HISO 10065:2018
Allied Health Data Standard

Published March 2018

Document information

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New Zealand Legislation

The following Acts of Parliament and Regulation have specific relevance to this standard. Readers must consider other Acts and Regulations and their amendments that are relevant to their own organisation, in the implementation or use of this standard.

- Health Act 1956
- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
- Health Information Privacy Code 1994
- Health Practitioners Competence Assurance Act 2003
- Privacy Act 1993 (revised 2008)
- Public Records Act 2005
- Retention of Health Information Regulations 1996

Contents

1 Introduction

This standard sets out the minimum data needed to classify and describe clinical activity undertaken for patients by allied health services in New Zealand. It provides a meaningful data set to reflect the allied health services and key workflow decisions that influence the patient's journey.

1.1 Purpose

The standard is designed to ensure allied health services received by patients are identified, classified and recorded in a common way, enabling the generation of knowledge applicable to service development, national benchmarking and comparative service analytics. The standard supports more consistent and detailed inter-district data sharing that can be used for allied health service delivery and workforce planning.

1.2 Scope

The standard defines the minimum data required to be captured by allied health staff in District Health Boards in New Zealand to record patient-related clinical activity. Standardised data will enable services to be meaningfully benchmarked to each other. The professional disciplines identified for inclusion at this stage are: occupational therapy, physiotherapy, social work, dietetics and speech and language therapy.

The data set includes comprehensive definitions of data applicable across the allied health physical health service spectrum. This is an 'all age' spectrum that includes inpatient, outpatient, emergency departments and community service settings.

To help guide the process of defining the data elements to be included within the collection, allied health workflow was defined to determine the main stakeholders or users of the data collected. The Australian National Allied Health Casemix Committee (NAHCC) (2001) has developed a matrix to highlight how the activity data needed at each stage of the allied health workflow (input, process, output and outcome) could vary by stakeholder (see Figure 1).

As patient/client interaction with the allied health disciplines are at the centre of this collection, the bare minimum and starting point for this collection focuses on client and departmental stakeholders (ie, axis A and B in Figure 1). Once this data set is standardised it is easier to build on the collection to provide the data required by the remaining stakeholders in future editions of this standard.

	1 INPUT	2 PROCESS	3 OUTPUT	4 OUTCOME
A:	CLIENT AXIS			
B:	DEPARTMENT AXIS			
C:	ORGANISATION AXIS			
D:	PURCHASER AXIS			
E:	PROFESSIONAL AXIS			
F:	PUBLIC AXIS			
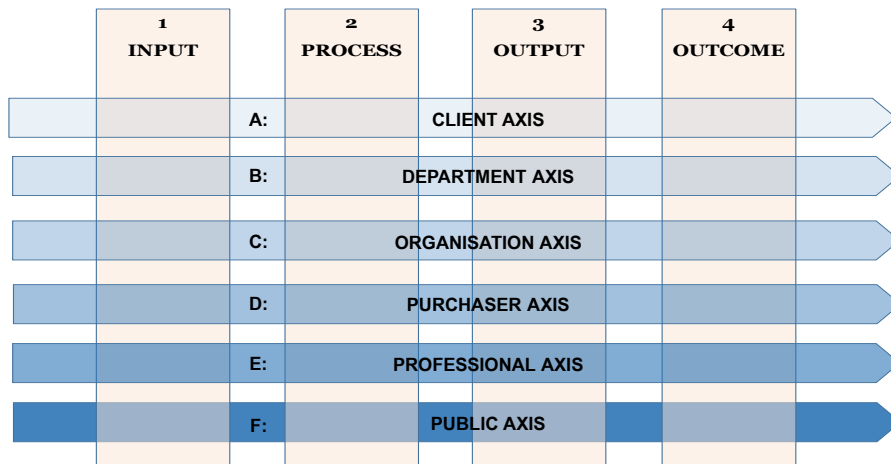
Figure 1: NAHCC grid highlighting the various stakeholders interested in allied health workflow (NAHCC, 2001, pp15[1])

1.3   Future development

There are plans to extend this standard to include more about the scope of allied health professions, organisational participation and activity. The standard will also be maintained to reflect the important requirement for SNOMED CT and other foundational standards for interoperability.

