hiso Health Information Standards Organisation
PAEREWA PĀRONGO HAUORA

Te Whatu Ora
Health New Zealand

PRIMHD Data Set Standard

HISO 10023.2:2023

Released May 2023

Te Kāwanatanga o Aotearoa
New Zealand Government

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Health New Zealand

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Contents

Working Group Representation

The following organisations contributed to the creation of this document:

- Taeaomanino Trust
- Northern DHB Support Agency
- Nelson-Marlborough District Health Board
- Southern District Health Board
- Te Menenga Pai Charitable Trust
- Midland Mental Health & Addictions Regional Network (HealthShare Ltd)
- Hutt Valley District Health Board
- Linkage Limited
- Progress to Health
- Pact Group
- Ministry of Health National Collections and Reporting
- Ministry of Health Mental Health Service Improvement

Version Control

Reason for Change	Version	Date
Original published document	Version 2.1	June 2010
Updated to replace code 'valid to' dates of 30-06-2011 with 30-06-2015.	Version 2.2	October 2010
General update applied following HISO review of PRIMHD. Changes made are significant and pervasive. They reflect a generic refresh of dates, legislative references, the incorporation of changes to the PRIMHD process and the inclusion of additional record indicator code groupings.	Version 3.0	June 2013
The Standard has been updated to indicate that the implementation of Section 2.10 (Supplementary Consumer Record) is on hold pending advice of an appropriate date likely to be July 2015.	Version 3.1	July 2014
The effective date for the collection of the Supplementary Consumer Record detail information (section 2.10) previously "on hold" is now confirmed as 1 July 2016. This standard is updated and renumbered to remain in step with 10023.1:2015 Business Process Standard and 10023.3:2015 Code Set Standard	2015	July 2015
Definition at section 2.10.2.5 clarified. Minor errata corrected. The Creative Commons license is updated to version 4.0.	2015	January 2016
Changes made to this version of the PRIMHD Standard suite derive from the Substance Addiction (Compulsory Assessment & Treatment) Act 2017. Minor administrative updates are included.	2017	August 2017
Addition of Family/Whānau Involvement as an Activity Type record (section **Error! Reference source not found.**)	2017	March 2021
Update of PRIMHD standard suite to new Te Whatu Ora branding. Other minor administrative updates.	2023	May 2023

Related documents

This document is to be used in conjunction with:

- HISO 10023.1:2023 PRIMHD Data Set Standard
- HISO 10023.3:2023 PRIMHD Code Set Standard.

New Zealand legislation

The following Acts of Parliament and Regulations have specific relevance to this standard.

- Children, Young Persons, and Their Families Act 1989
- Criminal Procedure (Mentally Impaired Persons) Act 2003
- Health Act 1956
- Health Information Privacy Code 2020
- 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
- Privacy Act 2020
- Substance Addiction (Compulsory Assessment and Treatment) Act 2017

1 Introduction

1.1 Documents

The PRIMHD standard comprises the following three documents:

- HISO 10023.1:2023 PRIMHD Data Process Standard
- HISO 10023.2:2023 PRIMHD Data Set Standard
- HISO 10023.3:2023 PRIMHD Code Set Standard

The standards are designed to promote interoperability of information systems within the health and disability sector.

1.2 Overview of the data set standard

This document defines the data to be collected in the national PRIMHD (Programme for the Integration of Mental Health Data) data set.

This document defines the elements of the data set in detail, providing an overview of each grouping of data 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

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, 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. 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. It was decided 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 https://www.ict.govt.nz/guidance-and-resources/standards-compliance/government-enterprise-architecture-for-new-zealand-standards-reference/

1.3 The purpose of PRIMHD

PRIMHD (pronounced ‘primed’) is a Te Whatu Ora single national mental health and addiction information collection of service activity and outcomes data for health tangata whaiora/consumers.

The vision for PRIMHD is to assist in the improvement of health outcomes for all mental health and addiction tangata whaiora/consumers in New Zealand by the provision of a single rich data source of national mental health and addiction information that can be used for multiple purposes.

The PRIMHD national collection is a reporting platform that enables operational performance reporting, benchmarking, service improvement and policy development for mental health and addiction services.

1.4 Collection of data

PRIMHD data is used to report in what services are being provided, who is providing the services, and what outcomes are being achieved for health tangata whaiora/consumers across New Zealand’s mental health and addiction sector. These reports enable better quality service planning and decision-making by mental health and addiction service providers, at the local regional and national levels.

Initially, PRIMHD data was collected at a district level. This has been expanded out to the Non-Government (NGO) sector as the NGO sector developed capability.

The data is stored in the PRIMHD datamart which is part of the Te Whatu Ora’s national data warehouse.

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

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 (ie 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 only data structure	Century (C), Year (Y), Month (M) and Day (D). Full date representation is either CCYY-MM-DD or DD-MM-CCYY.
Date/time data structure	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.
Representational class	For A, N & X data types, 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 ‘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.
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.

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 tangata whaiora/consumer receiving mental health and addiction healthcare services.

2.1 Healthcare User (HC) Record

The PRIMHD Healthcare User record is a collection of data elements that uniquely identify the health tangata whaiora/consumer who is receiving mental health and addiction 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 tangata whaiora/consumer of mental health and addiction 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 tangata whaiora/consumer, eg name changes.

c) The PRIMHD system will maintain the mental services and addiction information for each health tangata whaiora/consumer.

2.1.2 Healthcare User data elements

The following lists all the data elements for ‘Healthcare User’ (HCU) 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/gender	**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

Definition	The unique lifetime NHI number that has been used by the health tangata whaiora/consumer in the Referral Discharge record or the Legal Status record.		
Source standards			
Data type	Alphanumeric	**Representational class**	Identifier
Field size	**Max**: 7	**Representational layout**	AAANNNN
Data domain			
Guide for use	• 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. • 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. • 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.		
Verification rules	1. The person must be registered on the NHI before use. 2. Can be either the Master NHI number or the Secondary NHI number.		

2.1.2.2 Master HCU ID

Definition	The primary unique lifetime NHI number that has been used by the health tangata whaiora/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.		
Source standards			
Data type	Alphanumeric	**Representational class**	Identifier
Field size	**Max**: 7	**Representational layout**	AAANNNN

Data domain	
Guide for use	• Sourced from the NHI system. Registered Users can access the NHI System via the 0800 855151 number. • 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 • 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.
Verification rules	1. The person must be registered on the NHI before use. 2. Can only be the Master NHI number.

