

# **PRIMHD Data Set**

## **HISO 10023.2**

**Version 2.0**

To be used in conjunction with:  
HISO 10023.1 – Integrated Mental Health Data Process Standard  
and HISO 10023.3 – PRIMHD 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 chapter of the standard provides an introductory summary about HISO standards for the PRIMHD data set and what contributes to the development and makeup of the HISO standards for PRIMHD, including why standards are required for PRIMHD.

## 1.1 Overview of the data set standard for PRIMHD

This document defines the data to be provided in the national integrated mental health data set (PRIMHD). The PRIMHD (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>

## 1.2 The purpose of PRIMHD

The purpose of PRIMHD is to provide:

**Secure Information Access** and **Reporting** to underpin **Decision Support** and **Policy Development** through **Consistent** use of **Benchmarking**, **Standards** and **Key Performance Indicators**.

Facts about the **Value** of mental health services, supporting **Workforce Development** activities, **Cultural Relevance** and transforming mental health data into **Knowledge** to support our vision;

**“IMPROVED HEALTH OUTCOMES FOR ALL HEALTH CONSUMERS”**

### **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 PRIMHD 'Online Web-based Form Solution' will assist the NGO sector in their ability to capture and report information electronically.

### **1.4 The requirement for standards**

The PRIMHD will provide an integrated collection of service and outcome information for Health 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 PRIMHD 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 Health 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 PRIMHD 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.

### **1.5 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.

## 1.6 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
<b>Definition</b>	A statement that expresses the essential nature of the data element and its differentiation from all other data elements.
<b>Source standards</b>	Details of established data definitions or guidelines for data elements that have been cited in this standard.
<b>Data type</b>	Alphanumeric (X), Alphabetic (A), Numeric (N, numbers including decimals), Boolean (Y/N or checkbox on/off).
<b>Date only data structure</b>	Century (C), Year (Y), Month (M) and Day (D). Full date representation is either CCYY-MM-DD or DD-MM-CCYY.
<b>Date/Time data structure</b>	Century (C), Year (Y), Month (M), Day (D), Hour (H), Minute (M) and (S) Second. Time is recorded using the 24 hour clock. Full date/time representation is CCYY-MM-DDTHH:MM:SS.
<b>Representational class</b>	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.
<b>Field size</b>	Maximum number of characters that may be recorded in the field.
<b>Representational layout</b>	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.
<b>Data domain</b>	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 'PRIMHD 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.
<b>Guide for use</b>	Additional guidance to inform the use of the data element.
<b>Verification rules</b>	Quality control mechanisms that preclude non-valid codes from the data element.

## 2 PRIMHD RECORD TYPES

This chapter of the standard describes each of the record types and all applicable data elements that collectively form the Data Set of the PRIMHD file for a 'Health Consumer' receiving Mental Healthcare services.

### 2.1 Healthcare User (HC) Record Details

The PRIMHD Healthcare User record is a collection of data elements that uniquely identify the Health Consumer that is receiving Mental Health services. Information provided in the PRIMHD Legal Status and PRIMHD Referral Discharge records is validated against the National Health Index (NHI) system to derive and verify the data elements that make up the PRIMHD Healthcare User record.

#### 2.1.1 Healthcare User data requirements

- (a) Where the person is a Health Consumer of Mental Health services, the National Health Index (NHI) number/identifier 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 PRIMHD system will maintain the mental services information for each Health Consumer.

#### 2.1.2 Healthcare User data elements

The following lists all the data elements for 'Healthcare User' record, including those data elements that are derived either from data elements of other PRIMHD records or data elements from External Systems, such as the National Health Index (NHI).

Data Element	Reference	Data Element	Reference
(a) Event HCU ID	2.1.2.1	(d) Sex	2.1.2.4
(b) Master HCU ID	2.1.2.2	(e) Ethnicity	2.1.2.5
(c) Date of Birth	2.1.2.3		

##### 2.1.2.1 Event HCU ID

<b>Definition:</b>	The unique lifetime NHI number that has been used by the Health Consumer in the Referral Discharge record or the Legal Status record.		
<b>Source standards:</b>			
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Identifier
<b>Field size:</b>	<b>Max:</b> 7	<b>Representational layout:</b>	AAANNNN
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• Supplied in the Referral Discharge record or the Legal Status record so that the Event HCU ID can be validated by the NHI to determine if it is a Master NHI number or if it is a Secondary NHI number.</li> <li>• If the Event HCU ID is a Secondary NHI number then the appropriate Master NHI number is sourced from the NHI system and stored in the Master HCU ID data element of the PRIMHD Healthcare User record.</li> <li>• If the Event HCU ID is a Master NHI number then the Event HCU ID is copied to and stored in the Master HCU ID data element of the PRIMHD Healthcare User record.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. The person must be registered on the NHI before use.</li> <li>2. Can be either the Master NHI number or the Secondary NHI number.</li> </ol>		

### 2.1.2.2 Master HCU ID

<b>Definition:</b>	The primary unique lifetime NHI number that has been used by the Health Consumer or derived from the NHI where the Event HCU ID as provided in the Referral Discharge record or the Legal Status record is actually the Secondary NHI number.		
<b>Source standards:</b>			
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Identifier
<b>Field size:</b>	<b>Max:</b> 7	<b>Representational layout:</b>	AAANNNN
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Sourced from the NHI system.</li> <li>If the Event HCU ID is a Secondary NHI number then the appropriate Master NHI number is sourced from the NHI system and stored in the Master HCU ID data element</li> <li>If the Event HCU ID is also the Master NHI number then the Event HCU ID is copied to and stored in the Master HCU ID data element.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>The person must be registered on the NHI before use.</li> <li>Can only be the Master NHI number.</li> </ol>		

### 2.1.2.3 Date of Birth

<b>Definition:</b>	The DATE OF BIRTH of the Health Consumer who is being referred, discharged or is being assigned a legal status.		
<b>Source standards:</b>			
<b>Data type:</b>	Date	<b>Representational class:</b>	Full date
<b>Field size:</b>	<b>Max:</b> 10	<b>Representational layout:</b>	CCYY-MM-DD
<b>Data domain:</b>	Valid date.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Enter the full Date of Birth using year, month and day.</li> <li>Supplied in the Referral Discharge record or the Legal Status record so that the Event HCU ID can be verified by the NHI system.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be less than or equal to the date of record creation.</li> <li>Must be a valid date.</li> <li>Is validated by the National Health Index system.</li> </ol>		

#### 2.1.2.4 Sex

<b>Definition:</b>	A classification of the SEX of an individual, as supplied by the organisation.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 1	<b>Representational layout:</b>	A
<b>Data domain:</b>	Refer to Section 2.1.1.1 'Sex' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Code 'U' (Unknown) should only be used if the data is not collected at the point of practitioner contact, or the circumstances dictate that the data is not able to be collected.</li> <li>Supplied in the Referral Discharge record or the Legal Status record so that the Event HCU ID can be verified by the NHI system.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Valid code set value only.</li> <li>Is validated by National Health Index system.</li> </ol>		

#### 2.1.2.5 Ethnicity

<b>Definition:</b>	A classification of the ETHNICITY of an individual, as supplied by the organisation (refer to the Ethnicity Data Protocols, Ministry of Health).		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Numeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 4	<b>Representational layout:</b>	N(4)
<b>Data domain:</b>	Refer to Section 2.1.1.2 'Ethnicity' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Sourced from the NHI system</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Valid code set value only.</li> <li>Must be the actual ethnicity that is stored in the NHI system for the Health Consumer that matches all of the data elements in this PRIMHD Healthcare User record.</li> </ol>		

## 2.2 Legal Status (LS) Record Details

Information that describes a Health 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.