1.4   Implementation

There are a large number of valued stakeholders interested in allied health information. Moving towards a single standardised data set for five different professional disciplines nationally will require a significant paradigm shift in how information is collected. It is recognised that the transition to obtain all elements of this data set will take time, particularly in negotiation with any industry partners involved in the systems in place.

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[1] www.nahcc.org.au/pdfs/hah.pdf

1.5　Data element definitions

Each data element in this standard is defined according to a set of metadata components from ISO/IEC 11179 *Information Technology – Specification and standardization of data elements*, 2003.

Definition	A statement that expresses the essential nature of the data element and its differentiation from all other data elements in this standard		
Source standards	Established data definitions or guidelines pertaining to the data element		
Data type	Alphabetic (A) Numeric (N) Alphanumeric (X) Boolean	Representational class	Code, free text, value or identifier For date and time data types, use full date or partial date
Field size	Maximum number of characters	Representational layout	The arrangement of characters in the data element – eg: • 'A(50)' means up to 50 alphabetic characters • 'NNAAAA' means two numeric followed by four alphabetic characters Full date/time representation is YYYYMMDD hh:mm:ss
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 Each coded data element has a specified code set		
Guide for use	Additional guidance to inform the use of the data element		
Verification rules	Quality control mechanisms that preclude invalid values		

2 Data elements

This section describes the required set of allied health service and activity data elements. Together, these elements identify and describe a period of active care, from start to completion, between the allied health professional and the patient.

All data elements described in this standard are mandatory for collection.

2.1　District Health Board

The agency code for a District Health Board (DHB) under whose jurisdiction the patient receives the care provided.

Definition	An agency code to uniquely identify an individual DHB		
	The value is combined with local service coverage, regional information and a team name to avoid ambiguity in identification		
Source standards	DHB code table: www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/district-health-board-code-table		
Data type	Numeric	Representational class	Identifier
Field size	4	Representational layout	NNNN
Data domain	DHB codes		
Guide for use	The DHB agency code is assigned by the Ministry and is historically used to identify an organisation, institution or group of institutions in the Ministry legacy systems (NMDS, NBRS, MHINC et al)		
Verification rules	Valid code set value only		

2.2　Patient identifier

Definition	National Health Index (NHI) number – a unique identifier assigned by the NHI system to a patient to whom the care is provided		
Source standards	HISO 10046 Consumer Health Identity Standard: www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard		
	See also NHI data dictionary: www.health.govt.nz/publication/national-health-index-data-dictionary		
Data type	Alphanumeric	Representational class	Identifier
Field size	7	Representational layout	AAANNNN
Data domain	NHI numbers		
Guide for use	Only the NHI system generates the NHI number that is assigned to a patient identity		
	NHI numbers are not re-used once assigned to a patient identity		
	Where more than one number exists for a patient identity, one number is declared 'live' and all other numbers are made 'dormant' and attached to the live record		
	The NHI number is the primary key for patients' records		
Verification rules	See the source standards for the check digit algorithm and NHI number validation rules		

2.3 Date of Birth

Definition	The date of birth provided by the patient on presentation to indicate the day, month and year of their birth		
Source standards	HISO 10046 Consumer Health Identity Standard: www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard		
Data type	Date	Representational class	Full date
Field size	8	Representational layout	YYYYMMDD
Data domain			
Guide for use	Provides the ability to match data across databases, having both NHI and date of birth ensures accurate and robust cross referencing		
Verification rules	The date must be valid and cannot be in the future Date of Birth can be obtained from the patient and must be confirmed with the NHI system		

2.4 Allied health occupation

Definition	The professional occupation or discipline name of the service provided, for example: social work or indication of an event where merged services were provided (eg, transdisciplinary)		
Source standards	SNOMED CT Aligned to Australia New Zealand Classification of Occupations (ANZSCO): http://archive.stats.govt.nz/methods/classifications-and-standards/classification-related-stats-standards/occupation.aspx		
Data type	Numeric	Representational class	Code
Field size	18	Representational layout	N(18)
Data domain	SNOMED CT concepts: • Physiotherapist (link to SNOMED browser) • Occupational therapist • Speech and language therapist • Social worker • Dietitian • Transdisciplinary – new concept requested for SNOMED CT International Edition		
Guide for use	Only six options are available		
Verification rules	Valid code set value only		