2.1.2.3 Date of Birth

Definition	The date of birth of the health tangata whaiora/consumer who is being referred, discharged or is being assigned a legal status.		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	**Max**: 10	**Representational layout**	CCYY-MM-DD
Data domain	Valid date.		
Guide for use	• Enter the full Date of Birth using year, month and day. • Supplied in the Referral Discharge record or the Legal Status record so that the Event HCU ID can be verified by the NHI system.		
Verification rules	1. Must be a valid date less than or equal to the date of record creation. 2. Is validated by the National Health Index system.		

2.1.2.4 Sex/gender

Definition	A classification of the sex/gender of an individual, as supplied by the organisation.		
Source standards	HISO 10023.3:2023 PRIMHD Code Set Standard		
Data type	Alphanumeric	**Representational class**	Code
Field size	**Max**: 1	**Representational layout**	A
Data domain	Refer to Sex/gender section of PRIMHD code set standard.		
Guide for use	• 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. • Supplied in the Referral Discharge record or the Legal Status record so that the Event HCU ID can be verified by the NHI system. • The submitted gender (labelled sex in PRIMHD) must match the NHI gender. For reporting purposes, the gender of an individual is sourced directly from the National Health Index (NHI).		
Verification rules	1. Valid code set value only. 2. Is validated by National Health Index system.		

2.1.2.5 Ethnicity

Definition	A classification of the ethnicity of an individual, as supplied by the individual and as recorded in the NHI system (refer to the Ethnicity Data Protocols, Te Whatu Ora).		
Source standards	Ethnicity Data Protocols for the Health and Disability Sector, Te Whatu Ora.		
Data type	Numeric	**Representational class**	Code
Field size	**Max**: 4	**Representational layout**	N(4)

Data domain	Ethnicity Data Protocols for the Health and Disability Sector, Te Whatu Ora.
Guide for use	Data reported via NHI system, not part of the PRIMHD code set
Verification rules	1. Valid code set value only. 2. 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.

2.2 Legal Status (LS) Record

Information that describes a health tangata whaiora/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[1], the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, the Criminal Procedure (Mentally Impaired Persons) Act 2003, or the Substance Addiction (Compulsory Assessment & Treatment) Act 2017.

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 tangata whaiora/consumer's care under the compulsory treatment order

c) Health tangata whaiora/consumers may have more than one legal status current at any one time

d) The PRIMHD system will retain a history of a health tangata whaiora/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.

[1] Repealed 21 February 2018

Data Element	Reference	Data Element	Reference
(a) Legal Status ID	**2.2.2.1**	(h) Sex/gender	**2.1.2.4**
(b) Organisation ID	**2.2.2.2**	(i) Legal Status Code	**2.2.2.6**
(c) Submitting 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

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**	X(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			

2.2.2.2 Organisation ID

Definition	A unique lifetime identifier for the organisation that is submitting the PRIMHD data via a secure connection on behalf of the

	organisation providing healthcare services to the health tangata whaiora/consumer		
Source standards	HISO 10045 Health Provider Identity Standard (Draft)		
Data type	Alphanumeric	**Representational class**	Identifier
Field size	**Max**: 8	**Representational layout**	GXXNNN-C
Data domain			
Guide for use	G is a constant prefix. X is either an alpha or a numeric. N is numeric and C is the check digit.		
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. 3. Modulus 11 Algorithm is used to formulate the Check Digit.		

2.2.2.3 Submitting Organisation ID

Definition	A unique lifetime identifier for the organisation that is submitting the PRIMHD data via a secure connection on behalf of the organisation providing healthcare services to the health tangata whaiora/consumer		
Source standards	HISO 10045 Health Provider Identity Standard (Draft)		
Data type	Alphanumeric	**Representational class**	Identifier
Field size	**Max**: 8	**Representational layout**	GXXNNN-C
Data domain			
Guide for use	• G is a constant prefix. X is either an alpha or a numeric. N is numeric and C is the check digit. • Only to be used when the organisation providing the healthcare services to the health tangata whaiora/consumer IS NOT the organisation sending the PRIMHD data to the national system.		

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. 3. Modulus 11 Algorithm is used to formulate the Check Digit.

2.2.2.4 File Version

Definition	The version of the PRIMHD XML Schema that the data elements in the organisations extract file are compliant with.		
Source standards	HISO 10023.3:2023 PRIMHD Code Set Standard		
Data type	Numeric	**Representational class**	Code
Field size	**Max**: 3	**Representational layout**	N.N
Data domain	Refer to Section 2.2.1.1 ‘File Version’ code set.		
Guide for use	Supplied in the Referral Discharge and Legal Status records only.		
Verification rules	Valid code set value only.		

2.2.2.5 Responsible Clinician CPN

Definition	A unique lifetime identifier, from the HPI, for the responsible Clinician who assigned this legal status to the health tangata whaiora/consumer.		
Source standards	HISO 10045 Health Provider Identity Standard (Draft)		
Data type	Alphanumeric	**Representational class**	Identifier
Field size	**Max**: 6	**Representational layout**	NNXXXX
Data domain			

Guide for use	• 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). • HPI system-generated two numeric (the second of which is a check digit) plus four alphabetic characters.
Verification rules	1. The CPN includes a check digit in the second position. 2. Modulus 11 Check Digit Algorithm. 3. The person (Healthcare Provider) must be registered on the HPI before use.

2.2.2.6 Legal Status Code

Definition	Code describing a health tangata whaiora/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[2], the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, the Criminal Procedure (Mentally Impaired Persons) Act 2003, or the Substance Addiction (Compulsory Assessment & Treatment) Act 2017.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alphabetic	**Representational class**	Code
Field size	**Max**: 2	**Representational layout**	A(2)
Data domain	Refer to Section 2.2.1.2 'Legal Status Code' code set.		
Guide for use	This is required to be submitted by the assigning organisation when the Health Consumer's Legal Status is other than voluntary		
Verification rules	1. At least one code required. 2. Must be a valid code set value only.		

[2] repealed 21 February 2018

	3. The code must be valid for the date range the legal status is applicable. 4. Must be valid for the applicable Legal Status Code commencement and conclusion dates within the Legal Status Code table.

