TE AHO O TE KAHU CANCER CONTROL AGENCY

hiso Health Information Standards Organ
PAEREWA PĀRONGO HA

CANCER MULTIDISCIPLINARY MEETING DATA STANDARD

HISO 10038.4:2021

2021

New Zealand Government

MINISTRY OF HEALTH
MANATŪ HAUORA

Contributors

Te Aho o Te Kahu, the Cancer Control Agency is an independent departmental agency that was established to lead and unite efforts to deliver better cancer outcomes for Aotearoa.

Te Aho o Te Kahu is responsible for developing and publishing cancer-specific data standards.

In 2020, Te Aho o Te Kahu undertook a significant public consultation with cancer health professionals and subject matter experts across the sector to update the 2017 draft Multidisciplinary Meeting (MDM) Data Standard to ensure:

- identify the minimum set of data items required for clinical decision-making
- national consistency in the development and implementation of MDM systems and processes.

Te Aho o Te Kahu acknowledges the many people and organisations who contributed to the publication of this MDM Data Standard.

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1 INTRODUCTION

A cancer multidisciplinary meeting (MDM) is a regular meeting where health professionals from different specialities discuss and recommend options for a patient's treatment and care. These meetings are a key part of the philosophy of multidisciplinary care and facilitate a holistic approach to identify the best available and most appropriate treatment and care plan.

Access to high-quality patient information is vital for informed decision-making during the MDM process. Consistent and reliable data enables MDM attendees to agree on clinical recommendations for the treatment pathway that best meets the individual needs of a patient. This is particularly important for Māori and Pacific peoples who experience poorer access, timeliness and quality of health care, which contributes to avoidable and unfair differences present in cancer outcomes.

1.1 Background

In 2017, a draft Cancer Multidisciplinary Meeting Data Standard was developed by MDM subject matter experts and widely consulted with stakeholders. The draft standard defined a consistent way of capturing data to support interoperability between hospital systems and inform decision-making during an MDM. Although the draft data standard was not submitted for official Health Information Standard Organisation (HISO) endorsement at the time, it was useful for regions implementing MDM systems.

With consistent data standards for cancer across the health sector, high-quality data can be used to monitor and audit patient pathways locally, regionally and nationally to support the equitable delivery of care across the pathway and improve cancer outcomes.

The 2017 draft Cancer Multidisciplinary Meeting Data Standard has been updated to reflect:

- the release of the **New Zealand Cancer Action Plan 2019–2029**
- the incorporation of SNOMED CT, if applicable
- the revised optionality of each data element, identifying the key items to be collected to support clinical decision-making and for administration purposes
- a collective agreement on the preferred use of American Joint Committee on Cancer, *Cancer Staging Manual* 8th edition, January 2017 when appropriate. (Some cancers are not staged, and others use alternative systems such as FIGO or WHO. When possible, these systems will be mapped to TNM for analysis and reporting.)

This document has been developed in collaboration with MDM stakeholders and refined through an iterative process. Data items were selected primarily for their relevance in facilitating discussion and decision-making in an MDM and supporting MDM service delivery.

The Ministry of Health has developed an **Interoperability Roadmap** to support a modern, digitally enabled and data-driven health and disability system to improve equity and pae ora (healthy futures). An interoperable digital health ecosystem relies on the national adoption of data standards and collaboration across the health sector.

1.2 Purpose

The purpose of this document is to outline the nationally agreed data elements for capturing patient and cancer information to support the MDM process. The data standard aims to support Te Aho o Te Kahu and the Ministry of Health's vision to accelerate the shift to a fully interoperable digital health ecosystem.

For the purposes of this data standard, the MDM process refers to referral information, pathology and radiology review, MDM decisions, recommendations and administrative processes. The data items are organised into sections representing the different categories of information collected or generated during the MDM process.

This document also identifies the mandatory fields required for consistent, accessible and accurate data to support informed and equitable decision-making during an MDM and to record final recommendations. The final recommendations may change due to additional information and/or discussions between the patient and lead clinician.

Te Aho o Te Kahu, in partnership with the Ministry of Health and health sector, will ensure the data standard is reviewed and updated as required through the existing HISO process.

1.3 Scope

The data standard covers cancer data items that are relevant across most or all tumour groups. This standard should be used to support any Request for Proposal (RFP) process to select an MDM solution and/or as input into the design and development of a technical MDM solution.

The standard does not cover:

- paediatric cancer data
- tumour group specific data items
- family cancer history.

1.4 Definitions

Term	Definition
AJCC	American Joint Committee on Cancer (AJCC) develop evidence-based anatomic staging that supports clinicians in understanding and treatment cancer patients
ECOG score	The Eastern Cooperative Oncology Group (ECOG) score, also called the WHO or Zubrod score, is a measure of cancer patients' general wellbeing. The score runs from 0 to 5, with 0 denoting perfect health and 5 death. The measure is used to help assess a patient's ability to cope with different treatment protocols such as chemotherapy.
HISO	The Health Information Standards Organisation provides technical leadership and expert advice to the Ministry of Health on the development and adoption of health information standards.

Term	Definition
HSCAN	High Suspicion of Cancer is a judgement made by a clinician when concern is raised from assessing features, symptoms, signs and tumour specific risk factors.
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems version 10 – Australian Modification. ICD-10 is a health care classification system, providing a system of diagnostic codes for classifying diseases, including nuanced classifications of a variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease.
ICD-O	The International Classification of Diseases for Oncology (ICD-O) is a domain-specific extension of the International Statistical Classification of Diseases and Related Health Problems for tumour diseases. This classification is widely used by cancer registries to capture the morphology of a tumour.
Lead clinician	The clinician who assumes primary responsibility for the patient (subject to change as required).
Multidisciplinary meeting	Multidisciplinary meetings (MDMs) are deliberate, regular meetings either face-to-face or via videoconference, where health professionals with expertise in a range of different specialities discuss the options for patients' treatment and care prospectively. Prospective treatment and care planning involve making recommendations in real time, with an initial focus on the patient's primary treatment. MDMs take a holistic approach to patients' treatment and care.
MDM coordinator	A central administration role in the MDM process. It can include the coordination of patient MDM referrals, room bookings, technology support, sourcing patient data for discussion, getting pathology slides or radiological images for review and key aspects of documentation as part of the MDM pathway.
MDM recommendation	A recommendation for a specific action or sets of actions, related to the treatment or care plan, or further diagnostics for a patient, generated from an MDM discussion. The final treatment decision involves a discussion between patient and lead clinician
MDM referrer	The clinician referring a patient to an MDM, must provide the core referral information necessary to book the patient into the relevant MDM.
MDM template/ proforma	An electronic document used to capture MDM referral information and outcomes. A completed template will ideally provide a clear picture of who the patient is, their diagnosis, why they were presented to the MDM and what treatment or care plan was recommended at the MDM.
PACS	A Picture Archiving and Communication System (PACS) provides economical storage and convenient access to radiological images. Radiology reviews of patient images as part of the MDM process require the retrieval of these images from the PACS.
PAS	A Patient Administration System (PAS) is a specialised IT system that manages patient information in a hospital, including patient demographics, appointments, medical records tracking, diagnostic coding and patient tracking.
SNOMED CT	Systematized Nomenclature of Medicine – Clinical Terms is a systematic, computer-processable collection of medical terms that provide definitions and synonyms that cover anatomy, diseases, findings, procedures, microorganisms, substances and so on. It is a consistent way to store, retrieve and aggregate medical data across specialties and sites of care.
Tumour group or stream	A group of similar or related cancers, usually categorised according to the bodily system or organ they are associated with (eg, bowel, gynaecological, breast).

1.5 Legislation and regulations

The following legislation and regulations are relevant to this standard:

- Health Information Privacy Code 2020
- Health Practitioners Competence Assurance Act 2003
- Privacy Act 2020
- Public Records Act 2005
- Health (Retention of Health Information) Regulations 1996.

1.6 Related specifications

The following documents have been used to develop or are referenced in this standard.

- **New Zealand Cancer Health Information Strategy**. Wellington: Ministry of Health
- **New Zealand Cancer Plan: Better, faster cancer care 2015–2018**. Wellington: Ministry of Health
- **New Zealand Cancer Action Plan 2019–2029 – Te Mahere mō te Mate Pukupuku o Aotearoa 2019–2029.** Revised January 2020. Wellington: Ministry of Health
- MDM National Future State Business Requirements and Processes – future development pending
- **HISO 10001:2017 Ethnicity Data Protocols**
- **HISO 10038.0:2017 Preface to the Cancer Data Standards**
- **HISO 10038.3 Interim National Cancer Core Data Definitions Standard**
- **HISO 10046 Consumer Health Identity Standard**
- **Ministry of Health's Clinical Coding System code table.**

The current HISO Health Practitioner Index (HPI) standards are listed below. They were published in 2008 and, while they provide guidance on the particular HPI values referred to in this standard, they are not suitable for any other purpose.

