Cancer Multidisciplinary Meeting Data Standards

HISO 10038.4:2020

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**Contributors**

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There was also wider consultation in the development of this standard. See Appendix 4 for a list of people consulted on for their review and feedback on this standard.

The Cancer Control Agency took over responsibility for progressing this standard on 1 December 2019. The document was updated to reflect the use of SNOMED CT, incorporate suggested updates from HISO and other contributing revised standards.

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# Introduction

The *New Zealand Cancer Health Information Strategy* (Ministry of Health 2015) was published by the Ministry of Health in July 2015. The Strategy’s vision was to enable the *New Zealand Cancer Plan 2015–18* (Ministry of Health 2014) by delivering:

comprehensive, accessible and accurate information to support the delivery of care across the cancer pathway.

An updated action plan was released in 2019: the *New Zealand Cancer Action Plan: 2019–2029* (Ministry of Health 2019).

The *New Zealand Cancer Health Information Strategy* identified multidisciplinary meetings (MDMs) as an activity that produces a rich source of significant clinical information on cancer patients. These are aggregated to support clinical decision-making and include cancer staging, comorbidity and ethnicity data. MDMs are a starting point for improving the collection of cancer information that will support the delivery of care across the cancer pathway. Consequently, the MDM project was established under the Cancer Health Information Strategy programme.

## Purpose

This document defines the national data standards for cancer MDMs to ensure that minimum agreed patient and cancer data is collected and stored in a consistent manner, wherever this process occurs.

The associated *MDM National Future State Business Requirements and Processes* outlines the key business requirements and processes behind any future state MDM solution.

At present there is no intention to establish a national MDM collection of this data. However, this national data standard will help to create a foundation for secondary use of data and the potential for regional or national collection and analysis of MDM data.

## Scope

This data standard covers core cancer data items only; 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.

Outside the scope of this standard are:

* comorbidity data
* tumour group specific data items
* data to assess performance against the Ministry’s tumour standards
* family cancer history.

## Definitions

|  |  |
| --- | --- |
| Term | Definition |
| 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. |
| FCT | Faster cancer treatment is a Ministry of Health performance measure with the aim to improve health outcomes by reducing wait times for New Zealanders. |
| 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. |
| 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 involves 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.  In some cases, the disease stage or symptoms make it necessary to begin treatment before a patient’s case is presented at an MDM. Instead, a multidisciplinary discussion for ongoing planning is held at the earliest possible time.  If treatment plans need to be reviewed, presentation at subsequent MDMs may be warranted. |
| MDM coordinator | A central administration role in the MDM process. It can include the coordination of patient MDM referrals and bookings, sourcing patient data for discussion and getting pathology slides or radiological images for review. |
| MDM recommendation | A recommendation for a specific action or sets of actions, generally related to the treatment or further diagnosis of a patient, generated from an MDM discussion. |
| MDM referrer | The clinician referring a patient to an MDM, usually by providing 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 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). |

## Legislation and regulations

The following legislation and regulations are relevant to this standard:

* Health Information Privacy Code 1994
* Health Practitioners Competence Assurance Act 2003
* Privacy Act 1993 (revised 2008)
* Public Records Act 2005
* Health (Retention of Health Information) Regulations 1996.

## Related specifications

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

* New Zealand Cancer Health Information Strategy. Wellington: Ministry of Health

[www.health.govt.nz/publication/new-zealand-cancer-health-information-strategy](https://www.health.govt.nz/publication/new-zealand-cancer-health-information-strategy)

* New Zealand Cancer Plan: Better, faster cancer care 2015–2018. Wellington: Ministry of Health.

[www.health.govt.nz/publication/new-zealand-cancer-plan-better-faster-cancer-care-2015-2018](https://www.health.govt.nz/publication/new-zealand-cancer-plan-better-faster-cancer-care-2015-2018)

* New Zealand Cancer Action Plan 2019–2029 – Te Mahere mō te Mate Pukupuku o Aotearoa 2019–2029. Revised January 2020 Wellington: Ministry of Health.

[www.health.govt.nz/publication/new-zealand-cancer-action-plan-2019-2029](https://www.health.govt.nz/publication/new-zealand-cancer-action-plan-2019-2029)

* MDM National Future State Business Requirements and Processes
* Faster Cancer Treatment: High suspicion of cancer definitions

[nsfl.health.govt.nz/system/files/documents/publications/high\_suspicion\_of\_cancer\_definitions\_0.pdf](https://nsfl.health.govt.nz/system/files/documents/publications/high_suspicion_of_cancer_definitions_0.pdf)

* Faster Cancer Treatment Indicators: Business Rules and Data Definitions, v3.1, March 2014.

[nsfl.health.govt.nz/accountability/performance-and-monitoring/business-rules-and-templates-reporting/faster-cancer](https://nsfl.health.govt.nz/accountability/performance-and-monitoring/business-rules-and-templates-reporting/faster-cancer)

* HISO 10038.0:2017 Preface to the Cancer Data Standards

[www.health.govt.nz/publication/hiso-1003802017-preface-cancer-data-standards](https://www.health.govt.nz/publication/hiso-1003802017-preface-cancer-data-standards)

* HISO 10038.1 Interim National Cancer Core Data Business Process Standard

[www.health.govt.nz/publication/hiso-1003812011-interim-national-cancer-core-data-business-process-standard](https://www.health.govt.nz/publication/hiso-1003812011-interim-national-cancer-core-data-business-process-standard)

* HISO 10038.3 Interim National Cancer Core Data Definitions Standard

[www.health.govt.nz/publication/hiso-1003832011-interim-national-cancer-core-data-definitions-standard](https://www.health.govt.nz/publication/hiso-1003832011-interim-national-cancer-core-data-definitions-standard)

* Ministry of Health’s Clinical Coding System code table

[www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/clinical-coding-system-code-table](https://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/clinical-coding-system-code-table)

* HISO 10046 Consumer Health Identity Standard

[www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard](https://www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard)

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

[**www.health.govt.nz/publication/hiso-100052008-health-practitioner-index-hpi-data-set**](https://www.health.govt.nz/publication/hiso-100052008-health-practitioner-index-hpi-data-set)

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

[**www.health.govt.nz/publication/hiso-100062008-health-practitioner-index-hpi-code-set**](https://www.health.govt.nz/publication/hiso-100062008-health-practitioner-index-hpi-code-set)

### SNOMED CT

HISO has endorsed SNOMED CT as the clinical terminology to use in New Zealand and is used in various data elements in this standard. The SNOMED CT NZ Edition includes all content from the SNOMED International Edition and New Zealand specific content in a separate package called the SNOMED NZ Extension.

Refer to the Ministry of Health’s website for releases and to download the SNOMED NZ Edition.

[www.health.govt.nz/nz-health-statistics/classification-and-terminology/new-zealand-snomed-ct-national-release-centre/snomed-ct-subsets-and-maps](https://www.health.govt.nz/nz-health-statistics/classification-and-terminology/new-zealand-snomed-ct-national-release-centre/snomed-ct-subsets-and-maps)

For data elements where the use of SNOMED CT has been identified, the preferred term or synonym for the SNOMED concept should be displayed to the user and the term recorded with the correct SNOMED CT identifier. Active SNOMED CT concepts must be selected when determining values for data elements.

For further details of SNOMED CT concepts, refer to SNOMED International’s SNOMED CT Browser.

<https://browser.ihtsdotools.org/?>

Note: Where 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 to be advised (TBA).

