPI will facilitate the timely and secure exchange of health information, ensure the accurate and unique identification of practitioners, health workers, organisations and facilities and offer operational support for health organisations that use that data and provide information of interest to the public. Data is supplied by authorised data sources and distributed to authorised consumers. The Ministry of Health (as the HPI Administrator) manages the HPI.
Health Professional	A person who is, or is deemed to be, registered with an authority established or continued by section 114 of the HPCA Act 2003, as a practitioner of a particular health profession.
Health Worker	A person not registered with a responsible authority who works within the health sector.
Healthcare Provider	A person or organisation that provides consumer health care services.
Healthcare User	A person who accesses publicly funded healthcare, this person may also be referred to as a 'Consumer', 'Client' or 'Patient'.

Term	Definition
HoNOS	Health of the Nation Outcome Scales.
HoNOS - LD	Health of the Nation Outcome Scales – Learning Disabilities.
HoNOS - Secure	Health of the Nation Outcome Scales for users of secure services.
HoNOS65+	Health of the Nation Outcome Scales (for those over 65 years).
HoNOSCA	Health of the Nation Outcome Scales for Children and Adolescents.
HPI Administrator	The administrative staff – employed by the MoH – who authorise and maintain data about organisations; and monitor the data quality and consistency in the HPI (this includes practitioner, health worker, organisation, and facility uniqueness).
KPI Project	A Key Performance Indicator Framework for New Zealand Mental Health and Addiction Services
MHINC	Mental Health Information National Collection.
MH-SMART	Mental Health – Standard Measures of Assessment and Recovery
NGO	Non Government Organisation.
NZHS	New Zealand Health Information Service.
Organisation	An entity that provides services of interest to, or is involved in, the business of healthcare service provision. There may be a hierarchical (parent-child) relationship between organisations.
Patient	A person who accesses publicly funded healthcare, this person may also be referred to as a healthcare user, consumer, or client.
Person	An individual person who can assume multiple roles over time. In the HPI, 'person' is synonymous with practitioner, health worker, and user.
PHO	Primary Healthcare Organisation.
Practising Certificate	A practising certificate issued by the relevant authority (Responsible Authority) under section 26(3) or section 29(4), or deemed to have been issued under section 191(2), of the Health Practitioners Competence Assurance Act 2003. This may be issued annually or for a shorter interim period.
Practitioner	A person who is, or is deemed to be, or has been registered with, a Responsible Authority as a practitioner of a particular health profession under the HPCA Act 2003.
PRIMHED	Project for the Integration of Mental Health Data
Privacy	The right of an individual to control access to and distribution of, information about themselves.
Referral	Referral may take several forms, most notably: <ul style="list-style-type: none"> (a) request for management of a problem or provision of a service, e.g. a request for an investigation, intervention or treatment; (b) notification of a problem with the hope, expectation or imposition of its management, e.g. an exit summary in a setting, which imposes care/support responsibility on the recipient. <p>The common factor in all referrals is a communication whose intent is the transfer of care/support, in part or in whole.</p>
Referred To Healthcare Provider	The healthcare team/provider to which a consumer has been referred for advice or treatment by a referring healthcare provider. The 'Referred To Healthcare Provider' may be an individual or facility.

Term	Definition
Referring Healthcare Provider	The healthcare team/provider that is referring the consumer for advice or treatment. The referring team/provider generally has primary care responsibilities for the consumer. Typically, the referring team/provider will be a General Practitioner, but may be a referred to healthcare team/provider (see Referring Specialist).
Referring Specialist	A 'Referred To Healthcare Provider' who is referring a consumer for advice or treatment, but not back into the care/support of the 'Referring Healthcare Provider'.
Relationship	The HPI will be able to record one or more relationships between practitioner, health worker, organisation and facility records.
Service Provider	Any service that provides mental health and addiction services, including, but not limited to: NGOs; DHB Provider Arms; PCP; PHOs; other community agencies.
Specialist	See 'Referred To Healthcare Provider' and 'Referring Healthcare Provider', above. In the context of referrals, clinical status reports and exit summaries, a specialist is an individual, not a facility.
Team	A team consisting of a person or functionally discrete grouping of people providing mental health and addiction services within a service provider.

APPENDIX B BIBLIOGRAPHY

Details of established data definitions or guidelines for data elements that have been cited in this standard are:

AS/NZS 7799.2:2000 Information security management, Part 2: Specification for information security management systems: This standard forms the basis for an assessment of the information security information management systems (ISMS) of a whole, or part, of an organisation. It may be used as a basis for formal certification. This standard was formerly known as AS 4444.2:2000. AS/NZS 7799 should be read in conjunction with AS/NZS ISO/IEC 17799.

AS/NZS ISO/IEC 17799:2001 Information technology - Code of practice for information security management: Provides recommendations for information security management for use by those who are responsible for initiating, implementing or maintaining security in their organisation. It is helpful in developing organisational security standards and effective security management practice.

New Zealand Privacy Commissioner Web Site <www.privacy.org.nz>: Details current Commonwealth privacy legislation, regulations, codes, principles, and other privacy information/links relevant for New Zealand, for both the public and private sectors.

Health Level Seven (HL7): Is an international health data messaging standard published by Health Level Seven Inc. (Ann Arbor, USA). The standard provides guidance for data exchange formats and unification of software interfaces for administrative and clinical data. AS 4700 provides an implementation standard for Australia for this international HL7 Standard. See also Section 4 'Messaging' and www.hl7.org

Statistics New Zealand Country Code List (NZSCC99): Lists all countries with a four digit identification number.

NZHS Mental Health Information National Collection Data Dictionary (version 3.8) July 2006: Provides the business and data element rules for the current MHINC system.

MHRD New Zealand Mental Health Standards and Measures of Assessment and Recovery (MH-SMART) Initiative – Information Collection Protocol v1.1: Provides business rules, protocols, that were developed as part of the MH-SMART project.

HDZ 10011/PPC Referrals, Status and Discharge Business Process Standard (Pre Public Comment Draft): Provides guidance on business processes relating to a Consumers passage through the health sector.