- **HISO 10005:2008 Health Practitioner Index (HPI) Data Set**
- **HISO 10006:2008 Health Practitioner Index (HPI) Code Set**

An updated draft version of these standards (HISO 10045 Health Provider Identity Standard) is available from **standards@health.govt.nz**.

1.7 SNOMED CT

Most coded data elements use by default the SNOMED CT terminology for clinical information. The concepts making up each value domain are denoted by preferred term and linked to entries in the **SNOMED CT browser**. The SNOMED CT concept identifier (SCTID) can be viewed by hovering over the link.

Some data elements are restricted to a definite set of SNOMED CT concepts, while others are more open-ended and allow the user to select from a wider set of concepts, usually within a certain hierarchy or sub-hierarchy – eg, the set of all disease concepts.

See the **SNOMED CT Search and Data Entry Guide** for a guide to building a user-friendly search across the terminology.

Applications should use the SNOMED preferred term for display and capture the SNOMED concept identifier in the patient record.

The **SNOMED NZ edition**, incorporating the SNOMED CT international edition and released in April and October every year, is the standard distribution. SNOMED CT is free to use in New Zealand and easy to implement.

1.8 Data element template

Data element specifications in this standard conform to the requirements of ISO/IEC 11179 Information Technology – Metadata Registries (MDR).[1]

Definition	A statement that expresses the essential nature of the data element and its differentiation from other elements in the data set.		
Source standards	Established data definitions or guidelines relating to the data element.		
Data type	Alphabetic (A) Date Date/time 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 formatted arrangement of characters in alphanumeric elements, for example: • X(50) for a 50-character alphanumeric string • NNN for a 3-digit number • NNAAAA for a formatted alphanumeric identifier.
Value domain	The named, enumerated or described set of valid values or codes that are acceptable for the data element. Each coded data element has a specified code set.		
Obligation	Indicates if the data element is mandatory or optional in the context, or whether its appearance is conditional.		
Guide for use	Additional guidance to inform the use of the data element.		
Verification rules	Quality control mechanisms that preclude invalid values.		

[1] See **https://standards.iso.org/ittf/PubliclyAvailableStandards/index.html**

2 DATA ELEMENTS

This section describes the set of core minimum data to be captured to support treatment planning at an MDM. People with cancer often present at more than one MDM and, if so, should have multiple MDM records.

Any MDM technical solution must be able to capture this dataset multiple times for the same person, for the same cancer or a new cancer. Subsequent MDM records should be able to be prepopulated with the values from a previous record (eg, patient, general practice details).

2.1 Patient details

The format for the following list of patient details is sourced directly from the **HISO 10046 Consumer Health Identity Standard.** Please use this standard for full definitions and format of these items.

Data elements	
National Health Index (NHI) number	Contact details
Given name	Street address/address line 1
Family name (surname)	Additional street address/address line 2
Date of birth	Suburb/address line 3
Ethnicity (1–6)*	Town or city/address line 4
Gender**	Postcode
Sex***	Domicile code

* See **HISO 10001:2017 Ethnicity Data Protocols** for the collection and recording of ethnicity data.

** Gender is self-identified (personal preference) and is captured in the patient's NHI record.

*** Sex is assigned genetically and is important when determining treatment; therefore, it is a mandatory field. See **HISO 10038.3 Interim National Cancer Core Data Definitions Standard** for a definition of this data element.

2.2 General practice details

This lists the details required for the general practice that the patient is enrolled with.

Data elements	
General practice name and identifier	General practice phone number
Street address*	General practice email

* See **HISO 10005 HPI Data Set Standard** for details.

2.2.1 General practice

Record the facility details for the general practice the patient is enrolled with, if known, sourced from the HPI system. The format and description of the information are set out in Appendix 2: HPI sourced information. This also includes general dental practice details. This information is optional.

2.2.2 Street address

This is the physical location of the patient's general practice where the patient is enrolled. This information is optional.

2.2.3 General practice phone number

Definition	The phone number of the patient's general practice.		
Source standards	**ITU-T E.164 The international public telecommunication numbering plan**		
Data type	Numeric	**Representational class**	Free text
Field size	15	**Representational layout**	N(15)
Value domain	International ITU-T E.164 numbers		
Obligation	Optional		
Guide for use	International ITU-T E.164 numbers are variable length numeric strings without punctuation, composed of country code, area code or mobile network code, and subscriber number Numbers should be entered, validated and displayed as separate components, for example: • 64 4 232*nnnn* • 64 20 412*nnnnn*		
Verification rules	Valid phone number		

2.2.4 General practice email

Definition	The primary email address of the patient's general practice for communication purposes.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	50	**Representational layout**	X(50)
Value domain			
Obligation	Optional		
Guide for use	This is the secure email address that is used to distribute any relevant MDM outputs to the patient's general practice.		
Verification rules	Valid email address		

2.3 Core referral information and key questions

Along with the patient details, this section lists the patient's core referral information and key questions for an MDM.

Data elements	
Requested MDM facility	Source of referral
Requested MDM tumour group	Pathology reviews
Other MDM tumour group	Radiology reviews
Requested MDM date	Other investigation
Referrer	Patient discussion status
Lead clinician	Key questions for MDM
Presenter	

2.3.1 Requested MDM facility

The identity of the facility leading the MDM that the patient is being referred to is to be recorded.

Record the details for the MDM facility leading the MDM that the patient is being referred to, sourced from the HPI system. The format and description of the information are set out under 'Facility' in Appendix 2: HPI sourced information. This information is mandatory.

2.3.2 Requested MDM tumour group

Definition	The MDM tumour group that the patient is being referred to for presentation.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	See Appendix 1, Table 6: Multidisciplinary tumour group for suggested options.		
Obligation	Mandatory		
Guide for use			
Verification rules	Must be an active SNOMED CT concept.		

2.3.3 Other MDM tumour group

Definition	The name of the MDM tumour group that the patient is being referred to.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	250	**Representational layout**	X(250)
Value domain			
Obligation	Conditional. Mandatory if 'Other' is selected for Requested MDM tumour group.		
Guide for use	To be used when a tumour group is not listed in Appendix 1, Table 6: Multidisciplinary tumour group.		
Verification rules			

2.3.4 Requested MDM date

Definition	The date of the MDM that the patient is being referred to for presentation.		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	8	**Representational layout**	YYYYMMDD
Value domain	Valid date		
Obligation	Mandatory		
Guide for use	Can be either automatically populated or manually entered.		
Verification rules	A valid date that is equal to or more than the current date.		

2.3.5 Referrer

The details of the person submitting the MDM referral.

Record the details for the referrer submitting the MDM referral, sourced from the HPI system. The format and description of the information are set out under 'Health care practitioner' in Appendix 2: HPI sourced information.

2.3.6 Lead clinician

The details of the clinician responsible for coordinating the multidisciplinary care team providing cancer services for a patient.

Record the details of the lead clinician responsible for coordinating the multidisciplinary team caring for a patient, sourced from the HPI system. The format and description of the information are set out under 'Health care practitioner' in Appendix 2: HPI sourced information. This is a mandatory field.

2.3.7 Presenter

The details of the health care practitioner presenting the patient at the MDM in lieu of the lead clinician.

If the health care practitioner presenting the patient at the MDM is different from the lead clinician, record their details, sourced from the HPI system. The format and description of the information are set out under 'Health care practitioner' in Appendix 2: HPI sourced information.

2.3.8 Source of referral

Definition	The source of the patient referral to the MDM.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	See Appendix 1, Table 1: Source of referral for suggested SNOMED CT options.		
Obligation	Mandatory		
Guide for use			
Verification rules	Must be an active SNOMED CT concept.		

2.3.9 Pathology reviews

This section lists the data elements to capture for each pathology review. A patient may have more than one pathology review.

Pathology review required

Definition	Whether a formal review of the patient's pathology is required before the MDM.		
Source standards			
Data type	Boolean	**Representational class**	N/A
Field size	1	**Representational layout**	N(1,0)
Value domain			
Obligation	Mandatory		
Guide for use	**Value** / **Meaning** 1 — **Yes.** A formal review of the patient's pathology is required for the MDM. 0 — **No.** A formal review of the patient's pathology is not required for the MDM.		
Verification rules	Valid code		

Pathology type

Definition	The type of pathology requiring review (eg, biopsy).		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	A valid pathology procedure type SNOMED CT term from the **Biopsy (procedure) 86273004** hierarchy.		
Obligation	Optional		
Guide for use	A patient may have one or more pathology reviews, with each being stored against a separate instance of this data element. Pathology data should ideally be selectable via integration with the pathology system.		
Verification rules	Must be an active SNOMED CT concept.		