## Data element template

Data element specifications in this standard conform to the requirements of ISO/IEC 11179 Information Technology – Metadata Registries (MDR).[[1]](#footnote-2)

|  |  |  |  |
| --- | --- | --- | --- |
| **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 pertaining to the data element. | | |
| **Data type** | Alphabetic (A)  Date  Date/time  Numeric (N)  Alphanumeric (X)  Boolean  SNOMED CT identifier | **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. |
| **Data domain** | The valid values or codes that are acceptable for the data element.  Each coded data element has a specified code set.  Code sets use the SNOMED CT clinical terminology standard where possible. Enumerated SNOMED concepts are denoted by preferred term and linked to descriptions in the SNOMED International SNOMED CT Browser, see <https://browser.ihtsdotools.org/?>  Where there are many member concepts, a reference set is published in the SNOMED NZ Edition, available from the SNOMED Member Licensing and Distribution Service at <https://mlds.ihtsdotools.org/#/landing/NZ?lang=en>  New Zealand Medicines Terminology (NZMT) is the standard used to identify medicines. | | |
| **Obligation** | Indicates if the data element is mandatory, optional or conditional. | | |
| **Guide for use** | Additional guidance on using the data element. | | |
| **Verification rules** | Quality control mechanisms that preclude invalid values. | | |

# Background

A multidisciplinary meeting (MDM) project was established under the Cancer Health Information Strategy programme to improve the collection of cancer data using the rich source of clinical information created at MDMs.

The first phase of the MDM project was to understand how MDMs were conducted. This analysis identified any issues and opportunities for change in the context of process, tools and technology, and data and information.

The findings were summarised and used to develop a desired MDM future state in the form of a national set of MDM business requirements and processes, and data standards.

This data standard has been developed through collaboration with MDM stakeholders in the cancer sector and refined through an iterative process[[2]](#footnote-3) . Data items were selected primarily for their relevance in facilitating discussion and decision-making within the MDM and supporting MDM service delivery.

The data elements are organised into groups representing the different categories of information collected or generated throughout the MDM process (eg, core referral information, pathology review, MDM discussion and recommendations). These groups have been further broken down within the accompanying data model to illustrate the cardinal relationships between data elements.

# Data elements

This section describes the set of core minimum data to be captured to support treatment planning in a multidisciplinary meeting (MDM). People with cancer often present at multiple MDMs and, if so, should have multiple MDM records.

Any MDM technical solution needs to provide the ability 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, GP details).

## Patient details

The format for the following list of patient details are sourced directly from the HISO 10046 Consumer Health Identity Standard.

[www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard](https://www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard)

Please use this standard for full definitions and cardinality of these items.

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

\*See HISO 10038.3 Interim National Cancer Core Data Definitions Standard for a definition of this data element:

[www.health.govt.nz/publication/hiso-1003832011-interim-national-cancer-core-data-definitions-standard](file:///\\moh.govt.nz\dfs-userdata\userstate\Skerruis\Documents\Core%20Cancer%20Standard\MDM%202019\www.health.govt.nz\publication\hiso-1003832011-interim-national-cancer-core-data-definitions-standard)

## General practitioner details

This lists the patient’s general practitioner (GP) details.

|  |  |
| --- | --- |
| **Data elements** |  |
| GP name\* | GP practice phone number |
| Facility identifier\* | GP email |
| Street address\* |  |

\* See HISO 10005 Health Practitioner Index (HPI) Data Set for a definition of this data element.

[www.health.govt.nz/publication/hiso-100052008-health-practitioner-index-hpi-data-set](http://www.health.govt.nz/publication/hiso-100052008-health-practitioner-index-hpi-data-set)

The data elements that do not appear in the HISO 10005 Health Practitioner Index (HPI) Data Set and may be required for an MDM are below.

### General practitioner

The details for the patient’s general practitioner.

The relevant details to be captured for this data element includes the individual’s name, unique identifier and the assigning authority. See Appendix 3 for further details.

### GP practice phone number

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The phone number of the patient’s general practice. | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Free text |
| **Field size** | 30 | **Representational layout** | X(30) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** | The phone number must include the area code. | | |
| **Verification rules** |  | | |

### GP email

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The email of the patient’s general practitioner. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 50 | **Representational layout** | X(50) |
| **Data domain** | Free text | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | This is the secure email address that is used to distribute any relevant MDM outputs to the patient’s GP. | | |
| **Verification rules** |  | | |

## Core referral information and key questions

This section lists the patient’s core referral information and key questions for an MDM.

| **Data elements** |  |
| --- | --- |
| Requested MDM facility name | Review type |
| Requested MDM facility identifier | Pathology/radiology type |
| Requested MDM tumour group | Pathology/radiology accession number |
| Requested MDM date | Pathology/radiology date |
| Referrer | Pathology/radiology facility name |
| Lead clinician | Pathology/radiology facility identifier |
| Presenter | Questions for pathology/radiology |
| Source of referral | Patient discussion status |
| Pathology/radiology review required | Key questions for MDM |

### Requested MDM facility name

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The name of the facility hosting the MDM that the patient is being referred to. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Text |
| **Field size** | 255 | **Representational layout** | X(255) |
| **Data domain** |  | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Should be automatically populated. | | |
| **Verification rules** |  | | |

### Requested MDM facility identifier

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The unique identifier for the facility hosting the MDM that the patient is being referred to. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Identifier |
| **Field size** | 8 | **Representational layout** | FXXNNN-C |
| **Data domain** | Valid HPI identifier only | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The facility identifier is assigned by the HPI system at the time 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.  Should be automatically populated from the ‘Requested MDM facility name’ | | |
| **Verification rules** | A current valid HPI FAC. | | |

### Requested MDM tumour group

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The tumour group of the MDM that the patient is being referred to for presentation. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | Should be a subtype of ‘Specialist multidisciplinary team’ (408458006) from the SNOMED CT NZ Edition. | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### 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** | CCYYMMDD |
| **Data domain** | Valid date | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Should be automatically populated. | | |
| **Verification rules** | A valid date that is equal to or more than the current date. | | |

### Referrer

The details of the person submitting the MDM referral.

Includes the person’s full name, their unique identifier and the assigning authority. See Appendix 3 for further details.

### Lead clinician

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

Includes the person’s full name, their unique identifier and the assigning authority. See Appendix 3 for further details. See Appendix 3 for further details.

### Presenter

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

Includes the person’s full name, their unique identifier and the assigning authority. See Appendix 3 for further details.

### Source of referral

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The source of the patient referral to the MDM. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | See Appendix 2, Table 1: Source of referral for suggested options.  Alternatively, a valid SNOMED CT term from the ‘Environment’ (276339004) hierarchy that identifies the source of the patient referral. | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### Pathology/radiology review required

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

### Review type

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Indicates whether the record relates to a pathology or radiology review. | | |
| **Source standards** |  | | |
| **Data type** | Alphabetic | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | A |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | P | Pathology review | | R | Radiology review. | |  |  | | | |
| **Obligation** | Conditional. Mandatory if capturing responses to ‘Pathology/radiology review required’. | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Pathology/radiology type

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The type of pathology/radiology requiring review (eg, FNA, biopsy, MRI). | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | A valid pathology/radiology procedure type SNOMED CT term from the Procedure (71388002) hierarchy for the patient being presented. | | |
| **Obligation** | Conditional. Mandatory if ‘Pathology/radiology review required’ is ‘Yes’. | | |
| **Guide for use** | Pathology and radiology data should ideally be selectable via integration with the pathology/radiology system. | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### Pathology/radiology accession number