### 2.2.1 Legal Status data requirements

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

### 2.2.2 Legal Status data elements

The following lists all the data elements for 'Legal Status' record, including those data elements that have been previously detailed within this standard. Data elements that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Legal Status ID	2.2.2.1	(h) Sex	2.1.2.4
(b) Organisation ID	2.2.2.2	(i) Legal Status Code	2.2.2.6
(c) Submitting to MOH Org. ID	2.2.2.3	(j) LS Start Date/Time	2.2.2.7
(d) File Version	2.2.2.4	(k) LS End Date/Time	2.2.2.8
(e) Responsible Clinician CPN	2.2.2.5	(l) Extract From End Date/Time	2.2.2.9
(f) Event HCU ID	2.1.2.1	(n) Extracted Date/Time	2.2.2.10
(g) DoB	2.1.2.3	(o) Deleted Flag	2.2.2.11

#### 2.2.2.1 Legal Status ID

<b>Definition:</b>	An identifier for the corresponding record stored within the health provider's system.		
<b>Source standards:</b>			
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Free text
<b>Field size:</b>	<b>Max:</b> 20	<b>Representational layout:</b>	X(20)
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>This is used by some organisations as a reference field for checking data quality. It allows providers to link to their patient management systems.</li> </ul>		
<b>Verification rules:</b>			

### 2.2.2.2 Organisation ID

<b>Definition:</b>	A unique lifetime identifier for the organisation that is providing healthcare services to the Health Consumer		
<b>Source standards:</b>	HISO 10005 HPI Data Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Identifier
<b>Field size:</b>	<b>Max:</b> 8	<b>Representational layout:</b>	GXXNNN-C
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>G is a constant prefix. X is either an alpha or a numeric. N is numeric and C is the check digit.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>The organisation must be registered on the HPI before use.</li> <li>Must be a valid identifier in the HPI system organisation file.</li> <li>Modulus 11 Algorithm is used to formulate the Check Digit.</li> </ol>		

### 2.2.2.3 Submitting to MOH Organisation ID

<b>Definition:</b>	A unique lifetime identifier for the organisation that is submitting the PRIMHD data on behalf of the organisation providing healthcare services to the Health Consumer		
<b>Source standards:</b>	HISO 10005 HPI Data Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Identifier
<b>Field size:</b>	<b>Max:</b> 8	<b>Representational layout:</b>	GXXNNN-C
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>G is a constant prefix. X is either an alpha or a numeric. N is numeric and C is the check digit.</li> <li>Only to be used when the organisation providing the healthcare services to the Health Consumer IS NOT the organisation sending the PRIMHD data to the national system at the Ministry of Health.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>The organisation must be registered on the HPI before use.</li> <li>Must be a valid identifier in the HPI system organisation file.</li> <li>Modulus 11 Algorithm is used to formulate the Check Digit.</li> </ol>		

### 2.2.2.4 File Version

<b>Definition:</b>	The version of the PRIMHD XML Schema that the data elements in the organisations extract file are compliant with.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Numeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 3	<b>Representational layout:</b>	N.N
<b>Data domain:</b>	Refer to Section 2.2.1.1 'File Version' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Supplied in the Referral Discharge and Legal Status records only.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Valid code set value only.</li> </ol>		

### 2.2.2.5 Responsible Clinician CPN

<b>Definition:</b>	A unique lifetime identifier, from the HPI, for the responsible Clinician who assigned this Legal Status to the Health Consumer.		
<b>Source standards:</b>	HISO 10005 HPI Data Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Identifier
<b>Field size:</b>	<b>Max:</b> 6	<b>Representational layout:</b>	NNXXXX
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• A unique lifetime identifier for an individual practitioner and/or healthcare worker, which takes precedence over all other provider and clinician identifiers and is sourced from the Health Practitioner Index (HPI).</li> <li>• HPI system-generated two numeric (the second of which is a check digit) plus four alphabetic characters.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. The CPN includes a check digit in the second position.</li> <li>2. Modulus 11 Check Digit Algorithm.</li> <li>3. The person (Healthcare Provider) must be registered on the HPI before use.</li> </ol>		

### 2.2.2.6 Legal Status Code

<b>Definition:</b>	Code describing a Health 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.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphabetic	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 2	<b>Representational layout:</b>	A(2)
<b>Data domain:</b>	Refer to Section 2.2.1.2 'Legal Status Code' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• This is required to be submitted by the assigning organisation when the Health Consumer's Legal Status is other than voluntary</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. At least one code required.</li> <li>2. Must be a valid code set value only.</li> <li>3. The code must be valid for the date range the legal status is applicable.</li> <li>4. Must be valid for the applicable Legal Status Code commencement and conclusion dates within the Legal Status Code table.</li> </ol>		

### 2.2.2.7 LS Start Date/Time

<b>Definition:</b>	The date and time the legal status came into effect.		
<b>Source standards:</b>			
<b>Data type:</b>	Date/time	<b>Representational class:</b>	Full date and time
<b>Field size:</b>	<b>Max:</b> 19	<b>Representational layout:</b>	CCYY-MM-DDTHH:MM:SS
<b>Data domain:</b>	Valid date and time.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• Enter a full date and time including year, month, day, hour, minute and second.</li> <li>• If the applicable legal status date is not known, provision should be made to estimate the LS Start Date.</li> <li>• If the referral start time is not known, then 00:00:00 must be used</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. Must be less than or equal to the date of record creation.</li> <li>2. Must be a valid date and time.</li> <li>3. Must be greater than the Health Consumer's date of birth and less than or equal to their date of death, if the Health Consumer is deceased.</li> <li>4. Must be greater than the LS End Date of previous Legal Status record</li> <li>5. Must be less than or equal to the LS End Date in the current Legal Status record.</li> <li>6. Must be on or after the Legal Status Code commencement date in the Legal Status code set table;</li> <li>7. Must be on or before the Legal Status Code conclusion date in the Legal Status Code set table.</li> <li>8. Time is to be recorded using the 24 hour clock.</li> </ol>		

### 2.2.2.8 LS End Date/Time

<b>Definition:</b>	The date and time the legal status code ceased to apply.		
<b>Source standards:</b>			
<b>Data type:</b>	Date/time	<b>Representational class:</b>	Full date and time
<b>Field size:</b>	<b>Max:</b> 19	<b>Representational layout:</b>	CCYY-MM-DDTHH:MM:SS
<b>Data domain:</b>	Valid date and time		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• Enter a full date and time; including year, month, day, hour, minute and second.</li> <li>• If the referral start time is not known, then 23:59:59 must be used</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. Must be less than or equal to the date of record creation.</li> <li>2. Must be a valid date and time.</li> <li>3. Must be greater than or equal to the legal status start date/time.</li> <li>4. Must be greater than the Health Consumer's date of birth and less than or equal to their date of death, if the Health Consumer is deceased.</li> <li>5. Must be on or after the Legal Status Code commencement date in the Legal Status Code set table;</li> <li>6. Must be on or before the Legal Status Code conclusion date in the Legal Status Code set table.</li> <li>7. Time is to be recorded using the 24 hour clock.</li> </ol>		