Pathology accession number

Definition	The accession number of the pathology slide or pack requiring review.		
Source standards			
Data type	Alphanumeric	**Representational class**	Identifier
Field size	30	**Representational layout**	X(30)
Value domain	As defined by the individual organisation.		
Obligation	Optional		

Guide for use	A patient may have one or more pathology reviews, with each being stored against a separate instance of this data element. Pathology data should ideally be selectable via integration with the pathology system.
Verification rules	

Pathology date

Definition	The date when the pathology sample was taken.		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	8	**Representational layout**	YYYYMMDD
Value domain	Valid date		
Obligation	Optional		
Guide for use	A patient may have one or more pathology reviews, with each being stored against a separate instance of this data element. Pathology data should ideally be selectable via integration with the pathology system.		
Verification rules	A valid date that is less than or equal to the current date.		

Pathology provider facility

The identity of the facility storing the digital slide(s) to be reviewed.

Record the details of the facility storing the digital slide(s) to be reviewed, sourced from the HPI system. The format and description of the information are set out under 'Facility' in Appendix 2: HPI sourced information. This information is mandatory.

Pathology questions

Definition	The question(s) for the reviewing pathologist regarding the patient's pathology.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	500	**Representational layout**	X(500)
Value domain			
Obligation	Conditional. Mandatory if Pathology review required is marked 'Yes'.		
Guide for use	A patient may have one or more pathology reviews, with each being stored against a separate instance of this data element.		
Verification rules			

2.3.10 Radiology reviews

This section lists the data elements to capture for each radiology review. A patient may have more than one radiology review. This section also covers nuclear medicine reviews.

Radiology review required

Definition	Whether a formal review of the patient's radiology is required before the MDM.		
Source standards			
Data type	Boolean	**Representational class**	N/A
Field size	1	**Representational layout**	N(1,0))
Value domain	**Value** / **Meaning** 1 / **Yes.** A formal review of the patient's radiology is required for the MDM. 0 / **No.** A formal review of the patient's radiology is not required for the MDM.		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code		

Radiology type

Definition	The type of radiology requiring review (eg, MRI).		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	A valid radiology procedure type SNOMED CT term from the **Imaging (procedure) 363679005** hierarchy for the patient being presented.		
Obligation	Optional		
Guide for use	A patient may have one or more radiology reviews, with each being stored against a separate instance of this data element. Radiology data should ideally be selectable via integration with the radiology system.		
Verification rules	Must be an active SNOMED CT concept.		

Radiology accession number

Definition	The accession number of the radiology image requiring review.		
Source standards			
Data type	Alphanumeric	**Representational class**	Identifier

Field size	30	**Representational layout**	X(30)
Value domain	As defined by the individual organisation.		
Obligation	Optional		
Guide for use	A patient may have one or more radiology reviews, with each being stored against a separate instance of this data element. Radiology data should ideally be selectable via integration with the radiology system.		
Verification rules			

Radiology date

Definition	The date when the radiology image was taken.		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	8	**Representational layout**	YYYYMMDD
Value domain	Valid date		
Obligation	Optional		
Guide for use	A patient may have one or more radiology reviews, with each being stored against a separate instance of this data element. Radiology data should ideally be selectable via integration with the radiology system.		
Verification rules	A valid date that is less than or equal to the current date.		

Radiology provider facility

The identity of the facility storing the image(s) to be reviewed.

Record the details of the facility storing the image(s) to be reviewed, sourced from the HPI system. The format and description of the information are set out under 'Facility' in Appendix 2: HPI sourced information. This information is mandatory.

Radiology questions

Definition	The question(s) for the reviewing radiologist regarding the patient's radiology.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	500	**Representational layout**	X(500)
Value domain			
Obligation	Conditional. Mandatory if Radiology review required is marked 'Yes'.		
Guide for use	A patient may have one or more radiology reviews, with each being stored against a separate instance of this data element.		
Verification rules			

2.3.11 Other investigation

The following data elements identify the fields to be captured for investigations other than pathology and radiology. A patient may have more than one investigation to be reviewed.

Other investigation review required

Definition	Whether a formal review of the patient's other investigation is required before the MDM.		
Source standards			
Data type	Boolean	**Representational class**	N/A
Field size	1	**Representational layout**	N(1,0)
Value domain	**Value** / **Meaning** 1 / **Yes.** A formal review is required for the MDM. 0 / **No.** A formal review is not required for the MDM.		
Obligation	Optional		
Guide for use			
Verification rules	Valid code		

Investigation type

Definition	The type of investigation requiring review.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	250	**Representational layout**	X(250)
Value domain			
Obligation	Optional		
Guide for use	A patient may have one or more investigations to be reviewed, each being stored against a separate instance of this data element.		
Verification rules			

Investigation accession number

Definition	The accession number of an investigation requiring review.		
Source standards			
Data type	Alphanumeric	**Representational class**	Identifier
Field size	30	**Representational layout**	X(30)

Value domain	As defined by the individual organisation.
Obligation	Optional
Guide for use	A patient may have one or more investigations to be reviewed, each being stored against a separate instance of this data element.
Verification rules	

Investigation date

Definition	The date when the investigation took place.		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	8	**Representational layout**	YYYYMMDD
Value domain	Valid date		
Obligation	Optional		
Guide for use	A patient may have one or more investigations to be reviewed, each being stored against a separate instance of this data element.		
Verification rules	A valid date that is less than or equal to the current date.		

Investigation provider

The identity of the facility storing the investigation to be reviewed.

Record the details of the facility storing the investigation to be reviewed, sourced from the HPI system. The format and description of the information are set out under 'Facility' in Appendix 2: HPI sourced information. This information is mandatory.

Investigation questions

Definition	The question(s) for the health care practitioner regarding the patient's investigation.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	500	**Representational layout**	X(500)
Value domain			
Obligation	Conditional. Mandatory if Other investigation review required is marked 'Yes'.		
Guide for use			
Verification rules			

2.3.12 Patient discussion status

Definition	Indicates whether the patient is being submitted for formal discussion at the MDM or recorded.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	See Appendix 1, Table 2: Patient discussion status for suggested SNOMED CT options.		
Obligation	Mandatory		
Guide for use			
Verification rules	Must be an active SNOMED CT concept.		

2.3.13 Key questions for MDM

Definition	Specific questions for discussion at the MDM.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	500	**Representational layout**	X(500)
Value domain			
Obligation	Mandatory		
Guide for use			
Verification rules			

2.4 Clinical background

This section lists the data elements that capture the patient's history.

Data elements	
Previous MDM date	Previous MDM recommendations
Previous MDM tumour group	Previous treatment history
Other previous MDM tumour group	

2.4.1 Previous MDM date

Definition	The date of a previous cancer MDM where the patient was presented.
Source standards	

Data type	Date	**Representational class**	Full date
Field size	8	**Representational layout**	YYYYMMDD
Value domain	Valid date		
Obligation	Conditional. Mandatory if the patient has been presented at previous MDM(s).		
Guide for use	There may be multiple previous MDMs at which the patient has been presented. Each of these should be stored against a separate instance of field.		
Verification rules	A valid date that is less than or equal to the current date.		

2.4.2 Previous MDM tumour group

Definition	The tumour group of the MDM(s) that the patient was previously presented at.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	See Appendix 1, Table 1: Source of referral for suggested SNOMED CT options.		
Obligation	Conditional. Mandatory if the patient has been presented at a previous cancer MDM.		
Guide for use	There may be multiple previous MDMs at which the patient has been presented. Each of these should be stored against a separate instance of field.		
Verification rules	Must be an active SNOMED CT concept.		

2.4.3 Other previous MDM tumour group

Definition	The name of the MDM tumour group that the patient was previously presented at.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	250	**Representational layout**	X(250)
Value domain			
Obligation	Conditional. Mandatory if 'Other' is selected for Previous MDM tumour group.		
Guide for use	To be used when a tumour group is not listed in Appendix 1: Table 6: Multidisciplinary tumour group.		
Verification rules			

2.4.4 Previous MDM recommendations

Definition	The recommendations from a previous MDM the patient was presented at.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	See Appendix 1, Table 3: Recommendations for suggested SNOMED CT options.		
Obligation	Conditional. Mandatory if the patient has been presented at a previous cancer MDM.		
Guide for use	Multiple options may be selected. The patient may have been presented at multiple previous MDMs, with each set of recommendations being stored against a separate instance of this field.		
Verification rules	Must be an active SNOMED CT concept.		