2.2.2.7 LS Start Date/Time

Definition	The date and time the legal status came into effect.		
Source standards			
Data type	Date/time	**Representational class**	Full date and time
Field size	**Max**: 19	**Representational layout**	CCYY-MM-DDTHH:MM:SS
Data domain	Valid date and time.		
Guide for use	• Enter a full date and time including year, month, day, hour, minute and second. • If the applicable legal status date is not known, provision should be made to estimate the LS Start Date. • If the legal status start time is not known, then 00:00:00 must be used		
Verification rules	1. Must be less than or equal to the date of record creation. 2. Must be a valid date and time. 3. Must be greater than the health tangata whaiora/consumer's date of birth and less than or equal to their date of death, if the health tangata whaiora/consumer is deceased. 4. Must be greater than the LS End Date of previous Legal Status record unless the new LS is a concurrent one 5. Must be less than or equal to the LS End Date in the current Legal Status record.		

	6. Must be on or after the Legal Status Code commencement date in the Legal Status code set table; 7. Must be on or before the Legal Status Code conclusion date in the Legal Status Code set table. 8. Time is to be recorded using the 24 hour clock.

2.2.2.8 LS End Date/Time

Definition	The date and time the legal status code ceased to apply.		
Source standards			
Data type	Date/time	**Representational class**	Full date and time
Field size	**Max**: 19	**Representational layout**	CCYY-MM-DDTHH:MM:SS
Data domain	Valid date and time		
Guide for use	• Enter a full date and time; including year, month, day, hour, minute and second. • If the legal status time is not known, then 23:59:59 must be used		
Verification rules	1. Must be less than or equal to the date of record creation. 2. Must be a valid date and time. 3. Must be greater than or equal to the legal status start date/time. 4. Must be greater than the health tangata whaiora/consumer's date of birth and less than or equal to their date of death, if the health tangata whaiora/consumer is deceased. 5. Must be on or after the Legal Status Code commencement date in the Legal Status Code set table; 6. Must be on or before the Legal Status Code conclusion date in the Legal Status Code set table. 7. Time is to be recorded using the 24 hour clock.		

2.2.2.9 Extract From Date/Time

Definition	The actual reporting period commencement date and time for which the all data records in the extract file were collected from.		
Source standards			
Data type	Date/time	**Representational class**	Full date and time
Field size	**Max**: 19	**Representational layout**	CCYY-MM-DDTHH:MM:SS
Data domain	Valid date and time.		
Guide for use	• Enter the full date and time including year, month, day, hour, minute and second. • Should greater than the previous file's Extracted Date/time.		
Verification rules	1. Must be a valid date and time 2. Must be the actual reporting period commencement date and time for which all data records in the extract file were collected from. 3. Time is to be recorded using the 24 hour clock.		

2.2.2.10 Extracted Date/Time

Definition	The actual date and time that the PRIMHD extract file was created from the Organisations local system(s).		
Source standards			
Data type	Date/time	**Representational class**	Full date and time
Field size	**Max**: 19	**Representational layout**	CCYY-MM-DDTHH:MM:SS
Data domain	Valid date and time.		

Guide for use	• Enter the full date and time including year, month, day, hour, minute and second. • 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 be processed.
Verification rules	1. Must be a valid date and time. 2. Must be the actual date and time when the PRIMHD extract file was created for sending to be processed. 3. Time is to be recorded using the 24 hour clock.

2.2.2.11 Deleted Flag

Definition	A data element that indicates a record has been deleted.		
Source standards			
Data type	Alpha	**Representational class**	Code
Field size	**Max**: 7	**Representational layout**	A(7)
Data domain			
Guide for use	Used to indicate the deletion of a record of the associated data element from the PRIMHD database.		
Verification rules	Must always equal ‘DELETED’.		

2.3 Referral Discharge (RD) Record

A health referral is a specific request from one healthcare team/provider to another, for advice about, or treatment of, a health tangata whaiora/consumer. Mental health and addiction services referrals can also be received directly from the health tangata whaiora/consumer or the health tangata whaiora/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 tangata whaiora/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 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	**2.3.2.5**
(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/gender	**2.1.2.4**	(p) Deleted Flag	**2.2.2.11**

2.3.2.1 Referral ID

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**	X(20)
Data domain			
Guide for use	• 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. • Each referral discharge record must be unique within the source organisation.		
Verification rules	1. A Referral Identifier can have only one health tangata whaiora/consumer per organisation, per team. 2. The Identifier is assigned at source UNLESS it is assigned by the PRIMHD Online system (for NGOs) or on submission (other PRIMHD users).		

2.3.2.2 Referral From

Definition	The source from where the health tangata whaiora/consumer was referred in the beginning.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alphabetic	**Representational class**	Code
Field size	**Max**: 2	**Representational layout**	A(2)
Data domain	Refer to Section 2.3.1.1 ‘Referral From’ code set.		
Guide for use	Describes the groups of services or people who are referral sources.		
Verification rules	1. Must be a valid code set value only. 2. Must have only one per referral record.		

2.3.2.3 Referral To

Definition	The destination to where the Health Consumer was referred to when discharged from this referral.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alphabetic	**Representational class**	Code
Field size	**Max**: 2	**Representational layout**	A(2)
Data domain	Refer to Section 2.3.1.2 ‘Referral To’ code set.		
Guide for use	Describes the groups of services or people who are referral destinations.		
Verification rules	1. Must be a valid code set value only. 2. Must have one only per referral. 3. Must be supplied with the Referral End Date. 4. Has conditional validation where data is mandatory when discharging the health tangata whaiora/consumer.		

2.3.2.4 Referral End Code

Definition	A code that describes why the health tangata whaiora/consumer was discharged from the healthcare team.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alpha	**Representational class**	Code
Field size	**Max**: 2	**Representational layout**	A(2)
Data domain	Refer to Section 2.3.1.3 ‘Referral End Code’ code set.		

Guide for use	• A code that identifies whether this is a Discharge or a Discharge Referral (refer HISO 10011 RSD documentation). • A Discharge Referral within the hospital environment occurs when a health tangata whaiora/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.
Verification rules	1. Must be a valid code set value only. 2. If this field is populated, Referral Discharge End Date must be populated.

2.3.2.5 Referral Discharge Start Date/Time

Definition	The date and time on which the referral was received.		
Source standards			
Data type	Date/time	**Representational class**	Full date and time
Field size	**Max**: 19	**Representational layout**	CCYY-MM-DDTHH:MM:SS
Data domain	Valid date and time.		
Guide for use	• Enter the full date and time including year, month, day, hour, minute and second. • If the referral start date is not known, provision should be made to estimate the referral date. It is envisaged that only health tangata whaiora/consumers who have been in the care of the mental health and addiction service for many years will have partial dates. • If the RD Start Time is not known, then 00:00:00 must be used		
Verification rules	1. Must be less than or equal to the date of record creation.		