### 2.2.2.9 Extract From Date/Time

<b>Definition:</b>	The actual reporting period commencement date and time for which the all data records in the extract file were collected from.		
<b>Source standards:</b>			
<b>Data type:</b>	Date/time	<b>Representational class:</b>	Full date and time
<b>Field size:</b>	<b>Max:</b> 19	<b>Representational layout:</b>	CCYY-MM-DDTHH:MM:SS
<b>Data domain:</b>	Valid date and time.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Enter the full date and time including year, month, day, hour, minute and second.</li> <li>Should greater than the previous file's Extracted Date/time.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be a valid date and time</li> <li>Must be the actual reporting period commencement date and time for which all data records in the extract file were collected from.</li> <li>Time is to be recorded using the 24 hour clock.</li> </ol>		

### 2.2.2.10 Extracted Date/Time

<b>Definition:</b>	The actual date and time that the PRIMHD extract file was created from the Organisations local system(s).		
<b>Source standards:</b>			
<b>Data type:</b>	Date/time	<b>Representational class:</b>	Full date and time
<b>Field size:</b>	<b>Max:</b> 19	<b>Representational layout:</b>	CCYY-MM-DDTHH:MM:SS
<b>Data domain:</b>	Valid date and time.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Enter the full date and time including year, month, day, hour, minute and second.</li> <li>Should be automatically generated by the Organisations local system on the actual date and time when the PRIMHD extract file was created for sending to the Ministry to be processed.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be a valid date and time.</li> <li>Must be the actual date and time when the PRIMHD extract file was created for sending to the Ministry to be processed.</li> <li>Time is to be recorded using the 24 hour clock.</li> </ol>		

### 2.2.2.11 Deleted Flag

<b>Definition:</b>	A data element that indicates a Referral Discharge record has been deleted.		
<b>Source standards:</b>			
<b>Data type:</b>	Alpha	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 7	<b>Representational layout:</b>	A(7)
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Used to indicate the deletion of a Legal Status record and all the associated derived Healthcare User and child Activity, Classification, Collection Occasion, Outcome Tool and Outcome Item records from the PRIMHD database.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must always equal 'DELETED'.</li> </ol>		

## 2.3 Referral Discharge (RD) Record Details

A health referral is a specific request from one healthcare team/provider to another, for advice about, or treatment of, a Health Consumer. Mental health and addiction services referrals can also be received directly from the Health Consumer or the Health Consumer's family/whānau/significant other (self or relative referral), or via other agencies such as Education, Courts, Prisons, Social Welfare, etc. A Referral also includes internal referrals between teams.

A referral ends when the Health 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.

### 2.3.1 Referral Discharge data requirements

- (a) Each referral discharge record will have a single unique identifier and record.
- (b) There will be only one referral discharge record open per referral identifier, per team, per organisation at one time.

### 2.3.2 Referral Discharge data elements

The following table lists all the data elements for 'Referral Discharge' record, including those data elements that have been previously detailed within this standard. Data elements that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Referral ID	2.3.2.1	(i) Referral From	2.3.2.2
(b) Organisation ID	2.2.2.2	(j) Referral To	2.3.2.3
(c) Submitting to MOH Org. ID	2.2.2.3	(k) Referral End Code	2.3.2.4
(d) Team Code	2.9.2.1	(l) RD Start Date/Time	0
(e) Event HCU ID	2.1.2.1	(m) RD End Date/Time	2.3.2.6
(f) File Version	2.2.2.4	(n) Extract From End Date/Time	2.2.2.9
(g) DoB	2.1.2.3	(o) Extracted Date/Time	2.2.2.10
(h) Sex	2.1.2.4	(p) Deleted Flag	2.2.2.11

#### 2.3.2.1 Referral ID

<b>Definition:</b>	An Identifier that links a variety of activity, including diagnosis and outcome measurements together for one episode.		
<b>Source standards:</b>			
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Free text
<b>Field size:</b>	<b>Max:</b> 20	<b>Representational layout:</b>	X(20)
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• An Identifier generated by the source, that, when combined with the Organisation ID in the national collection, becomes a unique identifier for the referral discharge record.</li> <li>• Each referral discharge record must be unique within the source organisation.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. A Referral Identifier can have only one Health Consumer per organisation, per team.</li> <li>2. The Identifier is assigned at source in the Provider's system.</li> </ol>		

### 2.3.2.2 Referral From

<b>Definition:</b>	The source from where the Health Consumer was referred in the beginning.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphabetic	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 2	<b>Representational layout:</b>	A(2)
<b>Data domain:</b>	Refer to Section 2.3.1.1 'Referral From' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Describes the groups of services or people who are referral sources.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be a valid code set value only.</li> <li>Must have only one per referral record.</li> </ol>		

### 2.3.2.3 Referral To

<b>Definition:</b>	The destination to where the Health Consumer was referred to when discharged from this referral.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphabetic	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 2	<b>Representational layout:</b>	A(2)
<b>Data domain:</b>	Refer to Section 2.3.1.2 'Referral To' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Describes the groups of services or people who are referral destinations.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be a valid code set value only.</li> <li>Must have one only per referral.</li> <li>Must be supplied with the Referral End Date.</li> <li>Has conditional validation where data is mandatory when discharging the Health Consumer.</li> </ol>		

### 2.3.2.4 Referral End Code

<b>Definition:</b>	A code that describes why the Health Consumer was discharged from the healthcare team.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alpha	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 2	<b>Representational layout:</b>	A(2)
<b>Data domain:</b>	Refer to Section 2.3.1.3 'Referral End Code' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>A code that identifies whether this is a Discharge or a Discharge Referral (refer HISO RSD documentation).</li> <li>A Discharge Referral within the hospital environment occurs when a Health 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.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be a valid code set value only.</li> <li>If this field is populated, Referral Discharge End Date must be populated.</li> </ol>		

### 2.3.2.5 Referral Discharge Start Date/Time

<b>Definition:</b>	The date and time on which the referral was received.		
<b>Source standards:</b>			
<b>Data type:</b>	Date/time	<b>Representational class:</b>	Full date and time
<b>Field size:</b>	<b>Max:</b> 19	<b>Representational layout:</b>	CCYY-MM-DDTHH:MM:SS
<b>Data domain:</b>	Valid date and time.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• Enter the full date and time including year, month, day, hour, minute and second.</li> <li>• If the referral date is not known, provision should be made to estimate the referral date. It is envisaged that only Health Consumers who have been in the care of the mental health service for many years will have partial dates.</li> <li>• If the RD Start Time is not known, then 00:00:00 must be used</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. Must be less than or equal to the date of record creation.</li> <li>2. Must be greater than the Health Consumer's date of birth and less than or equal to their date of death, if the Health Consumer is deceased.</li> <li>3. Must be a valid date and time</li> <li>4. Must be less than or equal to the RD End Date/Time</li> <li>5. Must be on or after the Team Code Open Date in the Team table;</li> <li>6. Must be on or before the Team Code Close Date in the Team table.</li> <li>7. Time is to be recorded using the 24 hour clock.</li> </ol>		

### 2.3.2.6 Referral Discharge End Date/Time

<b>Definition:</b>	The date and time that all contact between the Health Consumer and the mental health team ends.		
<b>Source standards:</b>			
<b>Data type:</b>	Date/time	<b>Representational class:</b>	Full date and time
<b>Field size:</b>	<b>Max:</b> 19	<b>Representational layout:</b>	CCYY-MM-DDTHH:MM:SS
<b>Data domain:</b>	Valid date and time.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• Enter the full date and time including year, month, day, hour, minute and second.</li> <li>• If the Health 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.</li> <li>• If the RD End Time is not known, then 23:59:59 must be used</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. Must be less than or equal to the date/time of record creation;</li> <li>2. Must be greater than or equal to the RD Start Date/Time;</li> <li>3. Must be greater than the Health Consumer's date of birth and less than or equal to their date of death, if the Health Consumer is deceased.</li> <li>4. Must be a valid date and time</li> <li>5. Must be on or after the Team Code Open Date in the Team table;</li> <li>6. Must be on or before the Team Code Close Date in the Team table.</li> <li>7. If Referral End Code is populated, this field is mandatory.</li> <li>8. Time is to be recorded using the 24 hour clock.</li> </ol>		

## 2.4 Activity (AT) Record Details

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

### 2.4.1 Activity data requirements

- (a) There can be none or multiple activity records per 'Referral Record', per 'Team' and per 'Organisation', for the same Health Consumer.
- (b) The referral record is the parent record for all activity records.