2.4.5 Previous treatment history

Definition	The patient's history of treatment associated with their current cancer.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	500	**Representational layout**	X(500)
Value domain			
Obligation	Mandatory		
Guide for use			
Verification rules			

2.5 Current presentation

These items provide further information about the patient's current presentation.

Data elements	
Patient summary	ECOG status
Comorbidities	Histological tumour type
Other comorbidities	Patient preference and other factors
Primary site	Psychosocial or priority patient considerations

2.5.1 Patient summary

Definition	A clinical summary of the patient's current presentation.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	5,000	**Representational layout**	X(5000)
Value domain			
Obligation	Mandatory		
Guide for use	Clinical summary information and other clinical data should be automatically populated via integration with clinical systems if possible.		
Verification rules			

2.5.2 Comorbidities

Definition	A list of the patient's current comorbidities.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	See Appendix 1, Table 4: Comorbidities for suggested SNOMED CT options.		
Obligation	Mandatory		
Guide for use	The patient may have multiple comorbidities when they are presented. Users must be able to enter one or more comorbidities as required. Each of these should be stored against a separate instance of this field. This can include other or unknown.		
Verification rules	Must use active SNOMED CT concepts.		

2.5.3 Other comorbidities

Definition	Details of the patient's other comorbidities.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	250	**Representational layout**	X(250)
Value domain			
Obligation	Conditional. Mandatory if 'Other' is selected for Comorbidities.		
Guide for use	This field is used to capture other types of comorbidities that are not listed in Appendix 1, Table 4: Comorbidities. The patient may have multiple comorbidities when they are presented. Each of these should be stored against a separate instance of this field.		
Verification rules			

2.5.4 Primary site

Definition	The primary site of the cancer for which the patient is being presented to the MDM.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18))
Value domain	See Appendix 1, Table 7: Primary site for a list of suggested SNOMED CT terms.		
Obligation	Mandatory		
Guide for use	Clinical summary information and other clinical data should be automatically populated via integration with clinical systems if possible. This must be accompanied with details of the clinical term and the clinical coding system used.		
Verification rules	Must be an active SNOMED CT concept.		

2.5.5 ECOG status

Definition	The most recent performance status of the patient as defined by Eastern Cooperative Oncology Group (ECOG).		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	See Appendix 1, Table 5: ECOG performance status.		
Obligation	Optional		
Guide for use	Clinical summary information and other clinical data should be automatically populated via integration with clinical systems if possible.		
Verification rules	Must be an active SNOMED CT concept.		

2.5.6 Histological tumour type

Definition	The histological tumour type of the cancer for which the patient is being presented.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	**TBA**		
Obligation	Optional		
Guide for use			
Verification rules	Must be an active SNOMED CT concept.		

2.5.7 Patient preferences and other factors

Definition	Any relevant patient preferences about their cancer treatment or having the potential to influence MDM recommendations.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	1000	**Representational layout**	X(1000)
Value domain			
Obligation	Optional		
Guide for use	Any relevant patient preferences that could influence MDM recommendations.		
Verification rules			

2.5.8 Psychosocial or priority patient considerations

Definition	Details of priority patients and records of unique psychosocial or other factors that may influence comprehensive patient care plans.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	500	**Representational layout**	X(500)
Value domain			
Obligation	Optional		
Guide for use	This element is to identify patient factors that may influence comprehensive patient care plans (eg, referral to a cancer nurse or psychological and social support). Some hospitals already use methods or tools to identify and record priority patients and/or psychosocial factors. This element should remain flexible enough to accept data in several formats. For example, as an aggregated patient 'score' or 'rating' from an external system, a series of checkboxes or a free-text summary built into the patient's MDM record. Ideally, data is recorded using SNOMED CT if available.		
Verification rules			

2.6 Staging information

This section lists the data elements for capturing the patient's staging information. Staging systems classify patients with a similar prognosis into groups or stages.

TNM staging is an international staging classification system based on the anatomical site of the primary tumour and the extent of its spread.

- The T (tumour) component refers to the size of the tumour and whether or not it has spread to surrounding tissues.

- The N (nodes) component describes the presence or absence of tumour in regional lymph nodes.
- The M (metastasis) component refers to the presence or absence of tumour at sites distant from the primary site.

When clinically appropriate, at least one T, N or M needs to be recorded.

Where AJCC is not clinically appropriate, 'Other staging system' elements can be recorded.

NOTE: At the time of publication, Te Aho o Te Kahu (Cancer Control Agency), is undertaking projects to improve the quality and completeness of staging data. This section will be updated to reflect the outcome of this project. Please contact Te Aho o Te Kahu (Cancer Control Agency) for further information by emailing **info@teaho.govt.nz**.

Data elements for	
Clinical stage	Other staging
Pathological stage	Additional staging information
Post-therapy and post neoadjuvant therapy stage	Histopathological grade
Recurrence or retreatment stage	

2.6.1 Clinical stage

Clinical stage classification **(cTNM)** is based on patient history, physical examination, and any imaging done before initiation of treatment. Imaging study information may be used for clinical staging, but clinical stage may be assigned based on whatever information is available. No specific imaging is required to assign a clinical stage for any cancer site. When performed within this framework, biopsy information on regional lymph nodes and/or other sites of metastatic disease may be included in the clinical classification (source: AJCC 8th edition).

TNM: Clinical T stage

Definition	Clinical T stage is the coding system used to identify the presence of a primary tumour. It reflects the tumour size and extent of the primary cancer.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid T codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		
Guide for use	A system should provide the user the ability to select an AJCC TNM *Classification of Malignant Tumours* code and the information recorded using the SNOMED CT identifier.		
Verification rules	Must be an active SNOMED CT concept.		

TNM: Clinical N stage

Definition	Clinical N stage is the coding system used to denote the absence or presence of regional lymph node metastases. It classifies the extent of regional lymph node metastases.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid N codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		
Guide for use	A system should provide the user the ability to select an AJCC TNM *Classification of Malignant Tumours* code and the information recorded using the SNOMED CT identifier.		
Verification rules	Must be an active SNOMED CT concept.		

TNM: Clinical M stage

Definition	Clinical M stage is the coding system used to record the absence or presence of distant metastases.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid M codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		
Guide for use	A system should provide the user the ability to select an AJCC TNM *Classification of Malignant Tumours* code and the information recorded using the SNOMED CT identifier.		
Verification rules	Must be an active SNOMED CT concept.		

Clinical TNM edition used

Definition	Staging system edition number used.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	**SCTID** / **Clinical term** 443830009 — **American Joint Commission on Cancer, *Cancer Staging Manual*, 7th edition neoplasm staging system** 897275008 — **American Joint Commission on Cancer, *Cancer Staging Manual*, 8th edition neoplasm staging system**		

Obligation	Conditional. Mandatory if any TNM fields are populated.
Guide for use	Record the edition number. The nationally agreed standardised classification to use for staging is AJCC TNM *Classification of Malignant Tumours*, 8th edition, January 2017.
Verification rules	Must be an active SNOMED CT concept.

Clinical group stage

Definition	Clinical group stage is determined from aggregate information on the primary tumour (T), regional lymph nodes (N), and distant metastases (M), as well as any specific prognostic factors for certain cancer types.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid group stage codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		
Guide for use	Ensure that the edition number of the classification is recorded. Refer to the AJCC TNM *Classification of Malignant Tumours* for coding rules. Collect this data element from information provided by the treating doctor and recorded on the patient's medical record. Collection of this data element is conditional on the disease site being listed in the AJCC TNM *Classification of Malignant Tumours*.		
Verification rules	Must be an active SNOMED CT concept.		

Clinical stage date

Definition	Clinical stage date is the date of decision to treat.		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	8	**Representational layout**	YYYYMMDD
Value domain	Valid date		
Obligation	Conditional. Mandatory if group stage has been selected.		
Guide for use	The date may be the same as the MDM date.		
Verification rules	A valid date that is less than or equal to the current date.		

2.6.2 Pathological stage

Pathological stage classification **(pTNM)** is based on clinical stage information supplemented/modified by operative findings and pathological evaluation of the resected specimens. This classification applies when surgery is performed before initiation of adjuvant radiation or systemic therapy (source: AJCC 8th edition).