	2. Must be greater than the health tangata whaiora/consumer's date of birth and less than or equal to their date of death, if the health tangata whaiora/consumer is deceased. 3. Must be a valid date and time 4. Must be less than or equal to the RD End Date/Time 5. Must be on or after the Team Code Open Date in the Team table; 6. Must be on or before the Team Code Close Date in the Team table. 7. Time is to be recorded using the 24 hour clock.

2.3.2.6 Referral Discharge End Date/Time

Definition	The date and time that all contact between the health tangata whaiora/consumer and the mental health and addiction team ends.		
Source standards			
Data type	Date/time	**Representational class**	Full date and time
Field size	**Max**: 19	**Representational layout**	CCYY-MM-DDTHH:MM:SS
Data domain	Valid date and time.		
Guide for use	• Enter the full date and time including year, month, day, hour, minute and second. • If the health tangata whaiora/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. • If the RD End Time is not known, then 23:59:59 must be used		
Verification rules	1. Must be less than or equal to the date/time of record creation; 2. Must be greater than or equal to the RD Start Date/Time;		

	3. Must be greater than the health tangata whaiora/consumer's date of birth and less than or equal to their date of death, if the health tangata whaiora/consumer is deceased. 4. Must be a valid date and time 5. Must be on or after the Team Code Open Date in the Team table; 6. Must be on or before the Team Code Close Date in the Team table. 7. If Referral End Code is populated, this field is mandatory. 8. Time is to be recorded using the 24 hour clock.

2.4 Activity (AT) Record

Activity describes the types of activities, the location of activity, and the team that provided the activity. Activity details reported are: Occupied Bed, Bed Leave type; Contact type. The Activity also is defined by the Setting of the occupied bed, leave and contact occurred 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 tangata whaiora/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**	(f) Activity Setting	**2.4.2.4**
(b) Organisation ID	**2.2.2.2**	(g) Family/Whānau Involvement	**2.4.2.5**
(c) Activity ID	**2.4.2.1**	(h) AT Start Date/Time	**2.4.2.6**

(d) Healthcare Provider CPN	**2.4.2.2**	(i) AT End Date/Time	**2.4.2.7**
(e) Activity Type	**2.4.2.3**		

2.4.2.1 Activity ID

Definition	An identifier for the corresponding record stored within the organisation's system.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	**Max**: 20	**Representational layout**	X(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			

2.4.2.2 Healthcare Provider CPN (HPI CPN)

Definition	A unique lifetime identifier for an individual practitioner and/or healthcare provider, which takes precedence over all other provider and clinician identifiers and is sourced from the Healthcare Provider Index (HPI). It is mandatory for all Healthcare providers to record their assigned Common Person Number (CPN).		
Source standards	HISO 10045 Health Provider Identity Standard (Draft)		
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	1. The CPN includes a check digit in the second position. 2. Modulus 11 Check Digit Algorithm. 3. The person (Healthcare Worker) must be registered on the HPI before use.

2.4.2.3 Activity Type

Definition	A code that classifies the type of healthcare activity provided to the health tangata whaiora/consumer.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alphanumeric	**Representational class**	Code
Field size	**Max**: 3	**Representational layout**	ANN
Data domain	Refer to Section 2.4.1.1 ‘Activity Type’ code set.		
Guide for use	Activity Type is a code that is used to classify the type of healthcare activity provided to the health tangata whaiora/consumer.		
Verification rules	Must be a valid code in the Activity Type code set table.		

2.4.2.4 Activity Setting

Definition	The Activity Setting indicates the type of physical setting or contact channel that the activity was provided in.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alphanumeric	**Representational class**	Code
Field size	**Max**: 2	**Representational layout**	X(2)
Data domain	Refer to Section 2.4.1.2 ‘Activity Setting’ code set.		
Guide for use	Describes the type of setting the health tangata whaiora/consumer was accessing service in.		

Verification rules	Valid code set value only.

2.4.2.5 Family/Whānau Involvement

Definition	The Family/Whānau Involvement element indicates if there was family/whānau involvement with the service user at an activity		
Source standards	HISO 10023.3:2023 PRIMHD Code Set Standard.		
Data type	Numeric	**Representational class**	Code
Field size	**Max**: 1	**Representational layout**	X
Data domain	Refer to Section 2.4.1.3 ‘Family/Whānau Involvement’ code set.		
Guide for use	Indicates if Family/Whānau were involved with the service user at an activity		
Verification rules	Valid code set value only.		

2.4.2.6 Activity Start Date/Time

Definition	The date and time the health tangata whaiora/consumer commenced accessing this mental health activity.		
Source standards			
Data type	Date/time	**Representational class**	Full date and time
Field size	**Max**: 19	**Representational layout**	CCYY-MM-DDTHH:MM:SS
Data domain	Valid date or year and time.		
Guide for use	• Enter a full date and time including year, month, day, hour, minute and second. • Where the health tangata whaiora/consumer is an inpatient this is the date of admission. • Where the health tangata whaiora/consumer is a community outpatient, this is the date that they accessed a service.		

Verification rules	1. Must be less than or equal to the AT End Date/Time. 2. Must be greater than or equal to the Referral Start Date/Time and less than or equal to Referral End Date/Time. 3. Must be greater than the health tangata whaiora/consumer's date of birth and less than or equal to their date of death, if the health tangata whaiora/consumer is deceased. 4. Must be a valid date and time. 5. Time is to be recorded using the 24 hour clock.

2.4.2.7 Activity End Date/Time

Definition	The date and time the health tangata whaiora/consumer ceased receiving this mental health activity.		
Source standards			
Data type	Date/time	**Representational class**	Full date and time
Field size	**Max**: 19	**Representational layout**	CCYY-MM-DDTHH:MM:SS
Data domain	Valid date or year and time.		
Guide for use	• Enter a full date and time including year, month, day, hour, minute and second. • For non-inpatient services, activity start and end date will normally be the same day.		
Verification rules	1. Must be greater than or equal to the AT Start Date/Time. 2. Must be greater than or equal to the Referral Start Date/Time and less than or equal to Referral End Date/Time. 3. Must be greater than the health tangata whaiora/consumer's date of birth and less than or equal to their date of death, if the health tangata whaiora/consumer is deceased. 4. Must be a valid date and time.		

	5. Time is to be recorded using the 24 hour clock.

2.5 Classification (CN) Record

Details describing the clinical diagnosis and/or issue codes assigned to a health tangata whaiora/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 in HISO 10023.3:2023 PRIMHD Code Set Standard, Section 2.5.1.3.