### 2.4.2 Activity data elements

The following lists all the data elements for 'Activity' record, including those data elements that have been previously detailed within this standard. Data elements that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Referral ID	2.3.2.1	(e) Activity Type	2.4.2.3
(b) Organisation ID	2.2.2.2	(f) Activity Setting	2.4.2.4
(c) Activity ID	2.4.2.1	(g) AT Start Date/Time	2.4.2.5
(d) Healthcare Worker CPN	2.4.2.2	(h) AT End Date/Time	2.4.2.6

#### 2.4.2.1 Activity ID

<b>Definition:</b>	An identifier for the corresponding record stored within the organisation's system.		
<b>Source standards:</b>			
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Free text
<b>Field size:</b>	<b>Max:</b> 20	<b>Representational layout:</b>	X(20)
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• An Identifier used to enable organisations to reference records in the national collection against those held in their local systems.</li> </ul>		
<b>Verification rules:</b>			

#### 2.4.2.2 Healthcare Worker CPN (HPI CPN)

<b>Definition:</b>	A unique lifetime identifier for an individual practitioner and/or healthcare worker, which takes precedence over all other provider and clinician identifiers and is sourced from the Health Practitioner Index (HPI).		
<b>Source standards:</b>	HISO 10005 HPI Data Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Identifier
<b>Field size:</b>	<b>Max:</b> 6	<b>Representational layout:</b>	NNXXXX
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• HPI system-generated two numeric (the second of which is a check digit) plus four alphabetic characters.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. The CPN includes a check digit in the second position.</li> <li>2. Modulus 11 Check Digit Algorithm.</li> <li>3. The person (Healthcare Worker) must be registered on the HPI before use.</li> </ol>		

### 2.4.2.3 Activity Type

<b>Definition:</b>	A code that classifies the type of healthcare activity provided to the Health Consumer.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 3	<b>Representational layout:</b>	ANN
<b>Data domain:</b>	Refer to Section 2.4.1.1 'Activity Type' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Activity Type is a code that is used to classify the type of healthcare activity provided to the Health Consumer.</li> <li>Only one code should be recorded per team per contact.</li> </ul>		
<b>Verification rules:</b>	1. Must be a valid code in the Activity Type code set table.		

### 2.4.2.4 Activity Setting

<b>Definition:</b>	The Activity Setting indicates the type of physical setting or contact channel that the activity was provided in.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 2	<b>Representational layout:</b>	X(2)
<b>Data domain:</b>	Refer to Section 2.4.1.2 'Activity Setting' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Describes the type of setting the Health Consumer was accessing service in.</li> </ul>		
<b>Verification rules:</b>	1. Valid code set value only.		

### 2.4.2.5 Activity Start Date/Time

<b>Definition:</b>	The date and time the Health Consumer commenced accessing this mental health activity.		
<b>Source standards:</b>			
<b>Data type:</b>	Date/time	<b>Representational class:</b>	Full date and time
<b>Field size:</b>	<b>Max:</b> 19	<b>Representational layout:</b>	CCYY-MM-DDTHH:MM:SS
<b>Data domain:</b>	Valid date or year and time.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Enter a full date and time including year, month, day, hour, minute and second.</li> <li>Where the Health Consumer is an inpatient this is the date of admission.</li> <li>Where the Health Consumer is a community outpatient, this is the date that they accessed a service.</li> <li>If the AT Start Time is not known, then 00:00:00 must be used</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be less than or equal to the AT End Date/Time.</li> <li>Must be greater than or equal to the Referral Start Date/Time and less than or equal to Referral End Date/Time.</li> <li>Must be greater than the Health Consumer's date of birth and less than or equal to their date of death, if the Health Consumer is deceased.</li> <li>Must be a valid date and time.</li> <li>Time is to be recorded using the 24 hour clock.</li> </ol>		

#### 2.4.2.6 Activity End Date/Time

<b>Definition:</b>	The date and time the Health Consumer ceased receiving this mental health activity.		
<b>Source standards:</b>			
<b>Data type:</b>	Date/time	<b>Representational class:</b>	Full date and time
<b>Field size:</b>	<b>Max:</b> 19	<b>Representational layout:</b>	CCYY-MM-DDTHH:MM:SS
<b>Data domain:</b>	Valid date or year and time.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• Enter a full date and time including year, month, day, hour, minute and second.</li> <li>• For non inpatient services, activity start and end date will normally be the same day.</li> <li>• If the AT End Time is not known, then 23:59:59 must be used</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. Must be greater than or equal to the AT Start Date/Time.</li> <li>2. Must be greater than or equal to the Referral Start Date/Time and less than or equal to Referral End Date/Time.</li> <li>3. Must be greater than the Health Consumer's date of birth and less than or equal to their date of death, if the Health Consumer is deceased.</li> <li>4. Must be a valid date and time.</li> <li>5. Time is to be recorded using the 24 hour clock.</li> </ol>		

## 2.5 Classification (CN) Record Details

Details describing the clinical diagnosis and/or issue codes assigned to a Health Consumer by a healthcare organisation's team.

### 2.5.1 Classification data requirements

- (a) There can be multiple classification records per 'Referral Record'.
- (b) NGOs are not required to submit Classification records.
- (c) The Classification record must contain either Clinical Coding data or Issues Coding data, but not both.
- (d) The only coding systems currently permitted to be used in PRIMHD are listed below.
  - ICD-9-CM 2<sup>nd</sup> Edition – Australian version of the International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification.
  - ICD-10-AM 1<sup>st</sup> Edition – The International Statistical Classification of Diseases and Related Health Problems, 10<sup>th</sup> Revision, Australian Modification, 1<sup>st</sup> Edition.
  - ICD-10-AM 2<sup>nd</sup> Edition – The International Statistical Classification of Diseases and Related Health Problems, 10<sup>th</sup> Revision, Australian Modification, 2<sup>nd</sup> Edition.
  - ICD-10-AM 3<sup>rd</sup> Edition – The International Statistical Classification of Diseases and Related Health Problems, 10<sup>th</sup> Revision, Australian Modification, 3<sup>rd</sup> 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, 4<sup>th</sup> Edition.