TNM: Pathological T stage

Definition	Pathological T stage is the coding system used to identify the presence of primary tumour. It reflects the tumour size and extent of the primary cancer.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid T codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		
Guide for use	A system should provide the user the ability to select an AJCC TNM *Classification of Malignant Tumours* code and the information recorded using the SNOMED CT identifier.		
Verification rules	Must be an active SNOMED CT concept.		

TNM: Pathological N stage

Definition	Pathological N stage is the coding system used to denote the absence or presence of regional lymph node metastases. It classifies the extent of regional lymph node metastases.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid N codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		
Guide for use	A system should provide the user the ability to select an AJCC TNM *Classification of Malignant Tumours* code and the information recorded using the SNOMED CT identifier.		
Verification rules	Must be an active SNOMED CT concept.		

TNM: Pathological M stage

Definition	Pathological M stage is the coding system used to record the absence or presence of distant metastases.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid M codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		
Guide for use	A system should provide the user the ability to select an AJCC TNM *Classification of Malignant Tumours* code and the information recorded using the SNOMED CT identifier.		
Verification rules	Must be an active SNOMED CT concept.		

Pathological TNM edition used

Definition	Staging system edition number used.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	**SCTID** / **Clinical term** 443830009 — **American Joint Commission on Cancer, *Cancer Staging Manual*, 7th edition neoplasm staging system** 897275008 — **American Joint Commission on Cancer, *Cancer Staging Manual*, 8th edition neoplasm staging system**		
Obligation	Conditional. Mandatory if any TNM fields are populated.		
Guide for use	Record the edition number. The nationally agreed standardised classification to use for staging is AJCC TNM *Classification of Malignant Tumours*, 8th edition, January 2017.		
Verification rules	Must be an active SNOMED CT concept.		

Pathological group stage

Definition	Pathological group stage is determined from aggregate information on the primary tumour (T), regional lymph nodes (N), and distant metastases (M), as well as any specific prognostic factors for certain cancer types.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid group stage codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		
Guide for use	Record the edition number of the classification. Refer to the AJCC TNM *Classification of Malignant Tumours* for coding rules. Collect this data element from information provided by the treating doctor and recorded on the patient's medical record. Collection of this data element is conditional on the disease site being listed in the AJCC TNM *Classification of Malignant Tumours*.		
Verification rules	Must be an active SNOMED CT concept.		

Pathological stage date

Definition	Pathological stage date is the date at time of the surgery (ie, the date the specimen was collected).		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	8	**Representational layout**	YYYYMMDD
Value domain	Valid date		
Obligation	Conditional. Mandatory if group stage has been selected.		
Guide for use			
Verification rules	A valid date that is less than or equal to the current date.		

2.6.3 Post-therapy or Post Neoadjuvant Therapy stage

Post-therapy or Post Neoadjuvant Therapy stage is determined (**ycTNM and ypTNM**) after treatment for patients receiving system and/or radiation therapy alone or as a component of their initial treatment, or as neoadjuvant therapy before planned surgery, is referred to as post-therapy classification. It also may be referred to as post neoadjuvant therapy classification.

TNM: Post-therapy or Post Neoadjuvant Therapy T stage

Definition	Post-therapy or Post Neoadjuvant Therapy T stage is the coding system used to identify the presence of primary tumour. It reflects the tumour size and extent of the primary cancer.

Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid T codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		
Guide for use	A system should provide the user the ability to select an AJCC TNM *Classification of Malignant Tumours* code and the information recorded using the SNOMED CT identifier.		
Verification rules	Must be an active SNOMED CT concept.		

TNM: Post-therapy or Post Neoadjuvant Therapy N stage

Definition	Post-therapy or Post Neoadjuvant Therapy N stage is the coding system used to denote the absence or presence of regional lymph node metastases, and if present, the extent.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid N codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		
Guide for use	A system should provide the user the ability to select an AJCC TNM *Classification of Malignant Tumours* code and the information recorded using the SNOMED CT identifier.		
Verification rules	Must be an active SNOMED CT concept.		

TNM: Post-therapy or Post Neoadjuvant Therapy M stage

Definition	Post-therapy or Post Neoadjuvant Therapy M stage is the coding system used to record the absence or presence of distant metastases.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid M codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		
Guide for use	A system should provide the user the ability to select an AJCC TNM *Classification of Malignant Tumours* code and the information recorded using the SNOMED CT identifier.		
Verification rules	Must be an active SNOMED CT concept.		

Post-therapy or Post Neoadjuvant Therapy TNM edition used

Definition	Staging system edition number used.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	**SCTID** / **Clinical term** 443830009 / **American Joint Commission on Cancer, *Cancer Staging Manual*, 7th edition neoplasm staging system** 897275008 / **American Joint Commission on Cancer, *Cancer Staging Manual*, 8th edition neoplasm staging system**		
Obligation	Mandatory if any TNM fields are populated.		
Guide for use	Must capture the relevant SNOMED CT concept for the TNM edition used. The nationally agreed standardised classification to use for staging is AJCC TNM *Classification of Malignant Tumours*, 8th edition, January 2017.		
Verification rules	Must be an active SNOMED CT concept for the TNM edition used.		

Post-therapy or Post Neoadjuvant Therapy group stage

Definition	Post-therapy or Post Neoadjuvant Therapy group stage is determined from aggregate information on the primary tumour (T), regional lymph nodes (N), and distant metastases (M), as well as any specific prognostic factors for certain cancer types.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid group stage codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		
Guide for use	Ensure that the edition number of the classification is recorded. Choose the lower (less advanced) T category when there is any uncertainty. Refer to the AJCC TNM *Classification of Malignant Tumours* for coding rules. Collect this data element from information provided by the treating doctor and recorded on the patient's medical record. Collection of this data element is conditional on the disease site being listed in the AJCC TNM *Classification of Malignant Tumours.*		
Verification rules	Must be an active SNOMED CT concept.		

Post-therapy or Post Neoadjuvant Therapy stage date

Definition	Post-therapy or Post Neoadjuvant Therapy stage date is the time of decision to treat prior to the definitive intervention or at the time of restaging after the related definitive intervention.

Source standards			
Data type	Date	**Representational class**	Full date
Field size	8	**Representational layout**	YYYYMMDD
Value domain	Valid date		
Obligation	Conditional. Mandatory if group stage has been selected.		
Guide for use			
Verification rules	A valid date that is less than or equal to the current date.		

2.6.4 Recurrence or retreatment stage

Recurrence or retreatment staging classifications **(rTNM)** at the time of retreatment for a recurrence or disease progress is referred to as recurrence classification. It also may be referred to as retreatment classification.

TNM: Recurrence or retreatment T stage

Definition	Recurrence or retreatment T stage is the coding system used to identify the presence of primary tumour. It reflects the tumour size and extent of the primary cancer.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid T codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		
Guide for use	A system should provide the user the ability to select an AJCC TNM *Classification of Malignant Tumours* code and the information recorded using the SNOMED CT identifier.		
Verification rules	Must be an active SNOMED CT concept.		

TNM: Recurrence or retreatment N stage

Definition	Recurrence or retreatment N stage is the coding system used to denote the absence or presence of regional lymph node metastases. It classifies the extent of regional lymph node metastases.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid N codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		

Guide for use	A system should provide the user the ability to select an AJCC TNM *Classification of Malignant Tumours* code and the information recorded using the SNOMED CT identifier.
Verification rules	Must be an active SNOMED CT concept.

TNM: Recurrence or retreatment M stage

Definition	Recurrence or retreatment M stage is the coding system used to record the absence or presence of distant metastases.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid M codes from the current edition of the AJCC TNM *Classification of Malignant Tumours.*		
Obligation	Conditional. Mandatory if known.		
Guide for use	A system should provide the user the ability to select an AJCC TNM *Classification of Malignant Tumours* code and the information recorded using the SNOMED CT identifier.		
Verification rules	Must be an active SNOMED CT concept.		

Recurrence or Retreatment TNM edition used

Definition	Staging system edition number used.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	**SCTID** / **Clinical term** 443830009 — **American Joint Commission on Cancer, *Cancer Staging Manual,* 7th edition neoplasm staging system** 897275008 — **American Joint Commission on Cancer, *Cancer Staging Manual*, 8th edition neoplasm staging system**		
Obligation	Conditional. Mandatory if any TNM fields are populated.		
Guide for use	Must capture the relevant SNOMED CT concept for the TNM edition used. The nationally agreed standardised classification to use for staging is AJCC TNM *Classification of Malignant Tumours*, 8th edition, January 2017.		
Verification rules	Must be an active SNOMED CT concept for the TNM edition used.		