2.5   Role context

Definition	The context of role (the skill and professional capacity of the staff member) undertaking the service		
Source standards	SNOMED CT		
Data type	Numeric	Representational class	Code
Field size	18	Representational layout	N(18)
Data domain	SNOMED CT concept: • Allied health practitioner (link to SNOMED browser) • Allied health assistant – new concept requested for SNOMED CT International Edition • Allied health student – new concept requested for SNOMED CT International Edition		
Guide for use	Allied health practitioner – a staff member with tertiary qualification and accreditation to practice using their specified occupational title, as per 2.4 above Allied health assistant – a staff member not formally accredited with an allied health qualification Allied health student – a person registered to an accredited training programme but not formally registered to practice		
Verification rules	Valid code set value only The default value is 'Allied health practitioner'		

2.6   Service location

Definition	Where the patient is located at the time of service provision		
Source standards	SNOMED CT		
Data type	Numeric	Representational class	Code
Field size	18	Representational layout	N(18)
Data domain	• Inpatient environment (link to SNOMED browser) • Emergency department • Patient's residence • Community location (all locations not identified above including outpatient environments)		
Guide for use	The service location identifies and contributes to information about service provision aligned to patient need, but it does not capture information about the facility that the service staff operate from		
Verification rules	Valid code set value only		

2.7   Health specialty

Definition	A descriptor of specialty or scope of service that defines the most relevant care provided to the patient		
Source standards	National Collections - Common Code Tables/Health Specialty Codes		
Data type	Alphanumeric	Representational class	Code
Field size	3	Representational layout	ANN
Data domain	Health Specialty Code Table: www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/health-specialty-code-table		
Guide for use	Selection is based on which speciality the patient has been aligned to at point of care or which is most relevant to the scope of care being provided Selection of a health specialty will create greater visibility of staffing resource and activity by enabling association to a specified allied health occupation and role		
Verification rules	Valid code set value only		

2.8   Referrer

Definition	Source of referral for allied health service provision – either the professional group type, the patient or someone else acting for the patient		
Source standards	SNOMED CT		
Data type	Numeric	Representational class	Code
Field size	18	Representational layout	N(18)
Data domain	SNOMED CT concepts: • General practitioner • Medical officer • Nurse • Midwife • Allied health practitioner • Dentist • Patient (self) • Other		
Guide for use	Aligned to the National Patient Flow data collection This information is limited to the professional context and does not include the referrer's personal identification or responsible authority		
Verification rules	Valid code set value only		

2.9   Referral source

Definition	Unique identifier for the health provider organisation delivering the service		
Source standards	This number element is described at section 4.3 of the HPI data set specification: www.health.govt.nz/publication/hiso-100052008-health-practitioner-index-hpi-data-set		
Data type	Alphanumeric	Representational class	Identifier
Field size	6	Representational layout	GXXNNN
Data domain	HPI organisation numbers as provided by the Ministry		
Guide for use	G is a literal prefix HPI organisation identifier is assigned by the HPI system at the time the organisation record in the HPI is created		
Verification rules	HPI organisation identifier can be obtained from the organisation but must be confirmed with that held within the HPI system		

2.10   Clinician identifier – Responsible Authority members

A unique identifying number pertaining to the health provider that is delivering the service where that health practitioner is a member of a Responsible Authority as set out in the Health Practitioners Competence Assurance Act 2003[2].

This field uses the Health Provider Index (HPI) Common Person Number. Non-HPI registered practitioners are identified using section: 2.11 Clinician identifier – other practitioners, for example, social workers and speech and language therapists.

Definition	HPI identifier for the person who is directly providing the service		
Source standards	HPI documentation: www.health.govt.nz/our-work/health-identity/health-practitioner-index See also: HISO 10005:2008 Health Practitioner Index Data Set: www.health.govt.nz/publication/hiso-100052008-health-practitioner-index-hpi-data-set HISO 10006:2008 Health Practitioner Index Code Set: www.health.govt.nz/publication/hiso-100062008-health-practitioner-index-hpi-code-set		
Data type	Alphanumeric	Representational class	Identifier
Field size	6	Representational layout	NNAAAA
Data domain	HPI CPN numbers generated by the HPI system		

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[2] www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act/responsible-authorities-under-act

Guide for use	This field is only for use where the practitioner is a member of a Responsible Authority under the Health Practitioners Competence Assurance Act 2003
Verification rules	CPN can be obtained from the clinician but must be validated with the HPI system

2.11   Clinician identifier – other practitioners

A unique number to identify the health practitioner providing the service where that individual is not a member of a Responsible Authority under the Health Practitioners Competence Assurance Act 2003. This element is only to be used when element 2.10 Clinician identifier – Responsible Authority members cannot be completed.