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The accession number of the pathology slide or pack, or radiology image requiring review. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Identifier |
| **Field size** | 30 | **Representational layout** | X(30) |
| **Data domain** | A valid accession number from the patient’s pathology/radiology results. | | |
| **Obligation** | Optional | | |
| **Guide for use** | Pathology and radiology data should ideally be selectable via integration with the pathology/radiology system. | | |
| **Verification rules** |  | | |

### Pathology/radiology date

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date when the pathology/radiology sample or image was taken. | | |
| **Source standards** |  | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid date | | |
| **Obligation** | Conditional. Mandatory if a ‘Pathology/radiology type’ is selected for review. | | |
| **Guide for use** | Pathology and radiology data should ideally be selectable via integration with the pathology/radiology system. | | |
| **Verification rules** | A valid date that is less than or equal to the current date. | | |

### Pathology/radiology facility name

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The name of the facility storing the slide(s) or images to be reviewed. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Text |
| **Field size** | 255 | **Representational layout** | X(255) |
| **Data domain** |  | | |
| **Obligation** | Conditional. Mandatory if a ‘Pathology/radiology type’ is selected for review. | | |
| **Guide for use** | Pathology and radiology data should ideally be selectable via integration with the pathology/radiology system. | | |
| **Verification rules** |  | | |

### Pathology/radiology facility identifier

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The unique identifier for the facility storing the slide(s) or images to be reviewed. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Identifier |
| **Field size** | 8 | **Representational layout** | FXXNNN-C |
| **Data domain** | Valid HPI FAC identifier | | |
| **Obligation** | Conditional. Mandatory if a ‘Pathology/radiology type’ is selected for review. | | |
| **Guide for use** | Should be automatically populated from the ‘Pathology/radiology facility name’.  The facility identifier is assigned by the HPI system at the time that 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. | | |

### Questions for pathology/radiology

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The key question(s) for the reviewing pathologist/radiologist regarding the patient’s pathology/radiology. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 500 | **Representational layout** | X(500) |
| **Data domain** |  | | |
| **Obligation** | Conditional. Mandatory if ‘Pathology/radiology review required’ is ‘Yes’. | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Patient discussion status

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

### 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) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Clinical background

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

|  |  |
| --- | --- |
| **Data elements:** |  |
| Previous MDM date | Treatment history |
| Previous MDM tumour group | Comorbidities |
| Previous MDM recommendations |  |

### 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** | CCYYMMDD |
| **Data 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, with 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. | | |

### Previous MDM tumour group

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The tumour group of the MDM(s) that the patient was previously presented at. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | Should be a subtype of ‘Specialist multidisciplinary team’ (408458006) from the SNOMED CT NZ Edition. | | |
| **Obligation** | Conditional. Mandatory if the patient has attended a previous cancer MDM. | | |
| **Guide for use** | There may be multiple previous MDMs at which the patient has been presented, with each being stored against a separate instance of this data element. | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### Previous MDM recommendations

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The recommendations from a previous MDM the patient was presented at. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | See Appendix 2, for suggested options. | | |
| **Obligation** | Conditional. Mandatory if the patient has attended a previous cancer MDM. | | |
| **Guide for use** | Multiple options may be selected.  There may be multiple previous MDMs at which the patient has been presented, with each set of recommendations being stored against a separate instance of this data element. | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### 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) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Comorbidities

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A list of the patient’s current comorbidities. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** |  | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | A list of SNOMED CT comorbidities will be developed for each tumour group.  Users must be able to enter multiple comorbidities as required. | | |
| **Verification rules** | Must use active SNOMED CT concepts. | | |

## Family history

Understanding the history of cancer, treatment and outcomes of other biologically related family members may provide valuable information to consider when determining a patient’s treatment. The following information identifies what to record about each biologically related family member diagnosed with an associated cancer.

Other tumour-specific elements relating to the patient’s family history of cancer will be identified through engaging with tumour stream groups and included in tumour-specific additions to these data standards.

|  |  |
| --- | --- |
| **Data elements** |  |
| Biological relationship | Associated genes |
| Family history of cancer | Biological family – treatment history |
| Additional details of family history of cancer | Biological family – treatment outcome |
| Age at diagnosis | Additional treatment outcome details |

### Biological relationship

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Details the type of relationship between the genetically related family member to the patient. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | A valid SNOMED CT term from the ‘Relative’ (person) (125677006) hierarchy for the patient being presented. | | |
| **Obligation** | Conditional. Mandatory if known. | | |
| **Guide for use** | A separate record must be captured for each biological family member where a cancer(s) has been diagnosed.  For capturing the details of extended family members, using ‘paternal’ and ‘maternal’ SNOMED terms is recommended (eg, Paternal grandmother, Maternal uncle). | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### Family history of cancer

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Identifies the type of cancer the biological family member has previously been diagnosed with. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | A valid SNOMED CT term from the ‘Family history of neoplasm’ (situation) (266883004) hierarchy for the biological family member being captured. | | |
| **Obligation** | Mandatory if a Biological relationship has been recorded in section 3.5.1. | | |
| **Guide for use** | May have multiple entries for each biological family member. | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### Additional details of family history of cancer

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Additional details of the patient’s family history of cancer. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 500 | **Representational layout** | X(500) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** | This field provides the ability to capture supporting information of the biological family member as well as their condition and treatment outcome. | | |
| **Verification rules** |  | | |

### Age at diagnosis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The biological family member’s age when they were diagnosed with cancer(s). | | |
| **Source standards** |  | | |
| **Data type** | Number | **Representational class** | Value |
| **Field size** | 3 | **Representational layout** | NNN |
| **Data domain** |  | | |
| **Obligation** | Conditional. Mandatory if known. | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Associated genes

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Details any genes associated with the patient’s cancer that may have been inherited from the biological family member. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 500 | **Representational layout** | X(500) |
| **Data domain** |  | | |
| **Obligation** | Conditional. Mandatory if known. | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Biological family – treatment history

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The treatment given to the biological family member. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 500 | **Representational layout** | X(500) |
| **Data domain** |  | | |
| **Obligation** | Conditional. Mandatory if known. | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Biological family – treatment outcome

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The outcome of the treatment, patient and/or cancer. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | Suggested options for recording the outcomes may be subtypes of the ‘Qualifier value’ (362981000) hierarchy from the SNOMED CT, for example, In full remission (103338009), Decreased (1250004), Unsuccessful (385671000), Inconclusive (419984006). | | |
| **Obligation** | Conditional. Mandatory if known. | | |
| **Guide for use** | Users must be able to enter multiple outcomes as required. | | |
| **Verification rules** | Must be an active SNOMED CT concept(s). | | |

### Additional treatment outcome details

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Further details supporting the treatment outcomes the biological family member experienced. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 500 | **Representational layout** | X(500) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Current presentation

The following list of items provides further information about the patient’s current presentation.

| **Data elements** |  |
| --- | --- |
| FCT status | Date of initial diagnosis |
| HSCAN referral date | Recurrence or progression |
| Date of decision-to-treat | Metastatic site |
| Days on FCT pathway | ECOG status |
| FCT breach date | Histological tumour type |
| FCT days overdue | Patient preferences and other factors |
| Patient summary | Psychosocial or high-needs patient considerations |
| Primary site | Most valid basis of diagnosis\* |
| Histopathological grade\* | Clinical coding system\* |

\* See the HISO 10038.3 Interim National Cancer Core Data Definitions Standard at <https://www.health.govt.nz/publication/hiso-1003832011-interim-national-cancer-core-data-definitions-standard> for the full definition of this data element.