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**	(e) Diagnosis Type	**2.5.2.3**
(b) Organisation ID	**2.2.2.2**	(f) Clinical Code Value	**2.5.2.4**
(c) Classification ID	**2.5.2.1**	(g) CN Start Date/Time	**2.5.2.5**
(d) Clinical Coding System ID	**2.5.2.2**	(h) CN End Date/Time	**2.5.2.6**

2.5.2.1 Classification 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**	X(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			

2.5.2.2 Clinical Coding System ID

Definition	A code identifying the clinical coding system used for diagnosis and procedures.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Numeric	**Representational class**	Code
Field size	**Max**: 2	**Representational layout**	N(2)
Data domain	Refer to Section 2.5.1.1 ‘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	1. Must be a valid code in the Coding System ID code set table. 2. Must form part of a valid combination of Clinical Coding System ID and Clinical Code Value and Diagnosis Type.		

2.5.2.3 Diagnosis Type

Definition	A code that groups clinical codes or indicates the priority of a diagnosis.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alphabetic	**Representational class**	Code

Field size	**Max**: 1	**Representational layout**	A
Data domain	Refer to Section 2.5.1.2 ‘Diagnosis Type’ code set.		
Guide for use			
Verification rules	1. Must be a valid code in the Diagnosis Type code set table. 2. Must form part of a valid combination of Clinical Coding System ID and Clinical Code Value and Diagnosis Type.		

2.5.2.4 Clinical Code Value

Definition	A code used to classify the condition or issue.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alphanumeric	**Representational class**	Code
Field size	**Max**: 8	**Representational layout**	X(8)
Data domain			
Guide for use	This comes from one of several clinical coding systems, as listed in Section 2.5.1.1 ‘Clinical Coding System ID’.		
Verification rules	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.		

2.5.2.5 CN Start Date/Time

Definition	The date the clinical condition or issue was identified.		
Source standards			
Data type	Date/Time	**Representational class**	Full date and time

Field size	**Max**: 19	**Representational layout**	CCYY-MM-DDTHH:MM:SS
Data domain	Valid date or year and time.		
Guide for use	Enter a full date and time, including year, month, day, hour, minute and seconds.		
Verification rules	1. Must be less than or equal to the CN End Date/Time 2. Must be greater than or equal to the Referral Start Date/Time and less than or equal to Referral End Date/Time. 3. Must be greater than the health tangata whaiora/consumer's date of birth and less than or equal to their date of death, if the health tangata whaiora/consumer is deceased; 4. Must be a valid date and year. 5. Time is to be recorded using the 24 hour clock. 6. If Time is not known, enter '00:00:00'.		

2.5.2.6 CN End Date/Time

Definition	The date the clinical condition or issue ceased to apply.		
Source standards			
Data type	Date/Time	**Representational class**	Full date and time
Field size	**Max**: 19	**Representational layout**	CCYY-MM-DDTHH:MM:SS
Data domain	Valid date or year and time.		
Guide for use	Enter a full date and time, including year, month, day, hour, minute and seconds.		
Verification rules	1. Must be greater than or equal to the CN Start Date/Time; 2. Must be greater than or equal to the Referral Start Date/Time and less than or equal to Referral End Date/Time.		

	3. Must be greater than the health tangata whaiora/consumer's date of birth and less than or equal to their date of death, if the health tangata whaiora/consumer is deceased. 4. Must be a valid date and year. 5. Time is to be recorded using the 24 hour clock. 6. If Time is not known, enter '23:59:59'.

2.6 Collection Occasion (CO) Record

A 'Collection Occasion' CO 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 Provider 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

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**	X(20)
Data domain	Auto number.		
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			

2.6.2.2 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 10023.3:2017 PRIMHD Code Set Standard*.		
Data type	Alphanumeric	**Representational class**	Code
Field size	4	**Representational layout**	AANN
Data domain	Refer to Section 2.6.1.1 ‘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	1. Must be a valid code in the Reason For Collection code set.		

2.6.2.3 Collection Occasion Date/Time

Definition	The date and time on which the collection of the outcome measure(s) commenced.

Source standards			
Data type	Date/Time	**Representational class**	Full date and time
Field size	**Max**: 19	**Representational layout**	CCYY-MM-DDTHH:MM:SS
Data domain	Valid date or year and time.		
Guide for use	• Enter the full date and time including year, month, day, hour, minute and seconds. • For data collected at *admission* into an outcomes episode of care, the Collection Occasion date is the Admission Date. • For data collected at *review* during an extended outcomes episode of care, it is the review date on which the data was collected. • For data collected at *discharge* from an outcomes episode of care, the Collection Occasion date is the discharge date, ie the date of discharge in inpatient mental health service settings, or the date of last contact in community mental health service settings. • The collection date is the reference date for all reports and statistical analyses of the data collected at any given Collection Occasion.		
Verification rules	1. Must be less than or equal to the date and/or time of record creation. 2. Must be greater than or equal to the Referral Start Date/Time and less than or equal to Referral End Date/Time. 3. Must be greater than the health tangata whaiora/consumer's date of birth and less than or equal to their date of death, if the health tangata whaiora/consumer is deceased. 4. Must be a valid date and year. 5. Time is to be recorded using the 24 hour clock. 6. If Time is not known, enter '00:00:00'.		

2.6.2.4 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**	N(9)
Data domain			
Guide for use	The Episode Identifier is assigned by Te Whatu Ora's outcome system at the time that the episode record is created. It provides a link to build an outcomes episode from individual collection occasions.		
Verification rules	Must be a valid identifier in the Te Whatu Ora system before use.		

2.6.2.5 Protocol Version

Definition	The version of the information collection protocol under which the data has been collected and submitted.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alphanumeric	**Representational class**	Code
Field size	**Max**: 4	**Representational layout**	N(4)
Data domain	Refer to Section 2.6.1.2 'Protocol Version' code set.		
Guide for use			
Verification rules	Must be a valid code.		

2.6.2.6 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 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alphanumeric	**Representational class**	Code
Field size	4	**Representational layout**	AANN
Data domain	Refer to Section 2.6.1.3 'Focus of Care' code set.		
Guide for use	• Not used for HoNOSCA • Not collected for Admission collections		
Verification rules	Must be a valid code in the Focus Of Care code set.		