Definition	A unique employee identifier pertaining to the staff member who is directly providing the service but does not hold a Ministry HPI - CPN (Health Practitioner Index – Common Person Number).		
Source standards			
Data type	Alphanumeric	Representational class	Identifier
Field size	25	Representational layout	X(25)
Data domain			
Guide for use	Emp ID - This identifier is given by the employer organisation and must be unique to the employee at that particular organisation		
Verification rules	Must be a unique identifier for the practitioner (eg, an employee number)		

2.12   Referral receipt date

Definition	This is the date a referral is received by the discipline service		
Source standards			
Data type	Date	Representational class	Full date
Field size	8	Representational layout	YYYYMMDD
Data domain			
Guide for use	Date to be provided, plus point of contact/service This is critical to gaining knowledge of the timeliness of activity and aligns with the move towards identifying patient touch points with health care		
Verification rules	The date must be valid and cannot be in the future Full date representation is YYYYMMDD		

2.13　Prioritisation/acceptance date

Definition	This records the date the service referral is prioritised or accepted on to the active case load schedule		
Source standards			
Data type	Date	Representational class	Full date
Field size	8	Representational layout	YYYYMMDD
Data domain			
Guide for use	This is critical to gaining knowledge of the timeliness of activity and aligns with the move towards identifying patient touch points with health care		
Verification rules	Must be greater than or equal to the Referral receipt date (section 2.12) The date must be valid and cannot be in the future		

2.14　Patient contact date

Definition	This is the date attributed to a point of contact/service provided by the discipline's service. This could be direct or indirect contact.		
Source standards			
Data type	Date	Representational class	Full date
Field size	8	Representational layout	YYYYMMDD
Data domain			
Guide for use	This is critical to gaining knowledge of the timeliness of activity and aligns with the move towards identifying patient touch points with health care.		
Verification rules	Must be greater than or equal to the Prioritisation/acceptance date (see 2.13) The date must be valid and cannot be in the future		

2.15　Transfer of care date

Definition	The date the service provider identifies as concluding the patient's period of active care with a particular service provider		
Source standards			
Data type	Date	Representational class	Full date
Field size	8	Representational layout	YYYYMMDD

Data domain	Valid date
Guide for use	This is critical to gaining knowledge of the timeliness of activity and aligns with the move towards identifying patient touch points with health care
Verification rules	Must be greater than or equal to the Prioritisation/acceptance date (section 2.13) The date must be valid and cannot be in the future

2.16   Mode of delivery - Type of contact

Definition	This refers to the type of activity by which a patient's care is facilitated (eg, the completion of equipment applications are 'administration' or consultation with the patient directly by 'telephone').		
Source standards	www.health.govt.nz/publication/national-non-admitted-patient-collection-data-mart-data-dictionary Search for 'Mode of Delivery'		
Data type	Numeric	Representational class	Code set
Field size	2	Representational layout	NN
Data domain	01 In person (one patient to one clinician) 02 In person (one patient to many clinicians) 03 In person (one clinician to many patients) 04 Remote patient monitoring (eg, monitoring of patients health information communicated from a remote patient device) 05 Telephone 06 Videoconference 07 Non-contact (virtual), ie, an event where the patient is not present including family meetings, Multidisciplinary team meetings, and collegial discussions … 98 Administration 99 Did not attend (DNA)		
Guide for use	Multiple selections are available to be used to cover the sequential nature of activity (ie, 01 to 07) Note: Codes 98 and 99 are additional to those found in the source standard referenced above.		
Verification rules	Valid code set value only		

2.17   Activity commencement

Definition	The time a service activity commences		
Source standards			
Data type	Time	Representational class	Time
Field size	5	Representational layout	HH:MM
Data domain	Valid time		
Guide for use	Enter a full time (ie, hour and minute) The date that the service activity commences is recorded under section 2.14 Patient contact date Time is to be recorded using the 24-hour clock.		
Verification rules	Must be a valid time.		