### FCT status

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The Faster Cancer Treatment (FCT) status of the patient presented at the MDM. | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 2 | **Representational layout** | NN |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | 31 | The patient is on the 31-day FCT pathway. | | 62 | The patient is on the 62-day FCT pathway. | | 99 | The patient is not on an FCT pathway. | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | FCT data will ideally be automatically populated via interface with an FCT database when the referral is submitted. | | |
| **Verification rules** | Valid code | | |

### HSCAN referral date

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date the High Suspicion of Cancer (HSCAN) referral is initially received into secondary care. | | |
| **Source standards** | Faster Cancer Treatment Indicators: Business Rules and Data Definitions, v3.1, March 2014.  HISO 10038.3 Interim National Cancer Core Data Definitions Standard. | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid date | | |
| **Obligation** | Optional | | |
| **Guide for use** | If the referral is transferred to another DHB the date of referral remains the date that the referral was received by the first DHB.  FCT data will ideally be automatically populated via interface with an FCT database when the referral is submitted.  For further information on the definitions of High suspicion of cancer, refer to [nsfl.health.govt.nz/system/files/documents/publications/high\_suspicion\_of\_cancer\_definitions\_0.pdf](file:///\\moh.govt.nz\dfs-userdata\userstate\Skerruis\Documents\Core%20Cancer%20Standard\MDM%202019\nsfl.health.govt.nz\system\files\documents\publications\high_suspicion_of_cancer_definitions_0.pdf) | | |
| **Verification rules** | A valid date that is less than or equal to the current date. | | |

### Date of decision-to-treat

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date when the decision was made for the patient’s treatment plan or other management plan, following discussion between the patient and the clinician responsible for treatment. | | |
| **Source standards** | Faster Cancer Treatment Indicators: Business Rules and Data Definitions, v3.1, March 2014.  <https://nsfl.health.govt.nz/accountability/performance-and-monitoring/business-rules-and-templates-reporting/faster-cancer> | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid date | | |
| **Obligation** | Optional | | |
| **Guide for use** | Where there are two possible dates, record the earliest date. When a patient has been discussed in an MDM, it is in the patient’s best interest that the decision-to-treat discussion takes place with them as soon as possible after the MDM.  Where a decision-to-treat date is not routinely collected, the date that a booking request for treatment is made can be used as a surrogate for decision-to-treat date. The National Patient Flow collection requires that the outpatient attendance outcome decision is reported. The date that this is recorded is to be used in the first instance.  Where there is no outpatient attendance outcome decision recorded then use the following dates as the Date of decision-to-treat (for the associated treatment type):   * surgery – date booking for surgery was requested * chemotherapy/radiotherapy (or concurrent) – date chemotherapy or radiotherapy booking was requested * targeted therapy – date prescription was written * Non-intervention management – date the decision of non-intervention management was recorded in the patient’s record * best supportive care – date referral was written * patient declined treatment – date of outpatient visit * patient died – date of death.   FCT data will ideally be automatically populated via interface with an FCT database when the referral is submitted. | | |
| **Verification rules** | A valid date that is less than or equal to the current date. | | |

### Days on FCT pathway

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The number of days the patient has been on their FCT pathway. | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 4 | **Representational layout** | N(4) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** | FCT data will ideally be automatically populated via interface with an FCT database when the referral is submitted. | | |
| **Verification rules** |  | | |

### FCT breach date

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date when the patient will, or did, breach their target for the FCT pathway specified in the FCT status. | | |
| **Source standards** |  | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid date | | |
| **Obligation** | Conditional. Mandatory if the patient is on an FCT pathway. | | |
| **Guide for use** | FCT data will ideally be automatically populated via interface with an FCT database when the referral is submitted. | | |
| **Verification rules** |  | | |

### FCT days overdue

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The number of days that the patient has exceeded their FCT target. | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 4 | **Representational layout** | N(4) |
| **Data domain** | Valid number | | |
| **Obligation** | Optional | | |
| **Guide for use** | FCT data will ideally be automatically populated via interface with an FCT database when the referral is submitted. | | |
| **Verification rules** |  | | |

### 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) |
| **Data domain** |  | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Clinical summary information and other clinical data should be automatically populated via integration with clinical systems where possible. | | |
| **Verification rules** |  | | |

### Primary site

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The primary site of the cancer for which the patient is being seen. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | X(18)) |
| **Data domain** | Valid ICD-10 or SNOMED CT clinical term. | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Clinical summary information and other clinical data should be automatically populated via integration with clinical systems where possible.  This must be accompanied with details of term and the clinical coding system used. | | |
| **Verification rules** |  | | |

### Date of initial diagnosis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date of the initial suspected diagnosis of cancer. | | |
| **Source standards** |  | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid date | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Date of first suspected diagnosis as stated by a recognised medical practitioner.  Clinical summary information and other clinical data should be automatically populated via integration with clinical systems where possible. | | |
| **Verification rules** | A valid date that is less than or equal to the current date. | | |

### Recurrence or progression

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Extent of cancer that has recurred or progressed. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | |  | | | **SNOMED CT identifier** | **Meaning** | | TBA | Not a recurrence or progression | | TBA | Loco-regional | | TBA | Distant | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Clinical summary information and other clinical data should be automatically populated via integration with clinical systems where possible. | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### Metastatic site

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Anatomical site where the cancer has spread. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | Valid term representing an anatomical site from the ‘Body structure’ hierarchy of SNOMED CT. | | |
| **Obligation** | Optional | | |
| **Guide for use** | Clinical summary information and other clinical data should be automatically populated via integration with clinical systems where possible.  Users need to be able to record multiple entries for this item. | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### ECOG status

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The most recent performance status of the patient as defined by Eastern Cooperative Oncology Group (ECOG). | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | See Appendix 2, Table 4: ECOG performance status. | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Clinical summary information and other clinical data should be automatically populated via integration with clinical systems where possible. | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### Histological tumour type

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The histological tumour type of the cancer for which the patient is being presented. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | Valid term from the ‘Morphologically abnormal structure’ (49755003) SNOMED CT hierarchy. | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### 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) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** | Any relevant patient preferences that could influence MDM recommendations. For example, if a patient is personally attending an MDM and needs an interpreter, or if a patient has refused surgery before the MDM. | | |
| **Verification rules** |  | | |

### Psychosocial or high-needs patient considerations

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Details high-needs 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) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** | This element provides space 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 high-needs 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 as a free-text summary built into the patient’s MDM record. Ideally, data is recorded using SNOMED CT where available. | | |
| **Verification rules** |  | | |

## Staging information

This section lists the relevant 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.

Where a T, N or M stage is not captured, an ‘Other staging system’ element must be recorded.