2.7 Outcome Tool (OT) Record

'Outcome Tool' OT includes data regarding the measures or instruments used to gather data about health tangata whaiora/consumer outcomes. Currently, the HoNOS family of instruments (HoNOS, HoNOS65+, HoNOSCA, HoNOS-LD, HoNOS Secure and HoNOSI) have been implemented. The Alcohol and Drug Outcome Measure (ADOM) is also included as an Outcome Tool. HoNOS was developed in the United Kingdom for use by clinicians in their routine clinical work to measure health tangata whaiora/consumer outcomes. Future instruments could include a health tangata whaiora/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**	(e) Mode of Administration	**2.7.2.2**

(b) Organisation ID	**2.2.2.2**	(f) Collection Status	**2.7.2.3**
(c) Collection Occasion ID	**2.6.2.1**	(g) 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

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 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alphanumeric	**Representational class**	Code
Field size	**Max**: 2	**Representational layout**	AN
Data domain	Refer to Section 2.7.1.1 ‘Outcome Tool Type and Version’ code set.		
Guide for use			
Verification rules	Must be a valid code.		

2.7.2.2 Mode of Administration

Definition	The procedure or method used in the ascertainment and recording of the standard measure.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alphanumeric	**Representational class**	Code
Field size	4	**Representational layout**	AANN
Data domain	Refer to Section 2.7.1.2 ‘Mode of Administration’ code set.		
Guide for use			
Verification rules	Must be a valid code in the Mode Of Administration code set.		

2.7.2.3 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.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alphanumeric	**Representational class**	Code
Field size	4	**Representational layout**	AANN
Data domain	Refer to Section 2.7.1.3 ‘Collection Status’ code set.		
Guide for use	Identifies the status of the data.		
Verification rules	Must be a valid code in the Collection Status code set.		

2.7.2.4 Completion Date/Time

Definition	The date and time of completion of the outcome measure collection.		
Source standards			
Data type	Date/Time	**Representational class**	Full date and time
Field size	**Max**: 19	**Representational layout**	CCYY-MM-DDTHH:MM:SS
Data domain	Valid date or year and time.		
Guide for use	Enter the full date and time including year, month, day, hour, minute and second that the item was scored/collected.		
Verification rules	1. Must be less than or equal to the date and/or time of record creation. 2. Must be greater than or equal to the Referral Start Date/Time and less than or equal to Referral End Date/Time.		

	3. Must be greater than the health tangata whaiora/consumer's date of birth and less than or equal to their date of death, if the health tangata whaiora/consumer is deceased. 4. Must be a valid date and year. 5. Time is to be recorded using the 24 hour clock. 6. If Time is not known, enter '23:59:59'.

2.8 Outcome Item (OI) Record

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

2.8.1 Outcome Item data requirements

The 'Collection Occasion and Outcome Tool', along with its protocol, will determine 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

Definition	An identifier that indicates the Outcome Item that is being measured.
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*

Data type	Alphanumeric	**Representational class**	Identifier
Field size	**Max**: 3	**Representational layout**	X(3)
Data domain	Refer to Section 2.8.1.1 ‘Outcome Item Number’ code set. HoNOS, HoNOS65+, HoNOSCA, HoNOS Secure, HoNOS LD, HoNOSI, ADOM Item numbers.		
Guide for use	The primary key for the Outcome Item record.		
Verification rules	1. Must be a valid code in the Outcome Item code set. 2. Must be a valid Outcome Item for the Outcome Tool and protocol that is being used.		

2.8.2.2 Outcome Item Value

Definition	The value given to a particular outcome item code.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alphanumeric	**Representational class**	Code
Field size	**Max**: 1	**Representational layout**	X
Data domain	Refer to Section 2.8.1.2 ‘Outcome Item Value’ code set.		
Guide for use			
Verification rules	Must be a valid code for the Outcome Item Value within the code set (refer to Outcome Collection Protocol). Outcome Item Value code 03a is used		

2.9 Team (TR) Record

A team consists of a person or functionally discrete grouping of people providing mental health and addiction services. These codes are created and maintained by the Te Whatu Ora PRIMHD Data Management 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 the Te Whatu Ora PRIMHD Data Management team.

d) 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 and Name	**2.9.2.14**
(h) Team Service Type(s)	**2.9.2.7**	(p) Organisation Type	**2.9.2.15**

2.9.2.1 Team Code

Definition	A code, which uniquely identifies a team assigned by the data source. A person or functionally discrete grouping of people based in a particular location, providing mental health care to a health tangata whaiora/consumer group in either an inpatient or community setting. Uniquely linked to provider's Organisation Identifier.		
Source standards			
Data type	Alphanumeric	**Representational class**	Code (Identifier)
Field size	**Max**: 6	**Representational layout**	X(6)
Data domain:	Refer to Section 2.9.1.1 'Team Code' code set.		
Guide for use	• The Team Code is assigned by the Te Whatu Ora PRIMHD Data Management team. • This code has a minimum of 4 digits with a maximum of 6.		
Verification rules	1. Must be a valid identifier code in the Team Code ID table. 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. The Team code must be valid for the full date open and close range.		

2.9.2.2 Organisation ID

Definition	A unique lifetime identifier for the organisation that is providing healthcare services to the health tangata whaiora/consumer
Source standards	HISO 10045 Health Provider Identity Standard (Draft)

Data type	Alphanumeric	**Representational class**	Identifier
Field size	**Max**: 8	**Representational layout**	GXXNNN-C
Data domain			
Guide for use	G is a constant prefix. X is either an alpha or a numeric. N is numeric and C is the check digit.		
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. 3. Modulus 11 Algorithm is used to formulate the Check Digit.		

2.9.2.3 Facility ID

Definition	A unique lifetime identifier for a facility assigned by the data source.		
Source standards	HISO 10045 Health Provider Identity Standard (Draft)		
Data type	Alphanumeric	**Representational class**	Identifier
Field size	**Max**: 8	**Representational layout**	FXXNNN-C
Data domain			

Guide for use	• F is a constant prefix. X is either an alpha or a numeric. N is a numeric. C is the Check Digit. • The Facility Identifier is assigned by the HPI system at the time that the facility record in the HPI is created. • The Facility Identifier Check Digit is used to validate data entry of facility identifiers. • A Modulus 11 check digit routine is run over the six characters of the facility identifier to produce the Facility Identifier Check Digit.
Verification rules	1. The facility must be registered on the HPI before use. 2. Must be a valid identifier in the HPI system facility file. 3. Must be a Modulus 11 Check Digit Algorithm.

2.9.2.4 Team Name

Definition	The name by which the Team is known.		
Source standards			
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 (eg internal use), a short name (ie an abbreviated name by which the team is known) may be used.		
Verification rules			

2.9.2.5 Team Type

Definition	A code that categorises the primary function of the healthcare Team.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Numeric	**Representational class**	Code
Field size	**Max**: 2	**Representational layout**	N(2)
Data domain	Refer to Section 2.9.1.2 ‘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.		