Recurrence or retreatment group stage

Definition	Recurrence or retreatment group stage is determined from aggregate information on the primary tumour (T), regional lymph nodes (N), and distant metastases (M), as well as any specific prognostic factors for certain cancer types.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	X(18)
Value domain	SNOMED CT identifier that refers to the valid group stage codes from the current edition of the AJCC TNM *Classification of Malignant Tumours*.		
Obligation	Conditional. Mandatory if known.		
Guide for use	Ensure that the edition number of the classification is recorded. Choose the lower (less advanced) T category when there is any uncertainty. Refer to the AJCC TNM *Classification of Malignant Tumours* for coding rules. Collect this data element from information provided by the treating doctor and recorded on the patient's medical record. Collection of this data element is conditional on the disease site being listed in the AJCC TNM *Classification of Malignant Tumours*.		
Verification rules	Must be an active SNOMED CT concept.		

Recurrence or retreatment stage date

Definition	Recurrent or retreatment stage date is the time of decision to treat.		
Source standards			
Data type	Date	**Representational class**	Fulldate
Field size	8	**Representational layout**	YYYYMMDD
Value domain	Valid date		
Obligation	Conditional. Mandatory if group stage has been selected.		
Guide for use			
Verification rules	A valid date that is less than or equal to the current date.		

2.6.5 Other staging

Where TNM is not used or is not applicable, details of another staging system can be recorded using the following data elements.

Other staging system

Definition	Staging classification system other than TNM.		
Source standards			
Data type	Numeric	**Representational class**	Code

Field size	18	**Representational layout**	X(18)
Value domain			

SCTID	Clinical term
254383006	**FIGO staging system of gynaecological malignancy**
TBA	Chronic Lymphocytic Leukaemia CLL International Prognostic Index (CLL-IPI)
TBA	Binet Staging Classification for Chronic Lymphocytic Leukaemia
385346008	**Breslow system for melanoma staging**
TBA	Rai staging system for Chronic Lymphocytic Leukaemia
254372002	**Ann Arbor lymphoma staging system**
TBA	International Staging System (ISS) for myeloma
TBA	Revised International Staging System (R-ISS) for myeloma
TBA	Australian Clinico-pathological Staging (ACPS) system for colorectal cancer
74964007	**Other**
261665006	**Unknown**

Note: This list will be revised in a future review.

Obligation	Optional
Guide for use	TNM staging is not applicable to all tumour sites. Staging is of limited use in some cancers, for example, haematological malignancies. In these cases, use the most appropriate classification system. Use the current edition of each staging scheme.
Verification rules	Must be an active SNOMED CT concept.

Other staging system version

Definition	Version number of staging classification system other than TNM.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	10	**Representational layout**	X(10)
Value domain	Number, 1–87 88: Not applicable 99: Unknown edition		
Obligation	Optional		
Guide for use	Record the version number of the staging system used to stage this diagnosis of cancer.		
Verification rules			

Other staging system group stage

Definition	This describes the anatomical extent of disease at diagnosis based on stage categories of a staging classification other than the standard TNM classification.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	10	**Representational layout**	X(10)
Value domain	Supplementary values: 8888888888: Not applicable 9999999999: Unknown		
Obligation	Conditional. Mandatory if 'Other staging system' is populated.		
Guide for use	Applies to all cancer stage groupings where a staging classification other than the standard TNM classification is used. A separate data element captures TNM stage grouping. Record valid stage grouping codes from the current edition of the appropriate staging source for the cancer.		
Verification rules			

Other staging system stage date

Definition	The date when the patient's overall cancer stage was derived or agreed.		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	8	**Representational layout**	YYYYMMDD
Value domain	Valid date		
Obligation	Conditional. Mandatory if group stage has been selected.		
Guide for use			
Verification rules	A valid date that is less than or equal to the current date.		

2.6.6 Additional staging information

Definition	A free-text area for additional information about the patient's cancer staging.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	1000	**Representational layout**	X(1000)
Value domain			
Obligation	Optional		
Guide for use			
Verification rules			

2.6.7 Histopathological grade

See the **HISO 10038.3 Interim National Cancer Core Data Definitions Standard** for the full definition of this data element.

2.7 Pathology or radiology review

This section lists the items relating to a patient's pathology or radiology review.

Data elements	
Pathology concordance	Radiology concordance comments
Pathology concordance comments	Report summary
Radiology concordance	Reviewing health care practitioner

2.7.1 Pathology concordance

Definition	Indicates whether the patient's pathology reviews are in concordance.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)

Value domain

SCTID	Clinical term
373066001	**Yes (concordant)**
373067005	**No (discordant)**
385432009	**Not applicable**
103329007	**Not yet reported** (The review may not be complete, or has been done but not formerly reported to the MDM.) Use the SNOMED CT term 'Unavailable'.

Obligation	Optional
Guide for use	
Verification rules	Must be an active SNOMED CT concept.

2.7.2 Pathology concordance comments

Definition	Comments regarding the concordance or discordance of the patient's pathology review.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	1000	**Representational layout**	X(1000)
Value domain			
Obligation	Optional		
Guide for use			
Verification rules			

2.7.3 Radiology concordance

Definition	Indicates whether the patient's radiology reviews are in concordance.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain			
Obligation	Optional		
Guide for use			
Verification rules	Must be an active SNOMED CT concept.		

SCTID	Clinical term
373066001	**Yes (concordant)**
373067005	**No (discordant)**
385432009	**Not applicable**
103329007	**Not yet reported** (The review may not be complete, or has been done but not formerly reported to the MDM.) Use the SNOMED CT term of 'Unavailable'.

2.7.4 Radiology concordance comments

Definition	Comments regarding the concordance or discordance of the patient's radiology review.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	1000	**Representational layout**	X(1000)
Value domain			
Obligation	Optional		
Guide for use			
Verification rules			

2.7.5 Report summary

Definition	Reviewing health care practitioner's feedback or additional details of the patient's pathology or radiology.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	500	**Representational layout**	X(500)
Value domain			
Obligation	Optional		
Guide for use			
Verification rules			

2.7.6 Reviewing health care practitioner

The details of the health care practitioner who conducted the patient's MDM pathology or radiology review.

Record the details of the health care practitioner who conducted the patient's MDM pathology or radiology review, sourced from the HPI system. The format and description of the information are set out under 'Health care practitioner' in Appendix 2: HPI sourced information.

2.8 MDM meeting details

This section lists the data elements for where and when the MDM was held and who participated.

Data elements	
MDM facility	MDM chair

Data elements	
MDM date	MDM attendee
MDM tumour group	MDM quorum requirement
Other MDM tumour group	

2.8.1 MDM facility

The identity of the facility leading the MDM is to be recorded.

Record the details of the facility hosting the MDM, sourced from the HPI system. The format and description of the information are set out under 'Facility' in Appendix 2: HPI sourced information. This information is mandatory.

This may be the same as 2.3.1 Requested MDM facility.

2.8.2 MDM date

Definition	The date of the MDM.		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	8	**Representational layout**	YYYYMMDD
Value domain	Valid date		
Obligation	Mandatory		
Guide for use	This may be the same as 2.3.4 Requested MDM date.		
Verification rules	A valid date.		

2.8.3 MDM tumour group

Definition	The tumour group of the MDM.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	See Appendix 1, Table 6: Multidisciplinary tumour group for suggested SNOMED CT options.		
Obligation	Mandatory		
Guide for use	This may be the same as 2.3.2 Requested MDM tumour group.		
Verification rules	Must be an active SNOMED CT concept.		

2.8.4 Other MDM tumour group

Definition	The name of tumour group of the MDM.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	250	**Representational layout**	X(250)
Value domain			
Obligation	Conditional. Mandatory if 'Other' is selected for MDM tumour group.		
Guide for use	To be used when a tumour group is not listed in Appendix 1: Table 6: Multidisciplinary tumour group. This may be the same as 2.3.3 Other MDM tumour group.		
Verification rules			

2.8.5 MDM chair

The details of the clinician chairing the MDM.

Record the details for the clinician chairing the MDM, sourced from the HPI system. The format and description of the information are set out under 'Health care practitioner' in Appendix 2: HPI sourced information. This is optional.

2.8.6 MDM attendee

The details of the health care practitioners attending the MDM.

Record the details for each health care practitioner attending the MDM, sourced from the HPI system. The format and description of the information are set out under 'Health care practitioner' in Appendix 2: HPI sourced information. This may also include allied health professionals or supportive care (eg, Kaiawhina). This is an optional data element.

2.8.7 MDM quorum requirement

Definition	An indication of whether the quorum of the MDM was met.		
Source standards			
Data type	Boolean	**Representational class**	N/A
Field size	1	**Representational layout**	N(1,0)
Value domain			

Value	Meaning
1	**Yes.** The required quorum was met.
0	**No.** The required quorum was not available for the MDM.