NOTE: At the time of publication, the Cancer Control Agency was running a project to improve the quality and completeness of staging data. This section will be updated to reflect the outcome of this project. Please contact the Cancer Control Agency for further information by sending an email to [john.manderson@cancercontrolagency.govt.nz](mailto:john.manderson@cancercontrolagency.govt.nz) .

|  |  |
| --- | --- |
| **Data elements** |  |
| TNM: T stage | TNM: M date |
| TNM: T basis | TNM: M neoadjuvant therapy modifier |
| TNM: T date | TNM: M additional comments |
| TNM: T neoadjuvant therapy modifier | TNM edition used |
| TNM: T additional comments | Group stage |
| TNM: N stage | Group stage basis |
| TNM: N basis | Other staging system |
| TNM: N date | Other staging system version |
| TNM: N neoadjuvant therapy modifier | Other staging system for overall group stage |
| TNM: N additional comments | Stage date |
| TNM: M stage | Additional staging information |
| TNM: M basis |  |

### TNM: T stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | 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** | American Joint Committee of Cancer (AJCC) TNM Classification of Malignant Tumours  <https://cancerstaging.org/references-tools/Pages/Cancer-Staging-Resources.aspx> | | |
| **Data type** | Alphanumeric | **Representational class** | Code |
| **Field size** | 4 | **Representational layout** | X(4) |
| **Data domain** | Valid T codes from the current edition of the AJCC TNM Classification of Malignant Tumours. | | |
| **Obligation** | Conditional. TNM or another staging system must be used. | | |
| **Guide for use** | If primary stage is unknown use TX. | | |
| **Verification rules** |  | | |

### TNM: T basis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The evidence basis for the T stage measurement. | | |
| **Source standards** |  | | |
| **Data type** | Alphabetic | **Representational class** | Code |
| **Field size** | 2 | **Representational layout** | AA |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | c | Clinical | | p | Pathological | | yc | Post-therapy | | yp | Post-neoadjuvant | | r | Recurrence or retreatment | | a | Autopsy | | NOTE: All AJCC classifications are included for completeness. However, it is unlikely some, eg, autopsy (a) would be reported. | | | | |
| **Obligation** | Conditional. Mandatory if a T category has been selected. | | |
| **Guide for use** |  | | |
| **Verification rules** | Must be a valid code. | | |

### TNM: T date

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date the T stage was derived. | | |
| **Source standards** |  | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid date | | |
| **Obligation** | Conditional. Mandatory if a T category has been selected. | | |
| **Guide for use** |  | | |
| **Verification rules** | A valid date that is less than or equal to the current date. | | |

### TNM: T neoadjuvant therapy modifier

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Indicates whether the T measurement was taken post-neoadjuvant therapy. | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | 1 | Yes (true), the T measurement was taken post-neoadjuvant therapy. | | 0 | No (false), the T measurement was not taken post-neoadjuvant therapy. | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value | | |

### TNM: T additional comments

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Provides space to provide additional information about the T stage measurement. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 500 | **Representational layout** | X(500) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** | Only use to comment on the T stage information. Record general staging comments under ‘Additional staging information’. | | |
| **Verification rules** |  | | |

### TNM: N stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | 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** | AJCC TNM Classification of Malignant Tumours  <https://cancerstaging.org/references-tools/Pages/Cancer-Staging-Resources.aspx> | | |
| **Data type** | Alphanumeric | **Representational class** | Code |
| **Field size** | 3 | **Representational layout** | X(3) |
| **Data domain** | Valid N codes from the current edition of the AJCC TNM Classification of Malignant Tumours. | | |
| **Obligation** | Conditional. Either TNM or ‘Other staging system’ must be used. | | |
| **Guide for use** | Supplementary value:  88: Not applicable | | |
| **Verification rules** |  | | |

### TNM: N basis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The evidence basis for the N stage measurement. | | |
| **Source standards** |  | | |
| **Data type** | Alphabetic | **Representational class** | Code |
| **Field size** | 2 | **Representational layout** | AA |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | c | Clinical | | p | Pathological | | yc | Post-therapy | | yp | Post-neoadjuvant | | r | Recurrence or retreatment | | a | Autopsy | |  |  | | NOTE: All AJCC classifications are included for completeness. However, it is unlikely some, eg, autopsy (a) would be reported. | | | | |
| **Obligation** | Conditional. Required if a N category has been selected. | | |
| **Guide for use** |  | | |
| **Verification rules** | Must be a valid code. | | |

### TNM: N date

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date the N stage was derived. | | |
| **Source standards** |  | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid date | | |
| **Obligation** | Conditional. Mandatory if a N category has been selected. | | |
| **Guide for use** |  | | |
| **Verification rules** | A valid date that is less than or equal to the current date. | | |

### TNM: N neoadjuvant therapy modifier

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Indicates whether the N measurement was taken post-neoadjuvant therapy. | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | 1 | Yes (true), the N measurement was taken post-neoadjuvant therapy. | | 0 | No, (false), the N measurement was not taken post-neoadjuvant therapy. | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value | | |

### TNM: N additional comments

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Provides space to provide additional information regarding the N stage measurement. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 500 | **Representational layout** | X(500) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** | This element should only be used to comment on the N stage information. Record general staging comments under ‘Additional staging information’. | | |
| **Verification rules** |  | | |

### TNM: M stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | M stage is the coding system used to record the absence or presence of distant metastases. | | |
| **Source standards** | AJCC TNM Classification of Malignant Tumours  <https://cancerstaging.org/references-tools/Pages/Cancer-Staging-Resources.aspx> | | |
| **Data type** | Alphanumeric | **Representational class** | Code |
| **Field size** | 3 | **Representational layout** | X(3) |
| **Data domain** | Valid M codes from the current edition of the AJCC TNM Classification of Malignant Tumours. | | |
| **Obligation** | Conditional. Either TNM or ‘Other staging system’ must be used. | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### TNM: M basis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The evidence basis for the M stage measurement. | | |
| **Source standards** |  | | |
| **Data type** | Alphabetic | **Representational class** | Code |
| **Field size** | 2 | **Representational layout** | AA |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | c | Clinical | | p | Pathological | | yc | Post-therapy | | yp | Post-neoadjuvant | | r | Recurrence or retreatment | | a | Autopsy | |  |  | | NOTE: All AJCC classifications are included for completeness. However, it is unlikely some, eg, autopsy (a) would be reported. | | | | |
| **Obligation** | Conditional. Required if an M category has been selected. | | |
| **Guide for use** |  | | |
| **Verification rules** | Must be a valid code. | | |

### TNM: M date

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date the M stage was derived. | | |
| **Source standards** |  | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid date | | |
| **Obligation** | Conditional. Required if a M category has been selected. | | |
| **Guide for use** |  | | |
| **Verification rules** | A valid date that is less than or equal to the current date. | | |

### TNM: M neoadjuvant therapy modifier

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Indicates whether the M measurement was taken post-neoadjuvant therapy. | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | 1 | Yes (true), the M measurement was taken post-neoadjuvant therapy. | | 0 | No (false), the M measurement was not taken post-neoadjuvant therapy. | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value | | |

### TNM: M additional comments

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Provides space to provide additional information about the M stage measurement. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 500 | **Representational layout** | X(500) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** | This element should only be used to comment on the M stage information. Record general staging comments under ‘Additional staging information’. | | |
| **Verification rules** |  | | |

### TNM edition used

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Staging system edition number used. | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 2 | **Representational layout** | NN |
| **Data domain** | Number, 1–87  88: Not applicable  99: Unknown edition | | |
| **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. | | |
| **Verification rules** |  | | |

### Group stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Integrated stage at time of first definitive course of treatment. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Code |
| **Field size** | 8 | **Representational layout** | X(8) |
| **Data domain** | Valid group stage from the current edition of the AJCC TNM Classification of Malignant Tumours.  <https://cancerstaging.org/references-tools/Pages/Cancer-Staging-Resources.aspx> | | |
| **Obligation** | Optional | | |
| **Guide for use** | This is the integration of all staging data available at the time of, or as result of, first definitive course of treatment, that is, cTNM (clinical tumour, nodes and metastases) and pTNM (pathological tumour, nodes and metastases).  Ensure that the edition number of the classification is recorded.  Supplementary values:  8888: Not applicable  9999: Unknown, Stage X  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. | | |
| **Verification rules** | Valid stage grouping codes from the current edition of the AJCC TNM Classification of Malignant Tumours. | | |