2.9.2.6 Team Setting

Definition	A code that categorises the setting of the healthcare team.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alpha	**Representational class**	Code
Field size	**Max**: 1	**Representational layout**	A
Data domain	Refer to Section 2.9.1.3 ‘Team Setting’ code set.		
Guide for use	Use the most specific code available.		
Verification rules	Valid code set value only.		

2.9.2.7 Team Service Type

Definition	A code that categorises whether the team provides services to a specific ethnic group or delivers services in a manner responsive to a specific population.

Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alpha	**Representational class**	Code
Field size	**Max**: 2	**Representational layout**	A(2)
Data domain	Refer to Section 2.9.1.4 ‘Team Service Type’ code set.		
Guide for use	Use the most specific code available.		
Verification rules	Valid code set value only.		

2.9.2.8 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 10023.3:2023 PRIMHD Code Set Standard*.		
Data type	Numeric	**Representational class**	Code
Field size	**Max**: 1	**Representational layout**	N
Data domain	Refer to Section 2.9.1.5 ‘Team Target Population’ code set.		
Guide for use	Use the most specific code available.		
Verification rules	Valid code set value only.		

2.9.2.9 Team Open Date

Definition	The date on which the Team began its operation.		
Source standards			
Data type	Date	**Representational class**	Full or partial date
Field size	**Max**: 10	**Representational layout**	CCYY-MM-DD
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 (ie CCYY).
Verification rules	1. Must be less than or equal the Team Close Date. 2. Must be a valid date or year.

2.9.2.10 Team Close Date

Definition	The date on which the Team ceased its operation.		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	**Max**: 10	**Representational layout**	CCYY-MM-DD
Data domain	Valid date.		
Guide for use	Enter the full date including year, month and day.		
Verification rules	1. Must be greater than or equal to Team Open Date. 2. Must be a valid date.		

2.9.2.11 Comments

Definition	The supporting comments pertaining to the Team.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	**Max**: 255	**Representational layout**	X(255)
Data domain			
Guide for use	Any other free text comments that provide some further information about the Team in this Team record.		

Verification rules	

2.9.2.12 Provider ID

Definition	The CMS system identifier of the service provider for the NGO organisation.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	**Max**: 6	**Representational layout**	N(6)
Data domain			
Guide for use	Only used with NGO provider Teams.		
Verification rules	Must be a valid Provider ID Number from the CMS system.		

2.9.2.13 Contract ID

Definition	The CMS system identifier of the service contract for the NGO organisation for this specific team.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	**Max**: 8	**Representational layout**	N(8)
Data domain			
Guide for use	• Only used with NGO provider Teams. • Where multiple contracts apply, chose the most appropriate as only one Contract ID can be entered		
Verification rules	Must be a valid Contract Id Number from the CMS system.		

2.9.2.14 Agency Code and Name

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	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Alphanumeric	**Representational class**	Identifier
Field size	**Max**: 4	**Representational layout**	X(4)
Data domain	Refer to Section 2.9.1.6 ‘Agency Code and Name’ code set.		
Guide for use	• The agency code is assigned by Te Whatu Ora and is historically used to identify an organisation, institution or group of institutions in legacy systems (NMDS, NBRS, MHINC et al). • 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.		
Verification rules	Must be a valid code set value.		

2.9.2.15 Organisation Type

Definition	A code that enables differentiation between different organisational entities.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard*		
Data type	Numeric	**Representational class**	Code

Field size	**Max**: 3	**Representational layout**	N(3)
Data domain	Refer to 4.3.1 - Organisation Type Code Set (HISO HPI 4.3.1), and Refer to Section 2.9.1.7 ‘Organisation Type’ code set.		
Guide for use			
Verification rules	Valid code set value only.		

2.10 Supplementary Consumer Record

Information that describes the health tangata whaiora/consumers: employment, accommodation, and education and training status along with whether they have a wellness (relapse prevention or transition) plan.

For guidance on the collection and use of the Supplementary Consumer Records, please refer to the “Guide to PRIMHD Supplementary Outcome Indicators Collection and Use” – scroll down through the following page: **http://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data**

2.10.1 Supplementary consumer record data requirements

a) All organisations are responsible for recording supplementary consumer data for health tangata whaiora/consumers in their service

b) Supplementary consumer data may be collected for the same health tangata whaiora/consumer in different teams or organisations at the same time

c) The PRIMHD system retains a history of supplementary health tangata whaiora/consumer details where submitted;

d) PHO Registration will be derived and available in the datamart for reporting

2.10.2 Supplementary consumer record data elements

The following lists all the data elements for Supplementary Consumer 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) **Error! Reference source not found.**	**2.3.2.1**	(e) 2.10.2.3 Accommodation	**2.10.2.3**
(b) **Error! Reference source not found.**	**2.2.2.2**	(f) 2.10.2.4 Employment Status	**2.10.2.4**
(c) 2.10.2.1 Supplementary Consumer Record ID	**2.10.2.1**	(g) 2.10.2.5 Education and Training Status	**2.10.2.5**
(d) 2.10.2.2 Wellness (Relapse Prevention or Transition) Plan	**2.10.2.2**	(h) 2.10.2.6 Supplementary Consumer Record Collection Date	**2.10.2.6**

2.10.2.1 Supplementary Consumer Record ID

Definition	A unique 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**	X(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			

2.10.2.2 Wellness (Relapse Prevention or Transition) Plan

Definition	A code that records if a Wellness (Relapse Prevention or Transition) plan is in place.		
Source standard	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Numeric	**Representational class**	Code

Field size	**Max**: 1	**Representational layout**	N
Data domain	Refer to Section 2.10.1 ‘Wellness (Relapse Prevention or Transition) Plan’ code set.		
Guide for use			
Verification rules	Valid code set value only.		

2.10.2.3 Accommodation

Definition	A code that records the accommodation status of the tangata whaiora/consumer.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Numeric	**Representational class**	Code
Field size	**Max**: 1	**Representational layout**	N
Data domain	Refer to Section 2.10.2 ‘Accommodation’ code set.		
Guide for use			
Verification rules	Valid code set value only.		

2.10.2.4 Employment Status

Definition	A code that records the employment status of the tangata whaiora/consumer.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Numeric	**Representational class**	Code
Field size	**Max**: 1	**Representational layout**	N
Data domain	Refer to Section 2.10.3 ‘Employment Status’ code set.		
Guide for use			

Verification rules	Valid code set value only.