### 2.5.2 Classification data elements

The following lists all the data elements for 'Classification' record, including those data elements that have been previously detailed within this standard. Data elements that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Referral ID	2.3.2.1	(g) Issue Coding System ID	2.5.2.5
(b) Organisation ID	2.2.2.2	(h) Issue Type	2.5.2.6
(c) Classification ID	2.5.2.1	(i) Issue Code Value	2.5.2.7
(d) Clinical Coding System ID	2.5.2.2	(j) CN Start Date/Time	2.5.2.8
(e) Diagnosis Type	2.5.2.3	(k) CN End Date/Time	2.5.2.9
(f) Clinical Code Value	2.5.2.4		

### 2.5.2.1 Classification ID

<b>Definition:</b>	An identifier for the corresponding record stored within the health provider's system.		
<b>Source standards:</b>			
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Free Text
<b>Field size:</b>	<b>Max:</b> 20	<b>Representational layout:</b>	X(20)
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>An Identifier used to enable organisations to reference records in the national collection against those held in their local systems.</li> </ul>		
<b>Verification rules:</b>			

### 2.5.2.2 Clinical Coding System ID.

<b>Definition:</b>	A code identifying the clinical coding system used for diagnosis and procedures.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Numeric	<b>Representational Class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 2	<b>Representational layout:</b>	N(2)
<b>Data domain:</b>	Refer to Section 2.5.1.1 'Clinical Coding System ID' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>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).</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be a valid code in the Coding System Type code set table.</li> <li>Must form part of a valid combination of Clinical Coding System ID and Clinical Code Value and Diagnosis Type.</li> </ol>		

### 2.5.2.3 Diagnosis Type

<b>Definition:</b>	A code that groups clinical codes or indicates the priority of a diagnosis.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphabetic	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 1	<b>Representational layout:</b>	A
<b>Data domain:</b>	Refer to Section 2.5.1.2 'Diagnosis Code Type' code set.		
<b>Guide for use:</b>			
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be a valid code in the Diagnosis Code Type code set table.</li> <li>Must form part of a valid combination of Clinical Coding System ID and Clinical Code Value and Diagnosis Type.</li> </ol>		

#### 2.5.2.4 Clinical Code Value

<b>Definition:</b>	A code used to classify the condition or issue.		
<b>Source standards:</b>	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 PRIMHD Code Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 8	<b>Representational layout:</b>	X(8)
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>This comes from one of several clinical coding systems, as listed in Section 2.5.1d 'Clinical Coding Systems'.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be a valid code value in the specified coding system.</li> <li>Must form part of a valid combination of Coding System Type and Code Value and Code Type.</li> </ol>		

#### 2.5.2.5 Issue Coding System ID

<b>Definition:</b>	A code indicating the Issue Coding System(s) being used.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 2	<b>Representational layout:</b>	X(2)
<b>Data domain:</b>	Refer to Section 2.5.1.4 'Coding System Type' code set.		
<b>Guide for use:</b>			
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be a valid code in the Coding System Type code set table.</li> <li>Must form part of a valid combination of Issue Coding System ID and Issue Code Value and Issue Type.</li> </ol>		

#### 2.5.2.6 Issue Type

<b>Definition:</b>	A code that groups issue codes or indicates the priority of an issue.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphabetic	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 1	<b>Representational layout:</b>	A
<b>Data domain:</b>	Refer to Section 2.5.1.5 'Issue Code Type' code set.		
<b>Guide for use:</b>			
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be a valid code in the Issue Code Type code set table.</li> <li>Must form part of a valid combination of Issue Coding System ID and Issue Code Value and Issue Type.</li> </ol>		

### 2.5.2.7 Issue Code Value

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

### 2.5.2.8 CN Start Date/Time

<b>Definition:</b>	The date the clinical condition or issue was identified.		
<b>Source standards:</b>			
<b>Data type:</b>	Date/Time	<b>Representational class:</b>	Full date and time
<b>Field size:</b>	<b>Max:</b> 19	<b>Representational layout:</b>	CCYY-MM-DDTHH:MM:SS
<b>Data domain:</b>	Valid date or year and time.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Enter a full date and time, including year, month, day, hour, minute and seconds.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be less than or equal to the CN End Date/Time</li> <li>Must be greater than or equal to the Referral Start Date/Time and less than or equal to Referral End Date/Time.</li> <li>Must be greater than the Health Consumer's date of birth and less than or equal to their date of death, if the Health Consumer is deceased;</li> <li>Must be a valid date and year.</li> <li>Time is to be recorded using the 24 hour clock.</li> <li>If Time is not known, enter '00:00:00'.</li> </ol>		

### 2.5.2.9 CN End Date/Time

<b>Definition:</b>	The date the clinical condition or issue ceased to apply.		
<b>Source standards:</b>			
<b>Data type:</b>	Date/Time	<b>Representational class:</b>	Full date and time
<b>Field size:</b>	<b>Max:</b> 19	<b>Representational layout:</b>	CCYY-MM-DDTHH:MM:SS
<b>Data domain:</b>	Valid date or year and time.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Enter a full date and time, including year, month, day, hour, minute and seconds.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be greater than or equal to the CN Start Date/Time;</li> <li>Must be greater than or equal to the Referral Start Date/Time and less than or equal to Referral End Date/Time.</li> <li>Must be greater than the Health Consumer's date of birth and less than or equal to heir date of death, if the Health Consumer is deceased.</li> <li>Must be a valid date and year.</li> <li>Time is to be recorded using the 24 hour clock.</li> <li>If Time is not known, enter '23:59:59'.</li> </ol>		

## 2.6 Collection Occasion (CO) Record Details

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'.

### 2.6.1 Collection Occasion data requirements

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

### 2.6.2 Collection Occasion data elements

The following lists all the data elements for 'Collection Occasion' record, including those data elements that have been previously detailed within this standard. Data elements that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Referral ID	2.3.2.1	(f) Healthcare Worker CPN	2.4.2.2
(b) Organisation ID	2.2.2.2	(g) Outcome Episode ID	2.6.2.4
(c) Collection Occasion ID	2.6.2.1	(h) Protocol Version	2.6.2.5
(d) Reason for Collection	2.6.2.2	(i) Focus of Care	2.6.2.6
(e) Collection Occasion Date/Time	2.6.2.3		

#### 2.6.2.1 Collection Occasion ID

<b>Definition:</b>	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.		
<b>Source standards:</b>			
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Identifier
<b>Field size:</b>	<b>Max:</b> 20	<b>Representational layout:</b>	X(20)
<b>Data domain:</b>	Auto number.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>An Identifier used to enable organisations to reference records in the national collection against those held in their local systems.</li> </ul>		
<b>Verification rules:</b>			

#### 2.6.2.2 Reason for Collection

<b>Definition:</b>	The reason for the collection of the standard measures and individual data items on the identified Collection Occasion.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Code
<b>Field size:</b>	4	<b>Representational layout:</b>	AANN
<b>Data domain:</b>	Refer to Section 2.6.1.1 'Reason for Collection' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>The reason for the collection of the standard measures and individual data items on the identified Collection Occasion.</li> </ul>		
<b>Verification rules:</b>	1. Must be a valid code in the Reason For Collection code set.		

### 2.6.2.3 Collection Occasion Date/Time

<b>Definition:</b>	The date and time on which the collection of the outcome measure(s) commenced.		
<b>Source standards:</b>			
<b>Data type:</b>	Date/Time	<b>Representational class:</b>	Full date and time
<b>Field size:</b>	<b>Max:</b> 19	<b>Representational layout:</b>	CCYY-MM-DDTHH:MM:SS
<b>Data domain:</b>	Valid date or year and time.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• Enter the full date and time including year, month, day, hour, minute and seconds.</li> <li>• For data collected at <i>admission</i> into an outcomes episode of care, the Collection Occasion date is the Admission Date.</li> <li>• 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.</li> <li>• 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.</li> <li>• The collection date is the reference date for all reports and statistical analyses of the data collected at any given Collection Occasion.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. Must be less than or equal to the date and/or time of record creation.</li> <li>2. Must be greater than or equal to the Referral Start Date/Time and less than or equal to Referral End Date/Time.</li> <li>3. Must be greater than the Health Consumer's date of birth and less than or equal to their date of death, if the Health Consumer is deceased.</li> <li>4. Must be a valid date and year.</li> <li>5. Time is to be recorded using the 24 hour clock.</li> <li>6. If Time is not known, enter '00:00:00'.</li> </ol>		

### 2.6.2.4 Outcome Episode ID

<b>Definition:</b>	Unique identifier for each outcome episode at organisation level.		
<b>Source standards:</b>			
<b>Data type:</b>	Numeric	<b>Representational class:</b>	Identifier
<b>Field size:</b>	<b>Max:</b> 9	<b>Representational layout:</b>	N(9)
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. Must be a valid identifier in MH-SMART before use.</li> </ol>		

### 2.6.2.5 Protocol Version

<b>Definition:</b>	The version of the information collection protocol under which the data has been collected and submitted.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 4	<b>Representational layout:</b>	N(4)
<b>Data domain:</b>	Refer to Section 2.6.1.2 'Protocol Version' code set.		
<b>Guide for use:</b>			
<b>Verification rules:</b>	1. Must be a valid code.		