### Group stage basis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The evidence basis for the group stage measurement. | | |
| **Source standards** |  | | |
| **Data type** | Alphabetic | **Representational class** | Code |
| **Field size** | 2 | **Representational layout** | AA |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | c | Clinical | | p | Pathological | | yc | Post-therapy | | yp | Post-neoadjuvant | | r | Recurrence or retreatment | | a | Autopsy | |  |  | | NOTE: All AJCC classifications are included for completeness. However, it is unlikely some, eg, autopsy (a) would be reported. | | | | |
| **Obligation** | Conditional. Required if a group stage has been selected. | | |
| **Guide for use** | Also called a group stage classification. | | |
| **Verification rules** | Must be a valid code. | | |

### Other staging system

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Staging classification system other than TNM. | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 2 | **Representational layout** | NN |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | 2 | Durie & Salmon for multiple myeloma staging | | 3 | FAB for leukaemia classification | | 4 | Australian Clinico-pathological Staging (ACPS) system for colorectal cancer | | 6 | Ann Arbor staging system for lymphomas | | 7 | Binet Staging Classification for chronic lymphocytic leukaemia | | 8 | CML for chronic myeloid leukaemia | | 10 | FIGO for gynaecological cancers | | 11 | ISS for myeloma | | 12 | Rai staging system for chronic lymphocytic leukaemia | | 13 | Other | | 99 | Unknown | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | It is recommended that the AJCC TNM Classification of Malignant Tumours is used for all applicable tumour sites.  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** |  | | |

Notes: FAB = French-British-American classification; FIGO = International Federation of Gynecology and Obstetrics (Fédération Internationale de Gynécologie et d'Obstétrique); ISS = International Staging System.

### 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) |
| **Data 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 for overall 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) |
| **Data domain** | Supplementary values:  8888888888: Not applicable  9999999999: Unknown | | |
| **Obligation** | Conditional. Mandatory if ‘Other staging system’ is populated, otherwise optional. | | |
| **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** |  | | |

### 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** | CCYYMMDD |
| **Data domain** | Valid date | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | A valid date that is less than or equal to the current date. | | |

### 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) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Pathology/radiology review

This section lists the items relating to a patient’s pathology/radiology review.

|  |  |
| --- | --- |
| **Data elements** |  |
| Review type | Pathology/radiology summary |
| Pathology/radiology review available by requested MDM date | Reviewing pathologist/radiologist |
| Pathology/radiology review available by requested MDM date – comments | Pathology/radiology review date |
| Pathology/radiology review concordant with original report |  |

### Review type

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Indicates whether the record relates to a pathology or radiology review. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | |  | | | **SNOMED CT identifier** | **Meaning** | | 371528001 | Pathology report | | 371527006 | Radiology report | |  |  | | | |
| **Obligation** | Conditional. Required if capturing responses to 3.3.9 Pathology/radiology review required. | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Pathology/radiology review available by requested MDM date

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Indication of whether the pathologist’s/radiologist’s review will be completed within the requested timeframe. | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | 1 | Yes (true), the pathology/radiology review will be completed within requested timeframe. | | 0 | No (false), the pathology/radiology review will not be completed within requested timeframe. | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value | | |

### Pathology/radiology review available by requested MDM date – comments

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Additional details on the availability of pathology/radiology reviews within the requested timeframe. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 500 | **Representational layout** | X(500) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** | Allows reviewing pathologists/radiologists to comment on the availability of pathology/radiology reviews within the requested timeframe (eg, this space allows reviewing pathologists/radiologists to indicate that slides or original reviews have not yet been received from off-site facilities and cannot be reviewed by the requested MDM date). | | |
| **Verification rules** |  | | |

### Pathology/radiology review concordant with original report

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the review completed by the reviewing pathologist/radiologist is concordant with the patient’s original pathology/radiology. | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | 1 | Yes (true), the review completed by the reviewing pathologists/radiologists is concordant with the patient’s original pathology/radiology. | | 0 | No (false), the review completed by the reviewing pathologists/radiologist is not concordant with the patient’s original pathology/radiology. | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | Can be used to indicate whether an amended/supplementary pathology/radiology report is required. | | |
| **Verification rules** | Valid value | | |

### Pathology/radiology summary

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Reviewing pathologist’s/radiologist’s feedback or additional details of the patient’s pathology/radiology. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 500 | **Representational layout** | X(500) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Reviewing pathologist/radiologist

The details of the pathologist/radiologist who conducted the patient’s MDM pathology/radiology review.

The relevant details to be captured for this data element includes the full name, the person’s unique identifier and the assigning authority. See Appendix 3 for further details.

### Pathology/radiology review date

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date the patient’s pathology/radiology review was completed. | | |
| **Source standards** |  | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid date | | |
| **Obligation** | Conditional. Required if a review has been completed. | | |
| **Guide for use** |  | | |
| **Verification rules** | A valid date that is less than or equal to the current date. | | |

## MDM meeting details

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

|  |  |
| --- | --- |
| **Data elements** |  |
| MDM facility name | MDM chair |
| MDM facility identifier | MDM attendee |
| MDM date | Other MDM attendees |
| MDM tumour group | Quorum specialty |

### MDM facility name

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The name of the facility hosting the MDM. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Text |
| **Field size** | 255 | **Representational layout** | A(255) |
| **Data domain** |  | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Should be automatically populated. | | |
| **Verification rules** |  | | |

### MDM facility identifier

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The unique lifetime identifier for the facility hosting the MDM. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Identifier |
| **Field size** | 8 | **Representational layout** | FXXNNN-C |
| **Data domain** | Valid HPI identifier | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Should be automatically populated from the ‘MDM facility name’.  The facility identifier is assigned by the HPI system at the time that 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. | | |

### MDM date

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date of the MDM. | | |
| **Source standards** |  | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid date | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### MDM tumour group

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The tumour group of the MDM. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | A list of available options for this element could be constructed for each host facility, ideally using SNOMED CT terms. | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### MDM chair

The details of the clinician chairing the MDM.

Include the person’s the full name, their unique identifier and the assigning authority. See Appendix 3 for further details.

### MDM attendee

The details of the clinicians attending the MDM.

Includes the person’s the full name, their unique identifier and the assigning authority. See Appendix 3 for further details.

### Other MDM attendees

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The name(s) of other clinical attendees present at the MDM who were not recorded in ‘MDM attendees’. | | |
| **Source standards** |  | | |
| **Data type** | Alphabetic | **Representational class** | Free text |
| **Field size** | 50 | **Representational layout** | A(50) |
| **Data domain** |  | | |
| **Obligation** | Conditional. Mandatory if ‘MDM attendee’ has not been populated with any attendees. | | |
| **Guide for use** | This element is different from the ‘MDM attendee’ as it is a free-text field to record attendees who are not recorded in the reference table list available for the ‘MDM attendee’ element.  Users need to record multiple attendees. In practice, multiple instances of this element could appear on an MDM template as free-text boxes to record additional MDM attendees. | | |
| **Verification rules** |  | | |

### Quorum specialty

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A record of each clinical specialty represented at the MDM. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | A list of valid medical specialties (SNOMED CT coded). | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Should be partially automatically populated by mapping each ‘MDM attendee’ to their associated medical specialty. | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

## MDM discussion and recommendations

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

|  |  |
| --- | --- |
| **Data elements** |  |
| Discussion summary | Care plan recommendation |
| Radiology and pathology concordance | Care plan procedure type |
| Radiology and pathology concordance comments | Care plan additional details |
| Care plan number | Further investigations |
| Care plan type | Further referral specialty |
| Care plan intent | Further referral responsible clinician |
| Reason curative treatment is precluded | Clinician responsible for informing patient |