Obligation	Optional
Guide for use	Refer to the MDM terms of reference for the quorum requirements.
Verification rules	Valid code

2.9 MDM discussion and recommendations

This section lists the data elements for capturing discussions, decisions and recommendations made at the MDM.

Data elements	
Discussion summary	Care plan additional details
Care plan intent	Further investigations
Reason curative treatment is precluded	Further referral
Care plan recommendation	Further referral responsible clinician
Care plan procedure type	Clinician responsible for informing patient

2.9.1 Discussion summary

Definition	A summary of the MDM discussion and key outcomes reached.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	500	**Representational layout**	X(500)
Value domain			
Obligation	Mandatory		
Guide for use			
Verification rules			

2.9.2 Care plan intent

Definition	The intent of the associated care plan.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)

Value domain	**SCTID** / **Clinical term** 373808002 **Curative** 363676003 **Palliative**
Obligation	Mandatory
Guide for use	
Verification rules	Must be an active SNOMED CT concept.

2.9.3 Reason curative treatment is precluded

Definition	Records the reason why curative treatment has not been recommended as the intent for a care plan.		
Source standards			
Data type	Number	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	**SCTID** / **Clinical term** 373814009 **No anti-cancer treatment – advanced stage cancer** 373813003 **No anti-cancer treatment – poor performance status** 373816006 **No anti-cancer treatment – significant co-morbidity** 373818007 **No anti-cancer treatment – watchful waiting** 373817002 **No anti-cancer treatment available** 399626004 **No anti-cancer treatment due to unknown primary**		
Obligation	Conditional. Mandatory if **palliative** has been selected as the Care plan intent.		
Guide for use			
Verification rules	Must be an active SNOMED CT concept.		

2.9.4 Care plan recommendation

Definition	A single recommendation forming part of a care plan.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	See Appendix 1, Table 3: Recommendations for suggested SNOMED CT options.		
Obligation	Mandatory		
Guide for use	There may be multiple recommendations for each care plan. Users must be able to select one or more recommendations. Each of these should be stored against a separate instance of this field.		

Verification rules	Must be an active SNOMED CT concept.

2.9.5 Care plan procedure type

Definition	A procedure type recommended as part of the associated care plan.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	A valid SNOMED CT term from the **'Procedure' (71388002)** hierarchy.		
Obligation	Optional		
Guide for use	There may be multiple procedures recommended when the patient is presented. Users must be able to record one or more procedures. Each of these should be stored against a separate instance of this field. A SNOMED CT reference set will be developed in the future to support capturing the values for this data element.		
Verification rules	Must be an active SNOMED CT concept.		

2.9.6 Care plan additional details

Definition	Additional recommendations and/or a description of the conditions regarding the most appropriate care plan.		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	1000	**Representational layout**	X(1000)
Value domain			
Obligation	Optional		
Guide for use	This element can be useful when the most appropriate care plan is dependent on the outcome of further diagnostics (eg, 'if blood test X returns positive, Care plan 1 is the recommendation, otherwise Care plan 2…')		
Verification rules			

2.9.7 Further investigations

Definition	Details of further investigations or diagnostics recommended for the patient.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	Valid subtypes for SNOMED CT terms from either the following hierarchies: • **Imaging (363679005)** • **Biopsy (86273004)** • **Procedure (71388002)** for other types of investigations.		
Obligation	Optional		
Guide for use	There may be multiple instances of this element for each patient. Users must be able to enter one or more investigations. Each of these should be stored against a separate instance of this field.		
Verification rules	Must be an active SNOMED CT concept.		

2.9.8 Further referral

Definition	Where the patient is recommended for referral post-MDM.		
Source standards	Ministry of Health's Clinical speciality subset		
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	A valid health speciality code from the Ministry of Health's **Clinical speciality subset**. If **'Not applicable'** use SNOMED CT code 385432009.		
Obligation	Mandatory		
Guide for use	There may be multiple instances of this element for each patient. Users must be able to enter one or more recommended referrals. Each of these should be stored against a separate instance of this field.		
Verification rules	Must be an active SNOMED CT concept.		

2.9.9 Further referral responsible clinician

The details of the clinician who is responsible for further referral.

Record the details for the clinician who is responsible for further referral, sourced from the HPI system. The format and description of the information are set out under 'Health care practitioner' in Appendix 2: HPI sourced information.

2.9.10 Clinician responsible for informing patient

The details of the clinician responsible for informing the patient of the MDM outcome and recommendations.

Record the details of the clinician responsible for informing the patient of the MDM outcome and recommendations, sourced from the HPI system. The format and description of the information are set out under 'Health care practitioner' in Appendix 2: HPI sourced information.

2.10 Administration

This section lists other data elements for administration and tracking the MDM record.

Data elements	
MDM patient record status	Date record created
Referral declined reason	Date record modified
Deferral reason	Last modified by
Other reason	

2.10.1 MDM patient record status

Definition	The current status of the MDM record.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain			

SCTID	Clinical term
60811000210109	Submitted
60821000210104	Registered *(for MDM)*
60841000210105	Completed
60831000210102	Declined
60801000210107	Deferred
74964007	**Other**

Obligation	Mandatory
Guide for use	
Verification rules	Must be an active SNOMED CT concept.

2.10.2 Referral declined reason

Definition	Why the patient's MDM referral has been declined.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	**SCTID** / **Clinical term** 281331007 **Insufficient information** 408408004 **Inappropriate for presentation at MDM** *(SNOMED CT preferred term is 'Inappropriate referral)* 61071000210103 Incorrect tumour group 74964007 **Other**		
Obligation	Conditional. Mandatory if the MDM patient record status is 'declined'.		
Guide for use			
Verification rules	Must be an active SNOMED CT concept.		

2.10.3 Deferral reason

Definition	Why the patient was deferred to a future MDM.		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	**SCTID** / **Clinical term** 61051000210106 Results not ready (eg, diagnostics/tests not completed) 61061000210109 No presenter 61121000210103 Time constraints 61041000210108 Insufficient quorum 74964007 **Other**		
Obligation	Conditional. Mandatory if the MDM patient record status is 'deferred'.		
Guide for use			
Verification rules	Must be an active SNOMED CT concept.		

2.10.4 Other reason

Definition	Any other reason the referral was declined or deferred.

Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	250	**Representational layout**	X(250)
Value domain			
Obligation	Mandatory if 'Other' is recorded for **Rereferral declined reason** or **Deferral reason**		
Guide for use			
Verification rules			

2.10.5 Date record created

Definition	The date the patient's MDM record was created (the date the electronic MDM referral was initiated).		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	8	**Representational layout**	YYYYMMDD
Value domain	Valid date		
Obligation	Mandatory		
Guide for use	Should be automatically generated and recorded by the MDM system.		
Verification rules	A valid date that is less than or equal to the current date.		

2.10.6 Date record modified

Definition	The date the patient's MDM record was last modified.		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	8	**Representational layout**	YYYYMMDD
Value domain	Valid date		
Obligation	Mandatory		
Guide for use	Should be automatically generated and recorded by the MDM system.		
Verification rules	A valid date that is less than or equal to the current date.		

2.10.7 Last modified by

Definition	The name or identifier of the user who last made a change to the MDM patient record.
Source standards	

Data type	Alphanumeric	**Representational class**	Free text
Field size	50	**Representational layout**	X(50)
Value domain	Valid username or identifier		
Obligation	Mandatory		
Guide for use	Should be automatically generated and recorded by the MDM system.		
Verification rules			

3 IMPLEMENTATION REQUIREMENTS

Following are key requirements when implementing this standard:

- must support capturing and sharing of information electronically while ensuring it is secure and protects patients' privacy according to the **Privacy Act 2020**, **Health Information Privacy Code 2020**, and the **HISO 10029:2015 Health Information Security Framework**
- should support integration with NHI, HPI, NZBN and other master data sources referenced in this document
- should integrate with other health information systems
- should use automatically populated information if possible
- must be adaptable to apply new and modified data element requirements when future updates are published.

APPENDIX 1: SNOMED CT TERMS

These are the SNOMED CT data domains (range of allowable options for a particular data item) for selected items in this standard. Both the SNOMED CT clinical term and identifier are presented. Any system should capture the clinical term, the associated code and the SNOMED CT version, but only the clinical term should be visible to users.

Note: If a SNOMED code has not been provided, a suitable code either does not currently exist or code choices for the domain option are still under development. These will be added later. In this document, these entries are shown as TBA (to be advised). Reference sets for the below tables will be developed and included in a future release of the SNOMED New Zealand edition.