2.18   Activity completion

Definition	The date and time a service activity is concluded		
Source standards			
Data type	Date/time	Representational class	Full date and time
Field size	14	Representational layout	YYYYMMDD HH:MM
Data domain	Valid date and time.		
Guide for use	Elapsed activity time can be established by subtracting the combined Patient contact date (section 2.14) and Activity commencement time (section 2.17) from the date/time the activity was completed (this element) Time is recorded using the 24 hour clock		
Verification rules	Must be greater than or equal to the combined Patient contact date (section 2.14) and Activity commencement time (section 2.17) Must be a valid date and time		

2.19   Encounter outcome

Definition	The outcome of an episode of allied health activity which may include a single or series of allied health contacts with or about patients
Source standards	National Patient Flow file specification: www.health.govt.nz/system/files/documents/publications/npf_phase_3_file_specification-v3.2.pdf Search for 'Encounter Outcome Decision'

Data type	Numeric	Representational class	Code
Field size	2	Representational layout	NN

Data domain	01 Unrelated referral - referred elsewhere for something unrelated to the current referral reason. 02 Related referral - where the patient is going to be referred to another health specialty or organisation for the current referral reason (eg, tests, surgery being provided by another specialty) 04 Ongoing care – by the same service (default) 05 Nothing further required – by this service 07 Palliative care
Guide for use	It is important to be able to see the impact allied health staff have on a patient's journey. Patients may have many encounters with allied health staff and the purpose of this field is to capture details of where patients move onto following their allied health contact. In most cases the patient will have ongoing follow up and in this case nothing needs to be filled in (as default is ongoing care). However, if the patient is discharged or referred on to another profession for a related or unrelated reason we would like to know. • Unrelated referral – a communication by one health practitioner to another health practitioner whose intent is the transfer of care, in part or in whole of a Patient in regards to a specific condition. An unrelated referral would be for something new (eg, a patient you are seeing for cognitive rehabilitation requires a nurse for wound care) • Related referral – a subsequent referral related to the presenting referral, either across or within a specialty within secondary or tertiary care. A related referral would be one made relating to the reason you are seeing the patient (eg, you were referred a stroke patient who indicated that they had not yet seen a speech and language therapist for their aphasia) Aligned to the National Patient Flow data collection (July 2016)
Verification rules	Valid code set value only The default is '04 - ongoing care'

2.20 Encounter outcome reason

Definition	The reason for the outcome of an episode of allied health service provision		
Source standards			
Data type	Numeric	Representational class	Code
Field size	2	Representational layout	NN
Data domain	01 Service complete 02 Acute admission 03 Arranged admission – patient to be admitted within seven days 09 Patient medical reason - patient medically unwell and unable to participate in service or patient undergoing medical process 10 Patient choice/declined 11 Additional service required - Use where the Encounter outcome choice is Related referral; where there are additional services that are required by referral, and are related to the service being provided (eg, tests, consults, assessment) 20 Patient deceased 53 Service not delivered (ie, patient discharged prior to service being complete)		
Guide for use	Aligned to the National Patient Flow data collection		
Verification rules	Valid code set value only		

2.21 Responsibility for future care

Definition	The destination of the patient's care at the point of service completion and outcome identification		
Source standards	National Patient Flow file specification: www.health.govt.nz/system/files/documents/publications/npf_phase_3_file_specification-v3.2.pdf Search for 'Destination' – section 12.7		
Data type	Numeric	Representational class	Code
Field size	2	Representational layout	NN
Data domain	03 DHB – community support care (eg, specialist community nursing services, other community Allied Health service) 04 Other DHB 05 Other health specialty (eg, NGO or private practitioner) 06 Outpatient clinic		

	07 Aged residential care (as new resident)
	08 Hospice/palliative care services
	09 Primary care (default)
	10 Overseas
	11 Referrer
	12 Self care
	13 Inpatient care - if patient to be admitted or remain in hospital after discharge from allied health service
Guide for use	Aligned to the National Patient Flow data collection
Verification rules	Valid code set value only