### 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) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Radiology and pathology concordance

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Indicates whether the patient’s pathology and radiology are in concordance. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | |  | | | **SNOMED CT identifier** | **Meaning** | | TBA | Concordant | | TBA | Discordant | | TBA | Not applicable | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### Radiology and pathology concordance comments

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

### Care plan number

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Captures the preferentiality of the associated care plan where multiple care plans have been proposed. | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 1 | **Representational layout** | N |
| **Data domain** | A valid number from 1–8. The most preferred care plan generated at the MDM must be Care plan 1, with additional care plans numbered sequentially.  Should be automatically populated by the MDM system as care plans are added.  Up to eight care plans can be entered and prioritised. | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | A care plan is made up of a set of ‘Care plan recommendations’ (see below). Multiple care plans may be proposed at an MDM (or during post-MDM consultation with the patient). Each care plan is allocated a care plan number, with Care plan 1 representing the recommendations most preferred by the MDM attendees, Care plan 2 the second most preferred and so on.  Being able to record multiple care plans is useful when the care plan recommendations are relying on further information that is not available at the MDM (eg, pending test results). | | |
| **Verification rules** | Must be a valid number from 1–8. | | |

### Care plan type

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Identifies whether the associated care plan is a formal output of the MDM or has been generated through post-MDM consultation with the patient. | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | 1 | Care plan was generated through formal discussion at the MDM. | | 2 | Care plan was generated through post-MDM consultation with the patient. | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | This element is useful for analysing whether the MDM recommendations became the final plan agreed to by the patient. The solution should record whether the patient agreed with an MDM care plan or a different care plan devised through post-MDM consultation with the patient.  Should be automatically populated by the MDM system. | | |
| **Verification rules** | Valid value | | |

### Care plan intent

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The intent of the associated care plan. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | |  | | | **SNOMED CT identifier** | **Clinical term** | | 373808002 | Curative | | 363676003 | Palliative | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### 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** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | TBA | Stage | | TBA | Comorbidity | | TBA | Tumour type | | TBA | Other | |  |  | | | |
| **Obligation** | Conditional. Required for Care plan 1 if palliative has been selected as the care plan intent. | | |
| **Guide for use** |  | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### Care plan recommendation

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A single recommendation forming part of a care plan. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | See Appendix 2, Table 3: Recommendations. | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Users must be able to select multiple recommendations per care plan. | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### Care plan procedure type

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A procedure type recommended as part of the associated care plan. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | A valid SNOMED CT term from the ‘Procedure’ (71388002) hierarchy | | |
| **Obligation** | Optional | | |
| **Guide for use** | Users must be able to record multiple procedures. | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### 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) |
| **Data 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** |  | | |

### Further investigations

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Details of further investigations or diagnostics recommended for the patient. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | Valid type SNOMED CT terms for pathology/radiology procedures from the Procedure (71388002) hierarchy. | | |
| **Obligation** | Optional | | |
| **Guide for use** | There may be multiple instances of this element for each patient. | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### Further referral specialty

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A specialty that the patient is recommended for referral post-MDM. | | |
| **Source standards** | Ministry of Health’s health specialty code table:  [www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/health-specialty-code-table](file:///\\moh.govt.nz\dfs-userdata\userstate\Skerruis\Documents\Core%20Cancer%20Standard\MDM%202019\www.health.govt.nz\nz-health-statistics\data-references\code-tables\common-code-tables\health-specialty-code-table) | | |
| **Data type** | Alphanumeric | **Representational class** | Code |
| **Field size** | 3 | **Representational layout** | X(3) |
| **Data domain** | A valid health specialty code from the Ministry of Health’s health specialty code table. | | |
| **Obligation** | Optional | | |
| **Guide for use** | There may be multiple instances of this element for each patient. | | |
| **Verification rules** |  | | |

### Further referral responsible clinician

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

Includes the person’s full name, their unique identifier and the assigning authority. See Appendix 3 for further details.

### Clinician responsible for informing patient

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

Includes the person’s full name, their unique identifier and the assigning authority. See Appendix 3 for further details.

## Post-MDM patient consultation

This section lists the relevant data elements at or after the post-MDM consultation with the patient.

|  |  |
| --- | --- |
| **Data elements** |  |
| Patient discussion required | Agreement with MDM recommendations |
| Reason why patient discussion not required | Reason why patient does not agree to MDM recommendations |
| Patient informed by | Post-MDM patient consultation comments |
| Date patient informed of MDM outcome |  |

### Patient discussion required

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Indicates if a post-MDM discussion with the patient is necessary to agree and finalise the patient’s care plan. | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | 1 | Yes (true). Patient discussion post-MDM is required to agree care plan. | | 0 | No (false). Patient discussion post-MDM is not required to agree care plan. | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value | | |

### Reason why patient discussion not required

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The reason why patient consultation following the MDM, in order to agree on a care plan, is not required. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 200 | **Representational layout** | X(200) |
| **Data domain** |  | | |
| **Obligation** | Conditional. Mandatory if ‘No’ has been selected under ‘Patient discussion required’. | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Patient informed by

The details of the clinician who informed the patient of the MDM outcome.

Includes the person’s full name, their unique identifier and the assigning authority. See Appendix 3 for further details.

### Date patient informed of MDM outcome

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date the patient was informed of the outcome of their MDM presentation. | | |
| **Source standards** |  | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid date | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** | A valid date that is less than or equal to the current date. | | |

### Agreement with MDM recommendations

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Indicates which care plan the patient agrees to. | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | 1 | Patient agrees to Care plan 1. | | 2 | Patient agrees to Care plan 2 only. | | 3 | Patient agrees to Care plan 3 only. | | 4 | Patient agrees to Care plan 4 only. | | 5 | Patient agrees to Care plan 5 only. | | 6 | Patient agrees to Care plan 6 only. | | 7 | Patient agrees to Care plan 7 only. | | 8 | Patient agrees to Care plan 8 only. | | 9 | Patient does not agree to any care plan formulated at the MDM. The new agreed care plan needs recording. | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | This element must include an option to agree with each care plan previously developed at the MDM or, where the patient has not agreed to an existing care plan, indicate that a new care plan will be recorded. Upon choosing the ‘new’ option the user will be prompted to record a new set of recommendations, which will become the patient agreed care plan. | | |
| **Verification rules** | Valid value | | |

### Reason why patient does not agree to MDM recommendations

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The reason why the patient does not agree to any of the MDM care plans. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 200 | **Representational layout** | X(200) |
| **Data domain** |  | | |
| **Obligation** | Conditional. Mandatory if ‘Agreement with MDM recommendations’ has a value of 9. | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Post-MDM patient consultation comments

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Additional information regarding the post-MDM patient consultation. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Administration

This section lists other data elements relevant 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 |

### MDM patient record status

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The current status of the MDM record. | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | |  | | | **SNOMED CT identifier** | **Meaning** | | TBA | Submitted | | TBA | Registered | | TBA | Completed | | TBA | Other | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Must be an active SNOMED CT concept. | | |

### Referral declined reason

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The reason why the patient’s MDM referral has been declined. | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 2 | **Representational layout** | NN |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | 81 | Insufficient information | | 82 | Inappropriate for presentation at MDM | | 83 | Incorrect tumour group | | 84 | Other | |  |  | | | |
| **Obligation** | Conditional. Required if the referral has been declined. | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value | | |

### Deferral reason

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The reason why the patient was deferred to a future MDM. | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 2 | **Representational layout** | NN |
| **Data domain** | |  |  | | --- | --- | |  | | | **Value** | **Meaning** | | 01 | Results not ready | | 02 | No presenter | | 03 | Time constraints | | 04 | Insufficient quorum | |  |  | | | |
| **Obligation** | Mandatory if the patient was deferred. | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value | | |

### 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** | CCYYMMDD |
| **Data 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. | | |

### 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** | CCYYMMDD |
| **Data 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. | | |

### Last modified by

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The name or ID 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) |
| **Data domain** | Valid username or ID | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Should be automatically generated and recorded by the MDM system. | | |
| **Verification rules** |  | | |

# Adoption roadmap

The Cancer Control Agency will support those DHBs in the early implementation phases of an MDM IT system to encourage the adoption of this standard to ensure they are capturing sufficient data to support an efficient MDM process.