2.10.2.5 Education and Training Status

Definition	A code that identifies whether or not the tangata whaiora/consumer is in education and/or training.		
Source standards	*HISO 10023.3:2023 PRIMHD Code Set Standard.*		
Data type	Numeric	**Representational class**	Code
Field size	**Max**: 1	**Representational layout**	N
Data domain	Refer to Section 2.10.4 ‘Education and Training Status’ code set.		
Guide for use			
Verification rules	Valid code set value only.		

2.10.2.6 Supplementary Consumer Record Collection Date

Definition	The date on which the Supplementary record was collected.		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	**Max**: 10	**Representational layout**	CCYY-MM-DD
Data domain			
Guide for use	• Enter the full date including year, month and day. • Full date will be applied to all Supplementary consumer records that contain Wellness (Relapse Prevention or Transition) Plan, Accommodation, Employment Status, and Education and Training Status indicators. • Full date to be entered at each collection		

	• Multiple Supplementary consumer record collections may be made between Referral Discharge start and end dates.
Verification rules	1. Must be greater than or equal to Referral Discharge start date. 2. Must be less than or equal to Referral Discharge end date. 3. Must be a valid date.

Appendix A – Glossary

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

Term	Definition
Addiction	A generic term used to cover the two specific cases of Alcohol and Drug addiction. Note that Gambling is not part of the collection strategy operated through the PRIMHD system.
Admission/Admitted	In the case of mental health and addiction, this does not mean the admission of a tangata whaiora/consumer to a facility. It is where a tangata whaiora/consumer is accepted for treatment by a service, either by way of an inpatient admission, or with outpatient services.
ADOM	Alcohol and Drug Outcome Measure
Bed Night	A bed night is a bed occupied at midnight.
Tangata Whaiora/Consumer	A person who accesses publicly funded healthcare. This person may be referred to elsewhere as a 'Healthcare User', 'Client' or 'Patient'.
Contact	Contact is defined as an interaction (face-to-face or non face-to-face) between tangata whaiora/consumer and/or family/whānau with a healthcare organisation that will provide or is providing a service to the tangata whaiora/consumer, or contact between a healthcare organisation and other agencies. The contact is recorded/noted into the healthcare organisations record for that tangata whaiora/consumer and/or in the tangata whaiora/consumer's personal health record. All significant contacts should be noted, where significant means, but is not limited to, interactions that advise, change or alter the support and/or care/treatment being provided to the tangata whaiora/consumer.
CPN	Common Person Number.
DAMHS	Director of Area Mental Health Services.
Data Element	An atomic piece of data, eg first name, last name etc.
Data Group	Group of data elements of related data, eg tangata whaiora/consumer identification, demographic data.

Data Set	Collection of data groups, used for specific purposes, eg referral data set, discharge data set.
Data Source	An organisation (usually) or authorised person that supplies data about a practitioner, healthcare provider, organisation or facility to the HPI.
DHB	District Health Board.
Discharge / Exit	The relinquishing of tangata whaiora/consumer care/support in whole or in part by a healthcare provider or organisation. There are two common types of discharge: a) Administrative and; b) Clinical. 'Exit' may be referred to as 'Discharge'.
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 tangata whaiora/consumer	A tangata whaiora/consumer is someone who has or is accessing a Mental Health and /or Addiction service. A person who accesses publicly funded healthcare. This person may be referred to elsewhere as a 'Healthcare User', 'Client' or 'Patient'.
Healthcare Practitioner Index (HPI)	A centrally managed system that is used to collect and distribute practitioner, healthcare provider, organisation and facility data. The HPI will facilitate the timely and secure exchange of health information, ensure the accurate and unique identification of practitioners, healthcare providers, 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 recipients. Te Whatu Ora is the HPI Administrator and Manager.
Health Practitioner (Practitioner)	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 not registered with a responsible authority who works within the health sector.
	A person or organisation that provides tangata whaiora/consumer health care services.

Healthcare User	A person who accesses publicly funded healthcare, this person may also be referred to as a ‘tangata whaiora/consumer’, ‘Client’ or ‘Patient’.
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.
HoNOSI	Health of the Nation Outcome Scales for Infants
HPCA Act	Health Practitioners Competence Assurance Act 2003
HPI Administrator	The Te Whatu Ora administrative staff who authorise and maintain data about organisations; and monitor the data quality and consistency in the HPI (this includes practitioner, healthcare provider, organisation, and facility uniqueness).
KPI Project	A Key Performance Indicator Framework for New Zealand Mental Health and Addiction Services
Mental Health vs Psychiatric descriptors	Mental Health in general refers to the provision of a service(s) and/or to the agency/place that a service(s) is delivered to tangata whaiora/consumer. Psychiatric refers to a particular diagnosis (eg as per the DSM) or a specialist agency/place that a service is provided.
MHINC	Mental Health Information National Collection.
MH-SMART	Mental Health – Standard Measures of Assessment and Recovery
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 tangata whaiora/Consumers. The NHI facilitates the timely and secure exchange of health information, ensure the accurate and unique identification of Health tangata whaiora/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 tangata whaiora/consumers. Te Whatu Ora is the NHI Administrator and Manager.

NGO	Non-Government Organisation.
OICP	Outcome Information Collection Protocol
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.
PAS	Patient Administration System
Patient	A person who accesses publicly funded healthcare, this person may also be referred to as a tangata whaiora/consumer, healthcare user, recipient, or client.
Person	An individual person who can assume multiple roles over time. In the HPI, 'person' is synonymous with practitioner, healthcare provider, and user.
PHO	Primary Health 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.
PRIMHD	Programme 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, eg a request for an investigation, intervention or treatment; b) notification of a problem with the hope, expectation or imposition of its management, eg an exit summary in a setting, which imposes care/support responsibility on the tangata whaiora/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.

Referred To Healthcare Provider	The healthcare team/provider to which a tangata whaiora/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 tangata whaiora/consumer for advice or treatment. The referring team/provider generally has primary care responsibilities for the tangata whaiora/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 tangata whaiora/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, healthcare provider, organisation and facility records.
Service Provider	Any service that provides mental health and addiction services, including, but not limited to: NGOs; Te Whatu Ora Provider Arms; Primary Care Practitioner; 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.
Tangata whaiora/consumer	A tangata whaiora/consumer is someone who has or is accessing a mental health and /or addiction service. A person who accesses publicly funded healthcare. This person may be referred to elsewhere as a ‘Healthcare User’.
Team	A team consisting of a person or functionally discrete grouping of people providing mental health and addiction services within a service provider.