Table 1: Source of referral

Clinical term	SCTID
Public hospital	79993009
Private hospital	309895006
Other environment (to be used for other settings, eg, screening)	276339004

Table 2: Patient discussion status

Clinical term	SCTID
Formal MDM discussion (SNOMED CT preferred term: Multidisciplinary review)	708004003
Data collection only (SNOMED CT preferred term: Information gathering)	311791003

Table 3: Recommendations

Clinical term	SCTID
Surgical procedure	387713003
Radiation therapy	385798007
Chemotherapy	385786002
Combined chemotherapy and radiation therapy	703423002
Targeted therapy	61111000210108
Non-intervention management (this includes active surveillance)	TBA
Palliative care	103735009
Psychosocial	413736002
Clinical trial	110465008
Further diagnosis	306228005
Other therapy	276239002

Table 4: Comorbidities

Clinical term	SCTID
None	260413007
AIDS	62479008
Asthma	195967001
CHF – Congestive heart failure	42343007
Chronic kidney disease	709044004
Connective tissue disease	105969002
COPD – Chronic obstructive pulmonary disease	13645005
Crohn's disease	34000006
CVA – Cerebrovascular accident	230690007
Dementia	52448006
Diabetes mellitus	73211009
Hemiplegia	50582007
Ischemic heart disease	414545008
Leukaemia	93143009
Liver disease	235856003
Lymphoma	118600007
Neoplastic disease	55342001
Peptic ulcer disease	13200003
PVD – peripheral vascular disease	400047006
Transient ischemic	57357009
Other	74964007
Unknown	261665006

Table 5: ECOG performance status

Clinical term	SCTID
ECOG performance status – grade 0 (Fully active, able to carry on all pre-disease performance without restriction)	425389002
ECOG performance status – grade 1 Restricted in physically strenuous activity but ambulatory and can carry out work of a light or sedentary nature (eg, light housework, office work)	422512005
ECOG performance status – grade 2 (Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50 percent of waking hours)	422894000
ECOG performance status – grade 3 (Capable of only limited self-care, confined to bed or chair more than 50 percent of waking hours))	423053003
ECOG performance status – grade 4 (Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair)	423237006
ECOG performance status – grade 5 (Dead)	423409001

Table 6: Multidisciplinary tumour group

The following list is used for Requested MDM tumour group, Previous MDM tumour group and MDM tumour group.

Clinical term	SCTID
Bowel cancer multidisciplinary meeting	60621000210100
Breast cancer multidisciplinary meeting	60631000210103
Central nervous system cancer multidisciplinary meeting	60641000210106
Endocrine and neuroendocrine cancer multidisciplinary meeting	60651000210109
Gastrointestinal and upper gastrointestinal cancer multidisciplinary meeting	60661000210107
Gynaecological cancer multidisciplinary meeting	60671000210101
Haematology and myeloma multidisciplinary meeting	60681000210104
Head and neck cancer multidisciplinary meeting	60691000210102
Lung cancer multidisciplinary meeting	60701000210102
Lymphoma multidisciplinary meeting	60711000210100
Melanoma multidisciplinary meeting	60721000210105
Paediatric cancer multidisciplinary meeting	60761000210103
Pituitary cancer multidisciplinary meeting	60751000210101
Sarcoma multidisciplinary meeting	60741000210104
Spinal cancer multidisciplinary meeting	60731000210107
Thyroid cancer multidisciplinary meeting	60791000210108
Upper gastrointestinal and hepatocellular cancer multidisciplinary meeting	60781000210106
Urological cancer multidisciplinary meeting	60771000210109
Other	74964007

Table 7: Primary site

The following is a suggested list to be used for Primary site.

Note: A SNOMED CT reference set including the items on this list will be developed and incorporated in the New Zealand SNOMED CT edition. This list will be updated periodically.

Clinical term	SCTID
Brain structure	12738006
Bone marrow	14016003
Bone structure of cranium	89546000
Eye structure	81745001
Oral cavity structure	74262004
Oropharyngeal structure	31389004
Laryngeal structure	4596009
Hypopharyngeal structure	81502006
Nasal cavity structure	279549004
Nasal sinus structure	2095001
Salivary gland structure	385294005
Nasopharyngeal structure	71836000
Tongue structure	21974007
Thyroid structure	69748006
Oesophageal structure	32849002
Upper arm structure	53120007
Forearm structure	14975008
Spinal cord structure	2748008
Structure of vertebra	420345000
Breast structure	76752008
Chest wall structure	78904004
Thoracic cage structure	60413009
Lung structure	39607008
Mediastinal structure	72410000
Liver structure	10200004
Splenic structure	78961009
Stomach structure	69695003
Pancreatic structure	15776009
Kidney structure	64033007
Urinary bladder structure	89837001
Prostatic structure	41216001
Small intestinal structure	30315005

Clinical term	SCTID
Colon structure	71854001
Uterine structure	35039007
Rectum structure	34402009
Anal structure	53505006
Cervix uteri structure	71252005
Fallopian tube and ovary (combined site)	110642008
Vaginal structure	76784001
Vulval structure	45292006
Penile structure	18911002
Testis structure	40689003
Bone structure of pelvis	118645006
Thigh structure	68367000
Lower leg structure	30021000
Skin structure	39937001
Structure of lymph node	59441001
Other	74964007
Unknown body region	87100004

APPENDIX 2:
HPI SOURCED INFORMATION

This appendix identifies data elements that use a consistent format.

Provider information

Capture information relating to the health provider (an individual, facility or organisation that provides health care) using these formats.

Health care practitioner

These are the details of data elements for the health care practitioner referred to in this document. For every HPI-registered health care practitioner, the 'Health care practitioner name' is captured and the health care practitioner's 'HPI Common person number' must also be either captured or auto-populated.

For non HPI-registered health care practitioners, they will need to be identified by a name alone, using the 'Health care practitioner name' data element.

Health care practitioner name

Definition	The full name of the individual contributing to the care of the patient.		
Source standards	HISO 10045 Health Provider Identity Standard (draft standard available from **standards@health.govt.nz**)		
Data type	Alphabetic	**Representational class**	Text
Field size	50	**Representational layout**	A(50)
Value domain			
Obligation	Refer to the various sections for specific requirements.		
Guide for use	For every HPI-registered practitioner, use the name as recorded in the HPI system.		
Verification rules	Must be the same as the name assigned to the HPI CPN.		

HPI Common person number

Definition	A unique six-character identifier assigned by the HPI system to an individual person contributing to the care of the patient.		
Source standards	HISO 10045 Health Provider Identity Standard (draft standard available from **standards@health.govt.nz**)		
Data type	Alphanumeric	**Representational class**	Identifier
Field size	6	**Representational layout**	NCAAAA
Value domain	Valid HPI CPN only		
Obligation	Mandatory if a Health care practitioner name is submitted.		
Guide for use	Should be automatically populated. The HPI system generates a new unique CPN which is the primary key for person records. This CPN is not reused once assigned. If more than one CPN exists for a single person, one CPN is declared 'live' and all other CPNs are made 'dormant' and attached to the live record. The CPN is the primary key for person records. A Modulus 11 routine is used to produce the identifier check digit.		
Verification rules	N – is a number excluding zero "0" A – is an alpha character excluding the letters I and O C – is a check digit number in the second position calculated using check digit Modulus 11.		

Facility

When capturing information for a facility, the 'Facility name' and 'Facility identifier' must be either captured or auto populated.

Facility name

Definition	The name of the facility that is providing services associated with the patient's visit.		
Source standards	HISO 10045 Health Provider Identity Standard (draft standard available from **standards@health.govt.nz**)		
Data type	Alphanumeric	**Representational class**	Text
Field size	255	**Representational layout**	X(255)
Value domain			
Obligation	Mandatory		
Guide for use	For every HPI-registered organisation, use the organisation name as recorded in the HPI system.		
Verification rules	Must be the same as the facility name assigned to the HPI FAC identifier.		

Facility identifier

Definition	The unique identifier for the facility that is providing services associated with the patient's visit.		
Source standards	HISO 10045 Health Provider Identity Standard (draft standard available from **standards@health.govt.nz**)		
Data type	Alphanumeric	**Representational class**	Identifier
Field size	8	**Representational layout**	FXXNNN-C
Value domain	Valid HPI facility identifier		
Obligation	Mandatory		
Guide for use	The facility identifier is assigned by the HPI system when the facility record in the HPI is created. F is a constant prefix – all facility identification numbers start with 'F' X is either an alphabetic or a numeric N is a number C is the check digit established using the Modulus 11 system		
Verification rules	A valid HPI FAC identifier		