

Data Quality Statement HOSPITAL MORBIDITY DATA COLLECTION

Summary Details						
Background / history	The Hospital Morbidity Data Collection (HMDC) is a comprehensive data set containing records for all hospital separations of admitt patients from all public and private hospitals in Western Australia. The HMDC reflects what patients are hospitalised for, and the ca they receive. HMDC data is available from January 1970.					
Purpose	The HMDC provides the WA Health system with the necessary information for planning, allocating and evaluating health services within Western Australia. Other key purposes of the collection include: • Mandatory reporting to the Commonwealth • Monitoring and assessing state health service utilisation (public and private) • Strategic planning, resource allocation and performance measurement of all levels of health care • Safety and Quality • Health service funding and resource allocation • Epidemiological and medical and other research • Data linkage					
Governance - Legal and Policy - Data stewardship - Data custodianship	 Mandates for this collection include the following two Acts: For public hospitals, and contracted health entities: Part 17 of the Health Services Act 2016 For private hospitals: Part 111c of the Private Hospitals and Health Services Act 1927 Data Steward: Assistant Director General Data Custodian: Principal Data Management Officer 					
Data collection	Both demographic and clinical data elements are collected as part of capturing clinical activity. Clinical coding staff translate the patient's medical record for each separation into a series of diagnosis and procedure codes using ICD-10-AM/ACHI/ACS Eleventh Edition, as per the rules stipulated by the Australian Coding Standards and local WA coding policy. The data are provided to the HMDC as electronic records via regular data extracts.					



Type of data collected	HMDC collects information about each episode of care, to reflect the care provided to the patient at separation. Each episode of care is reflected via a single 'care type'.							
	 Patient demographic information: age, sex, country of birth and other identifying elements Administrative information: admission date, separation date, funding source, source of referral, mode of separation etc. Clinical information: principal diagnosis which indicates the principal reason for the patient's admission, additional diagnoses relevant to the episode of care and procedures performed during the episode of care 							
Scope of data	HMDC Inclusions The HMDC includes all episodes of care that occur in the following Western Australian health services: • Public acute hospitals • Public psychiatric hospitals • Private acute hospitals (licensed by the WA Health System) • Private psychiatric hospitals (licensed by the WA Health System) • Private day surgeries (licensed by the WA Health System)							
	 HMDS Exclusions The HMDC does not include episodes of care (or equivalent unit of measurement) pertaining to: Patients attending emergency, outpatient or community health services Patients in residential aged care facilities Patients classified as flexible care or residential aged care residing in publicly funded hospitals Patients in community residential care facilities Patients treated in the Defence Force or other non-Western Australian health services Still births Mothers electing to deliver at home and newborns delivered at home (excluding those in an approved Homebirth program and newborns requiring formal admission to hospital post-delivery) Patients admitted for services that do not meet admission criteria as per the Admission Policy MP 0058/17 							
Frequency/timing	The collection contains data from 1 January 1970. Over the years, the data have been collected using different methods. Currently, coded records are received daily from public hospitals. Private hospitals provide files containing separations for a calendar month.							



Quality	Data is available from January of 1970 onwards. Fundamentally, the collection scope or purpose has not changed. There have been several changes over the years in the number and type of collected data items, and data item values. Changes to clinical coding classification systems can affect interpretability of data over time.					
Further information	Website references:					
	inpatientdatacollections@health.wa.gov.au					
	https://ww2.health.wa.gov.au/Articles/A_E/Data-Quality-Team					



Data Variables – Hospital Morbidity Data Collection

Data Variables						
Variable description	Definition	Туре	Length	Permitted Values	Collection requiremen ts	Additional notes
Admission age in years	Person age at time of admission	Numeric	3	N/A	Derived	Calculated by year of [Admission Date] minus year of [Date of Birth]. If month/day of [Admission Date] is earlier than month/day of [Date of Birth], it is subtracted by 1.
Sex	Sex is the biological distinction between male and female.	Numeric	1	1 - Male 2 - Female 3 - Indeterminate	Mandatory	webPAS: Gender (note this naming in webPAS does not represent what is required to be collected in this data item)
Admission Status	The urgency of the patient's admission to hospital and whether the admission occurred on an emergency or elective basis.	Numeric	1	3 - Elective - waitlist 4 - Elective - not waitlist 6 - Emergency - Emergency Department admission 7 - Emergency - Direct admission	Mandatory	
Care Type	The overall nature of clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (other care).	Numeric	2	21 - Acute Care 22 - Rehabilitation Care 23 - Palliative Care 24 - Psychogeriatric Care 25 - Maintenance Care 26 - Newborn 27 - Organ Procurement 28 - Boarder 29 - Geriatric Evaluation and Management 32 - Mental Health Care	Mandatory	
Subset admission date - MM/YYYY	The date on which an admitted patient commences an episode of care that can be formal or statistical.	Date	7		Mandatory	
Subset separation date - MM/YYYY	The date on which an admitted patient completes an episode of care. The patient can be formally or statistically discharged from hospital. If a patient dies in hospital, the separation date is the date of death.	Date	7		Mandatory	
Mode of separation	Status at separation of person (discharge/transfer/death) and place to which person is released (where applicable).	Numeric	2	1 - Discharge/transfer to an acute hospital 2 - Discharge/transfer to a residential aged care service 3 - Discharge/transfer to a psychiatric hospital 4 - Discharge/transfer to other health care accommodation 5 - Statistical discharge Type Change 6 - Left against medical advice/discharge at	Mandatory	



				own risk 7 - Discharge from Leave 8 - Deceased 9 - Other/Home		
Subset date of birth - MM/YYYY	The date of birth of the person	Date	7		Mandatory	
Indigenous status	Whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin.	Numeric	1	1 - Aboriginal but not Torres Strait Islander 2 - Torres Strait Islander but not Aboriginal 3 - Both Aboriginal and Torres Strait Islander 4 - Neither Aboriginal nor Torres Strait Islander	Mandatory	
Total leave days	Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay	Numeric	4		Conditional	
Principal diagnosis	The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code.	Alphanumeric	10	As per ICD10-AM codes	Mandatory	
Co-diagnosis	Co-diagnosis information	Alphanumeric	10	As per ICD10-AM codes	Mandatory where applicable	0.13% of records for FY2019/20 contain a co- diagnosis
Additional diagnoses	A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment, as represented by a code.	Alphanumeric	10	As per ICD10-AM codes	Mandatory	
SA1	A designated region representing the smallest unit for the release of Census data used for describing a location, as represented by a code.	Numeric	11		Derived	
Admission date	The date on which an admitted patient commences an episode of care that can be formal or statistical.	Date	8		Mandatory	



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Separation date	The date on which an admitted patient completes an episode of care. The patient can be formally or statistically	Date	8	Mandatory	
	discharged from hospital. If a patient dies in hospital, the separation date is the date of death.				
Hospital identifier	The identifier for the establishment in which the episode or event occurred. Each separately administered health care establishment is to have a unique identifier. In Western Australia, this is a unique four-digit number that is assigned globally by HMDS to each establishment that is required to report admitted activity information to the HMDS.	Numeric	4	Mandatory	
UMRN (Client Identifier)	Person identifier unique within an establishment	Alphanumeric	10	Mandatory	Field was not requested, however may be required(!)