A review may be required in one year to ensure the standard remains fit for purpose, based on implementation experience.

There is no set timeframe for the adoption of this standard, however these requirements should be included within any Request for Proposal (RFP) or similar process to procure an MDM IT system and should be met by any new MDM IT system implemented by the sector. HISO will work with the Cancer Control Agency to track the level of adoption in district health boards.

# Appendix 1: Data entry timeline

The diagram below shows the data collection and collation timeline, with the key points in the MDM process where the data groups are collected to build the MDM patient record.

Note that minimum referral data consists of the mandatory elements across the ‘NHI’, ‘Patient demographics’, ‘GP details’ and ‘Core referral information and key questions’.

Figure 1: MDM data entry timeline



# Appendix 2: SNOMED CT terms

The SNOMED CT data domain (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 both the clinical term and the associated code, but only the clinical term should be visible to users.

Table 1: Source of referral

|  |  |
| --- | --- |
| **Clinical term** | **SNOMED CT identifier** |
| Public hospital | 79993009 |
| Private hospital | 309895006 |
| Environment (to be used for other settings, eg, screening) | 276339004 |

Table 2: Patient discussion status

|  |  |
| --- | --- |
| **Clinical term** | **SNOMED CT identifier** |
| For formal discussion  *(SNOMED CT preferred term: Multidisciplinary review)* | 708004003 |
| Data collection only  *(SNOMED CT preferred term: Information gathering)* | 311791003 |

Table 3: Recommendations

|  |  |
| --- | --- |
| **Clinical term** | **SNOMED CT identifier** |
| Surgical procedure | 387713003 |
| Radiation therapy | 385798007 |
| Chemotherapy | 385786002 |
| Combined chemotherapy and radiation therapy | 703423002 |
| Targeted therapy | TBA |
| Non-intervention management | TBA |
| Palliative care | 103735009 |
| Clinical trial | 110465008 |
| Other therapy | 276239002 |

Table 4: ECOG performance status

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

# Appendix 3: Data elements for health providers

The following lists the common data elements that are required for the health providers referred to in this document.

Table 5: Health provider name

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The full name of the person contributing to the care of the patient or the MDM. | | |
| **Source standards** |  | | |
| **Data type** | Alphabetic | **Representational class** | Text |
| **Field size** | 50 | **Representational layout** | A(50) |
| **Data domain** |  | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | This information should be automatically generated and stored within the MDM system logs. | | |
| **Verification rules** |  | | |

Table 6: Health provider identifier

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The unique identifier for the person contributing to the care of the patient or the MDM. | | |
| **Source standards** | HPI documentation:  [www.health.govt.nz/our-work/health-identity/health-practitioner-index](http://www.health.govt.nz/our-work/health-identity/health-practitioner-index)  See also:   * HISO 10005:2008 Health Practitioner Index Data Set: [www.health.govt.nz/publication/hiso-100052008-health-practitioner-index-hpi-data-set](http://www.health.govt.nz/publication/hiso-100052008-health-practitioner-index-hpi-data-set) * HISO 10006:2008 Health Practitioner Index Code Set: [www.health.govt.nz/publication/hiso-100062008-health-practitioner-index-hpi-code-set](http://www.health.govt.nz/publication/hiso-100062008-health-practitioner-index-hpi-code-set) | | |
| **Data type** | Alphanumeric | **Representational class** | Identifier |
| **Field size** | 6 | **Representational layout** | NNAAAA |
| **Data domain** | HPI Common Person Number (CPN) generated by the HPI system | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Should be automatically populated.  This field uses the Health Provider Index Common Person Number (HPI\_CPN), a unique identifier for the health practitioner delivering the service. | | |
| **Verification rules** | CPN can be obtained from the clinician but must be validated with the HPI system. | | |

Table 7: Assigning authority

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The source of the unique identifier for the health provider. | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Code |
| **Field size** | 10 | **Representational layout** | X(10) |
| **Data domain** |  | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | TBD | | |
| **Verification rules** |  | | |

# Appendix 4: Document consultation

People who reviewed and provided feedback on this document

| Name | MDM relevance |
| --- | --- |
| Andrew Simpson | National Clinical Director Cancer |
| Clare Possenniskie | Cancer services – Reporting perspective |
| Aimee Harmes-Broad | MDM coordinator (or equivalent role) |
| Trina Nixon | MDM coordinator (or equivalent role) |
| Nikki Cole | MDM coordinator (or equivalent role) |
| Kat Norton | MDM coordinator (or equivalent role) |
| Morag Macleod | MDM coordinator (or equivalent role) |
| Angela Lawrence | MDM coordinator (or equivalent role) |
| Vicki Thomson | MDM coordinator (or equivalent role) |
| Linda Hunter | MDM coordinator (or equivalent role) |
| Andrea Reilly | Cancer nurse |
| Judy Warren | Cancer nurse |
| James Entwisle | MDM radiology review |
| Kim McAnulty | MDM radiology review |
| Janine Joubert | MDM pathology coordination |
| Gavin Harris | MDM pathology review |
| Shaun Costello | Clinical |
| Adrian Balasingam | Clinical |
| Ralph van Dalen | MDM chair |
| Paul Dawkins | MDM chair |
| Jim Edwards | MDM chair |
| Doug Iupati | MDM chair |
| Stephanie Fletcher | Consumer representative |
| Sandra Sheen | Consumer representative |
| Stephanie Turner | Hei Āhuru Mōwai |
| Professor Ross Lawrenson | Primary care representative |
| Tim Dunn | Regional perspective and Regional Cancer Network reporting |
| Margie Hamilton | Regional perspective and Regional Cancer Network reporting |
| Janfrey Doak | Regional perspective and Regional Cancer Network reporting |
| Geeta Gala | Regional perspective and Regional Cancer Network reporting |
| Jo Anson | Strategic regional |
| Jan Smith | Strategic regional |
| Cassandra Luckwell | Strategic regional |
| Di Riley | Strategic regional |
| Anne-Marie Wilkins | Tumour stream development facilitator/cancer nurse coordinator |
| Bronwyn Marshall | Service delivery and change management |
| Jane Trolove | Service delivery and change management |
| Richard Small | Service manager |
| Rosey Wilson | Service manager – medical services |
| Shona Haggart | Faster cancer treatment |
| Barbara Cox | Regional cancer and blood |
| Judi Tapp | Project manager |
| Nathan Billing | Information technology, local perspective |
| Lance Elder | Information technology, local perspective |

1. See https://standards.iso.org/ittf/PubliclyAvailableStandards/index.html [↑](#footnote-ref-2)
2. The stakeholder groups are detailed in the associated MDM National Future State Business Requirements and Processes document. [↑](#footnote-ref-3)