### 2.6.2.6 Focus of Care

<b>Definition:</b>	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.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Code
<b>Field size:</b>	4	<b>Representational layout:</b>	AANN
<b>Data domain:</b>	Refer to Section 2.6.1.3 'Focus of Care' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• Not used for HoNOSCA</li> <li>• Not collected for Admission collections</li> </ul>		
<b>Verification rules:</b>	1. Must be a valid code in the Focus Of Care code set.		

## 2.7 Outcome Tool (OT) Record Details

'Outcome Tool' includes data regarding the measures or instruments used to gather data about Health 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 Health Consumer outcomes. Future instruments could include a Health Consumer measure, a cultural measure, an NGO measure and a functioning measure.

### 2.7.1 Outcome Tool data requirements

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

### 2.7.2 Outcome Tool data elements

The following lists all the data elements for 'Outcome Tool' record, including those data elements that have been previously detailed within this standard. Data elements that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Referral ID	2.3.2.1	(d) Mode of Administration	2.7.2.2
(b) Organisation ID	2.2.2.2	(e) Collection Status	2.7.2.3
(c) Collection Occasion ID	2.6.2.1	(f) Completion Date/Time	2.7.2.4
(d) Outcome Tool Type and Version	2.7.2.1		

#### 2.7.2.1 Outcome Tool Type and Version

<b>Definition:</b>	A code that identifies the Outcome Tool, and the Version of that tool, which is used for a particular outcome collection.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 2	<b>Representational layout:</b>	AN
<b>Data domain:</b>	Refer to Section 2.7.1.1 'Outcome Tool Type and Version' code set.		
<b>Guide for use:</b>			
<b>Verification rules:</b>	1. Must be a valid code.		

#### 2.7.2.2 Mode of Administration

<b>Definition:</b>	The procedure or method used in the ascertainment and recording of the standard measure.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Code
<b>Field size:</b>	4	<b>Representational layout:</b>	AANN
<b>Data domain:</b>	Refer to Section 2.7.1.2 'Mode of Administration' code set.		
<b>Guide for use:</b>			
<b>Verification rules:</b>	1. Must be a valid code in the Mode Of Administration code set.		

### 2.7.2.3 Collection Status

<b>Definition:</b>	The completion status of the data recorded and, if missing data is recorded, the reason for the non-completion of the measure.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Code
<b>Field size:</b>	4	<b>Representational layout:</b>	AANN
<b>Data domain:</b>	Refer to Section 2.7.1.3 'Collection Status' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>States the status of the data.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be a valid code in the Collection Status code set.</li> </ol>		

### 2.7.2.4 Completion Date/Time

<b>Definition:</b>	The date and time of completion of the outcome measure collection.		
<b>Source standards:</b>			
<b>Data type:</b>	Date/Time	<b>Representational class:</b>	Full date and time
<b>Field size:</b>	<b>Max:</b> 19	<b>Representational layout:</b>	CCYY-MM-DDTHH:MM:SS
<b>Data domain:</b>	Valid date or year and time.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>Enter the full date and time including year, month, day, hour, minute and second that the item was scored/collected.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be less than or equal to the date and/or time of record creation.</li> <li>Must be greater than or equal to the Referral Start Date/Time and less than or equal to Referral End Date/Time.</li> <li>Must be greater than the Health Consumer's date of birth and less than or equal to their date of death, if the Health Consumer is deceased.</li> <li>Must be a valid date and year.</li> <li>Time is to be recorded using the 24 hour clock.</li> <li>If Time is not known, enter '23:59:59'.</li> </ol>		

## 2.8 Outcome Item (OI) Record Details

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

### 2.8.1 Outcome Item data requirements

The 'Outcome Item' will determine the value of which items or measures will be collected.

### 2.8.2 Outcome Item data elements

The following lists all the data elements for 'Outcome Item' record, including those data elements that have been previously detailed within this standard. Data elements that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Referral ID	2.3.2.1	(d) Outcome Tool Type and Version	2.7.2.1
(b) Organisation ID	2.2.2.2	(e) Outcome Item Code	2.8.2.1
(c) Collection Occasion ID	2.6.2.1	(f) Outcome Item Value	2.8.2.2

#### 2.8.2.1 Outcome Item Code

<b>Definition:</b>	An identifier that indicates the Outcome Item that is being measured.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Identifier
<b>Field size:</b>	<b>Max:</b> 3	<b>Representational layout:</b>	X(3)
<b>Data domain:</b>	Refer to Section 2.8.1.1 'Outcome Item Number' code set. HoNOS, HoNOS65, HoNOSCA, HoNOS Secure, HoNOS LD Item numbers.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>The primary key for the Outcome Item record.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be a valid code in the Outcome Item code set.</li> <li>Must be a valid Outcome Item for the Outcome Tool and protocol that is being used.</li> </ol>		

#### 2.8.2.2 Outcome Item Value

<b>Definition:</b>	The value given to a particular outcome item code.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 1	<b>Representational layout:</b>	X
<b>Data domain:</b>	Refer to Section 2.8.1.2 'Outcome Item Value' code set.		
<b>Guide for use:</b>			
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>Must be a valid code for the Outcome Item Value within the code set.</li> <li>Outcome Item Code codes A-J, X and Z are only valid when the following "Outcome Item Value" codes are used: <ol style="list-style-type: none"> <li>HoNOS: Outcome Item Value code 08a</li> <li>HoNOS 65+: Outcome Item Value code 08a</li> </ol> </li> <li>Outcome Item Code codes A-E, X and Z are only valid when HoNOS LD: Outcome Item Value code 03a is used</li> </ol>		

## 2.9 Team (TR) Record Details

A team consist of a person or functionally discrete grouping of people providing mental health and addiction services. These codes are created and maintained by the Ministry of Health Information Directorate, Sector Services, Data Management Services, Data Quality National Systems Team.

### 2.9.1 Team 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 Information Directorate.
- (d) the PRIMHD will retain a history of team information.

### 2.9.2 Team data elements

The following lists all the data elements for a 'Team' record, including those data elements that have been previously detailed within this standard. Data elements that have been previously detailed have not been repeated. Instead there is a reference to the applicable chapter/section in this standard.

Data Element	Reference	Data Element	Reference
(a) Team Code	2.9.2.1	(i) Team Target Population	2.9.2.8
(b) Organisation ID	2.9.2.2	(j) Team Open Date	2.9.2.9
(c) Facility ID	2.9.2.3	(k) Team Close Date	2.9.2.10
(d) File Version	2.2.2.4	(l) Comments	2.9.2.11
(e) Team Name	2.9.2.4	(m) Provider ID	2.9.2.12
(f) Team Type	2.9.2.5	(n) Contract ID	2.9.2.13
(g) Team Setting	2.9.2.6	(o) Agency Code	2.9.2.14
(h) Team Service Type	2.9.2.7	(p) Organisation Type	2.9.2.15

#### 2.9.2.1 Team Code

<b>Definition:</b>	A code, which uniquely identifies a healthcare team assigned by MoH. A person or functionally discrete grouping of people based in a particular location, providing mental health care to a Health Consumer group in either an inpatient or community setting. Uniquely linked to provider's Organisation Identifier.		
<b>Source standards:</b>			
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Code (Identifier)
<b>Field size:</b>	<b>Max:</b> 6	<b>Representational layout:</b>	X(6)
<b>Data domain:</b>	Refer to Section 2.9.1.1 'Team Code' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• The Team Code is assigned by MoH.</li> <li>• This code has a minimum of 4 digits with a maximum of 6.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. Must be a valid identifier code in the Team Code ID Table that has been assigned by the Information Directorate.</li> <li>2. Must be a minimum of 4 characters and a maximum of 6 characters.</li> <li>3. Must have valid HPI Organisation and Facility Identifiers assigned in the Team table.</li> <li>4. At least one code required.</li> <li>5. The code must be valid for the date open and close range the team is applied to.</li> </ol>		

### 2.9.2.2 Organisation ID

<b>Definition:</b>	A unique lifetime identifier for the organisation that is providing healthcare services to the Health Consumer		
<b>Source standards:</b>	HISO 10005 HPI Data Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Identifier
<b>Field size:</b>	<b>Max:</b> 8	<b>Representational layout:</b>	GXXNNN-C
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>G is a constant prefix. X is either an alpha or a numeric. N is numeric and C is the check digit.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>The organisation must be registered on the HPI before use.</li> <li>Must be a valid identifier in the HPI system organisation file.</li> <li>Modulus 11 Algorithm is used to formulate the Check Digit.</li> </ol>		

### 2.9.2.3 Facility ID

<b>Definition:</b>	A unique lifetime identifier for a facility assigned by the data source.		
<b>Source standards:</b>	HISO 10005 HPI Data Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Identifier
<b>Field size:</b>	<b>Max:</b> 8	<b>Representational layout:</b>	FXXNNN-C
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>F is a constant prefix. X is either an alpha or a numeric. N is a numeric. C is the Check Digit.</li> <li>The Facility Identifier is assigned by the HPI system at the time that the facility record in the HPI is created.</li> <li>The Facility Identifier Check Digit is used to validate data entry of facility identifiers.</li> <li>A Modulus 11 check digit routine is run over the six characters of the facility identifier to produce the Facility Identifier Check Digit.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>The facility must be registered on the HPI before use.</li> <li>Must be a valid identifier in the HPI system facility file.</li> <li>Must be a Modulus 11 Check Digit Algorithm.</li> </ol>		

### 2.9.2.4 Team Name

<b>Definition:</b>	The name by which the Team is known.		
<b>Source standards:</b>	xNAL – OrganisationName.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Free text
<b>Field size:</b>	<b>Max:</b> 255	<b>Representational layout:</b>	X(255)
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>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.</li> </ul>		
<b>Verification rules:</b>			

### 2.9.2.5 Team Type

<b>Definition:</b>	A code that categorises the primary function of the healthcare Team.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Numeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 2	<b>Representational layout:</b>	N(2)
<b>Data domain:</b>	Refer to Section 2.9.1.2 'Team Type' code set.		
<b>Guide for use:</b>	Use the most specific code available. Codes for inpatient and community teams should only be used when there is no other code applicable.		
<b>Verification rules:</b>	Valid code set value only.		

### 2.9.2.6 Team Setting

<b>Definition:</b>	A code that categorises the setting of the healthcare team.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alpha	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 1	<b>Representational layout:</b>	A
<b>Data domain:</b>	Refer to Section 2.9.1.3 'Team Setting' code set.		
<b>Guide for use:</b>	Use the most specific code available.		
<b>Verification rules:</b>	Valid code set value only.		

### 2.9.2.7 Team Service Type(s)

<b>Definition:</b>	A code that categorises whether the team is a designated cultural service healthcare team.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alpha	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 2	<b>Representational layout:</b>	A(2)
<b>Data domain:</b>	Refer to Section 2.9.1.4 'Team Service Type' code set.		
<b>Guide for use:</b>	Use the most specific code available.		
<b>Verification rules:</b>	Valid code set value only.		

### 2.9.2.8 Team Target Population

<b>Definition:</b>	A code that categorises the age group or target population group that the healthcare team provides service to.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Numeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 1	<b>Representational layout:</b>	N
<b>Data domain:</b>	Refer to Section 2.9.1.5 'Team Target Population' code set.		
<b>Guide for use:</b>	Use the most specific code available.		
<b>Verification rules:</b>	Valid code set value only.		

### 2.9.2.9 Team Open Date

<b>Definition:</b>	The date on which the Team began its operation.		
<b>Source standards:</b>			
<b>Data type:</b>	Date	<b>Representational class:</b>	Full or partial date
<b>Field size:</b>	<b>Max:</b> 10	<b>Representational layout:</b>	CCYY-MM-DD
<b>Data domain:</b>	Valid date or year.		
<b>Guide for use:</b>	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).		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. Must be less than or equal the Team Close Date.</li> <li>2. be a valid date or year.</li> </ol>		

### 2.9.2.10 Team Close Date

<b>Definition:</b>	The date on which the Team ceased its operation.		
<b>Source standards:</b>			
<b>Data type:</b>	Date	<b>Representational class:</b>	Full date
<b>Field size:</b>	<b>Max:</b> 10	<b>Representational layout:</b>	CCYY-MM-DD
<b>Data domain:</b>	Valid date.		
<b>Guide for use:</b>	Enter the full date including year, month and day.		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. Must be greater than or equal to Team Open Date.</li> <li>2. Must be a valid date.</li> </ol>		

### 2.9.2.11 Comments

<b>Definition:</b>	The supporting comments pertaining to the Team.		
<b>Source standards:</b>			
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Free text
<b>Field size:</b>	<b>Max:</b> 255	<b>Representational layout:</b>	X(255)
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• Any other free text comments that provide some further information about the Team in this Team record.</li> </ul>		
<b>Verification rules:</b>			

### 2.9.2.12 Provider ID

<b>Definition:</b>	The CMS system identifier of the service provider for the NGO organisation.		
<b>Source standards:</b>			
<b>Data type:</b>	Numeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 6	<b>Representational layout:</b>	N(6)
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• Only used with NGO provider Teams.</li> </ul>		
<b>Verification rules:</b>	<ol style="list-style-type: none"> <li>1. Must be a valid Provider ID Number from the CMS system.</li> </ol>		

### 2.9.2.13 Contract ID

<b>Definition:</b>	The CMS system identifier of the service contract for the NGO organisation for this specific team.		
<b>Source standards:</b>			
<b>Data type:</b>	Numeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 8	<b>Representational layout:</b>	N(8)
<b>Data domain:</b>			
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• Only used with NGO provider Teams.</li> <li>• Where multiple contracts apply, chose the most appropriate</li> </ul>		
<b>Verification rules:</b>	1. Must be a valid Contract Id Number from the CMS system.		

### 2.9.2.14 Agency Code

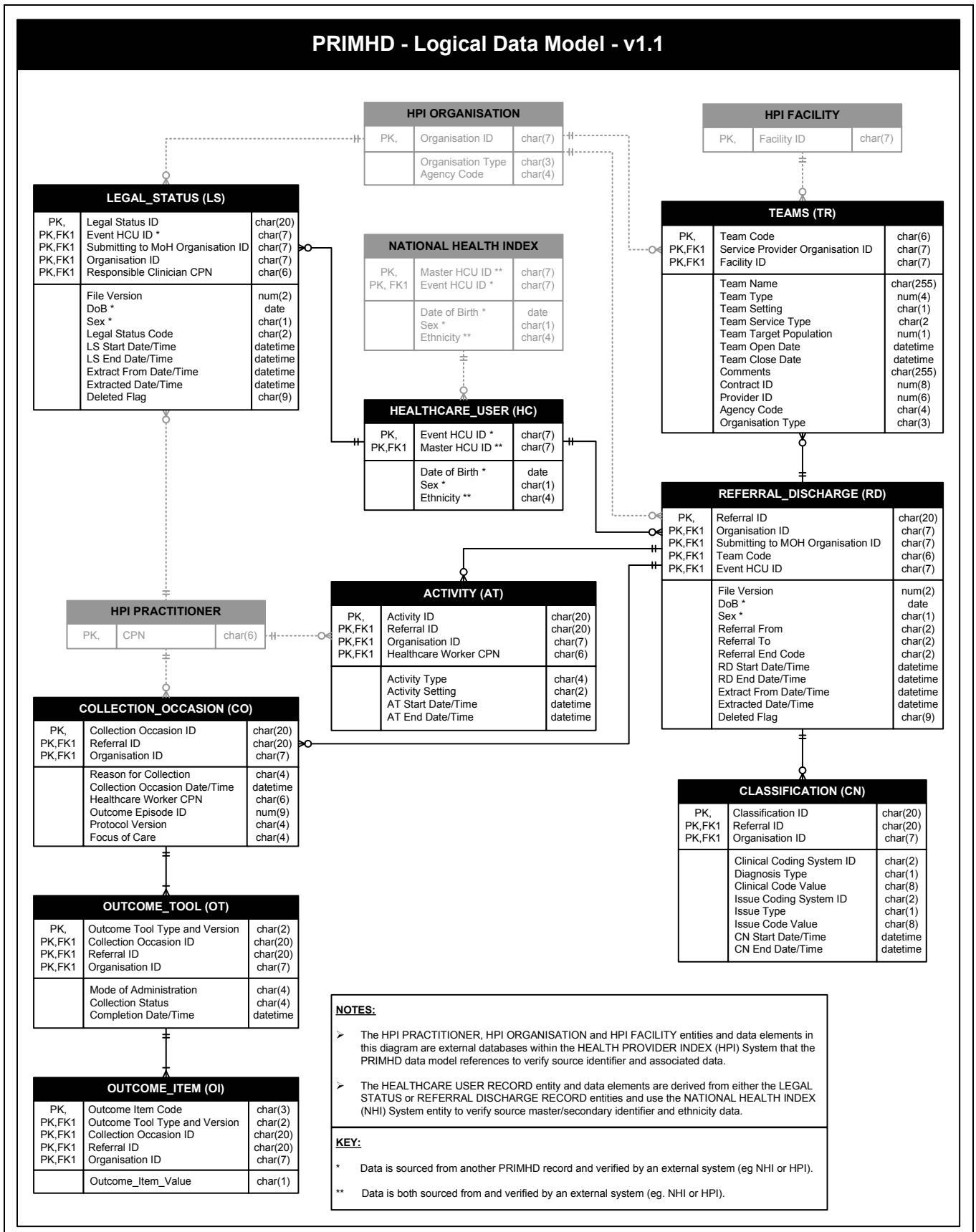
<b>Definition:</b>	A code that uniquely identifies an agency. An agency is the historical or legacy systems terminology for an organisation, institution or group of institutions that contracts directly with the principal health services purchaser to deliver healthcare services to the community.		
<b>Source standards:</b>	HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Alphanumeric	<b>Representational class:</b>	Identifier
<b>Field size:</b>	<b>Max:</b> 4	<b>Representational layout:</b>	X(4)
<b>Data domain:</b>	Refer to Section 2.9.1.6 'Agency Code' code set.		
<b>Guide for use:</b>	<ul style="list-style-type: none"> <li>• The agency code is assigned by MoH and is historically used to identify an organisation, institution or group of institutions in MoH legacy systems (NMDS, NBRS, MHINC et al).</li> <li>• 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 PRIMHD Organisation Identifier data element, where the team/provider's systems are not able to use HPI Organisation Identifiers.</li> </ul>		
<b>Verification rules:</b>	1. Must be a valid code set value from NMDS, NBRS and MHINC that has been mapped to its replacement HPI Organisation Identifier.		

### 2.9.2.15 Organisation Type

<b>Definition:</b>	A code that enables differentiation between different organisational entities.		
<b>Source standards:</b>	HISO HPI Common Code Set, and HISO 10023.3 PRIMHD Common Code Set.		
<b>Data type:</b>	Numeric	<b>Representational class:</b>	Code
<b>Field size:</b>	<b>Max:</b> 3	<b>Representational layout:</b>	N(3)
<b>Data domain:</b>	Refer to 4.3.1 - Organisation Type Code Set (HISOHPI4.3.1), and Refer to Section 2.9.1.7 'Organisation Type' code set.		
<b>Guide for use:</b>			
<b>Verification rules:</b>	1. Valid code set value only.		

# APPENDIX A LOGICAL DATA MODEL

The following diagram is an informative representation of the Logical Data Model for the PRIMHD Operational Data Store only. Details of the physical entity relationship diagram for the PRIMHD Datamart are in Appendix B of the PRIMHD File Specification v2.0



## APPENDIX B 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 Health Consumer to a facility. It is where a Health Consumer is accepted for treatment by a service, either by way of an inpatient admission, or with outpatient services.
CLIC	Client Information Collection database.
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. Health 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.
Discharge	The relinquishing of Health Consumer care/support in whole or in part by a healthcare provider or organisation. There are two common types of discharge: (a) Administrative discharge, and (b) Clinical discharge.
Facility	A single physical location from which health goods and/or services are provided.
Health Consumer	A person who accesses publicly funded healthcare. This person may be referred to elsewhere as a 'Healthcare User', 'Client' or 'Patient'.
Health Practitioner Index (HPI)	A centrally managed system 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 Health 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.
Healthcare Provider	A person or organisation that provides Health Consumer health care services.
Healthcare User	A person who accesses publicly funded healthcare, this person may also be referred to as a 'Health Consumer', 'Client' or 'Patient'.
Healthcare Worker	A person not registered with a responsible authority who works within the health sector.
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.

Term	Definition
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).
ID	Ministry of Health's Information Directorate
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.
National Health Index (NHI)	National Health Index is a centrally managed system that is used to collect and distribute data about Healthcare Users or Health Consumers. The NHI will facilitate the timely and secure exchange of health information, ensure the accurate and unique identification of Health Consumers 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 Health Consumers. The Ministry of Health (as the NHI Administrator) manages the NHI.
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, Health 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.
PRIMHD	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: (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 Health Consumer. The common factor in all referrals is a communication whose intent is the transfer of care/support, in part or in whole.
Referral Discharge	A referral occurring in the context of discharge and comprising a referral discharge record with a referral end date/time and a referral end code.

Term	Definition
Referred To Healthcare Provider	The healthcare team/provider to which a Health Consumer has been referred for advice or treatment by a referring healthcare provider. The 'Referred To Healthcare Provider' may be an individual or facility.
Referring Healthcare Provider	The healthcare team/provider that is referring the Health Consumer for advice or treatment. The referring team/provider generally has primary care responsibilities for the Health 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 Health 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 C 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](http://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](http://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:** Provides guidance on business processes relating to a Health Consumers passage through the health sector.