hiso Health Information Standards Organisation
PAEREWA PĀRONGO HAUORA

Cancer Multidisciplinary Meeting Data Standards

HISO 10038.4:2020

Published March 2020

New Zealand Government

MINISTRY OF HEALTH
MANATŪ HAUORA

Contributors

The Cancer Health Information Strategy team, Ministry of Health, led the initial development of this standard with significant input from the following individuals and groups.

- Tim Dunn, Project Manager, Central Cancer Network
- DHB Cancer Managers, Central Cancer Network
- Stephanie Fletcher, MDM consumer representative
- Central Cancer MDM chairs, coordinators and clinical resourcing group
- Janfrey Doak, Project Manager, Southern Cancer Network
- Kim McAnulty, Radiologist, Waikato DHB
- Shaun Costello, Radiation, Southern DHB
- Margie Hamilton, Project Manager, Midland Cancer Network
- Ralph van Dalen, Colorectal MDM Chair, Waikato DHB

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.

Citation: Ministry of Health. 2020. *HISO 10038.4:2020 Cancer Multidisciplinary Meeting Data Standard*. Wellington: Ministry of Health.

Published in April 2020 by the Ministry of Health
PO Box 5013, Wellington 6140, New Zealand

ISBN 978-1-98-859782-9 (online)
HP 7389

Health Information Standards Organisation (HISO) standards are published by the Ministry of Health for the New Zealand health and disability sector.

MINISTRY OF HEALTH
MANATŪ HAUORA

This document is available at health.govt.nz

Contents

1 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.

1.1 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.

1.2 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.

1.3 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).

1.4 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.

1.5 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

- 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
- 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
- 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
- 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
- HISO 10038.0:2017 Preface to the Cancer Data Standards

  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
- HISO 10038.3 Interim National Cancer Core Data Definitions Standard

  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
- HISO 10046 Consumer Health Identity Standard

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

  www.health.govt.nz/publication/hiso-100062008-health-practitioner-index-hpi-code-set

1.5.1 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

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).

1.6 Data element template

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

Definition	A statement that expresses the essential nature of the data element and its differentiation from other elements in the data set.		
Source standards	Established data definitions or guidelines 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.		

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

2 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] . 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.

[2] The stakeholder groups are detailed in the associated MDM National Future State Business Requirements and Processes document.

3 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).

3.1 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

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

3.2 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

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.

3.2.1 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.

3.2.2 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			

3.2.3 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			

3.3 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

3.3.1 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			

3.3.2 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.		

3.3.3 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.		

3.3.4 Requested MDM date

Definition	The date of the MDM that the patient is being referred to for presentation.		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	8	**Representational layout**	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.		

3.3.5 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.

3.3.6 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.

3.3.7 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.

3.3.8 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.		

3.3.9 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	

3.3.10 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	

3.3.11 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.		

3.3.12 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			

3.3.13 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.		

3.3.14 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			

3.3.15 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.		

3.3.16 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			

3.3.17 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.		

3.3.18 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			

3.4 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	

3.4.1 Previous MDM date

Definition	The date of a previous cancer MDM where the patient was presented.		
Source standards			
Data type	Date	**Representational class**	Full date
Field size	8	**Representational layout**	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.		

3.4.2 Previous MDM tumour group

Definition	The tumour group of the MDM(s) that the patient was previously presented at.		
Source standards			
Data type	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.		

3.4.3 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.		

3.4.4 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			

3.4.5 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.		

3.5 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

3.5.1 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.		

3.5.2 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.		

3.5.3 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			

3.5.4 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			

3.5.5 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			

3.5.6 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			

3.5.7 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).		

3.5.8 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			

3.6 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.

3.6.1 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		

3.6.2 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**		
Verification rules	A valid date that is less than or equal to the current date.		

3.6.3 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.		

3.6.4 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			

3.6.5 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			

3.6.6 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			

3.6.7 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			

3.6.8 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			

3.6.9 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.		

3.6.10 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.		

3.6.11 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.		

3.6.12 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.		

3.6.13 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.		

3.6.14 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			

3.6.15 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			

3.7 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** .

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	

3.7.1 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			

3.7.2 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.

3.7.3 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.		

3.7.4 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		

3.7.5 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			

3.7.6 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			

3.7.7 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.

3.7.8 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.		

3.7.9 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		

3.7.10 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			

3.7.11 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			

3.7.12 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.

3.7.13 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.		

3.7.14 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		

3.7.15 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			

3.7.16 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			

3.7.17 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.		

3.7.18 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.

3.7.19 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.

3.7.20 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			

3.7.21 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			

3.7.22 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.		

3.7.23 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			

3.8 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	

3.8.1 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			

3.8.2 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		

3.8.3 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			

3.8.4 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

3.8.5 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			

3.8.6 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.

3.8.7 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.		

3.9 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

3.9.1 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			

3.9.2 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.		

3.9.3 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			

3.9.4 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.		

3.9.5 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.

3.9.6 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.

3.9.7 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			

3.9.8 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.		

3.10 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

3.10.1 Discussion summary

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

3.10.2 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.

3.10.3 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			

3.10.4 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.		

3.10.5 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		

3.10.6 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.

3.10.7 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.

3.10.8 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.		

3.10.9 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.		

3.10.10 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			

3.10.11 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.		

3.10.12 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**		
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			

3.10.13 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.

3.10.14 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.

3.11 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	

3.11.1 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		

3.11.2 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			

3.11.3 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.

3.11.4 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.		

3.11.5 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

3.11.6 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			

3.11.7 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			

3.12 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

3.12.1 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.

3.12.2 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

3.12.3 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

3.12.4 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.		

3.12.5 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.		

3.12.6 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			

4 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.

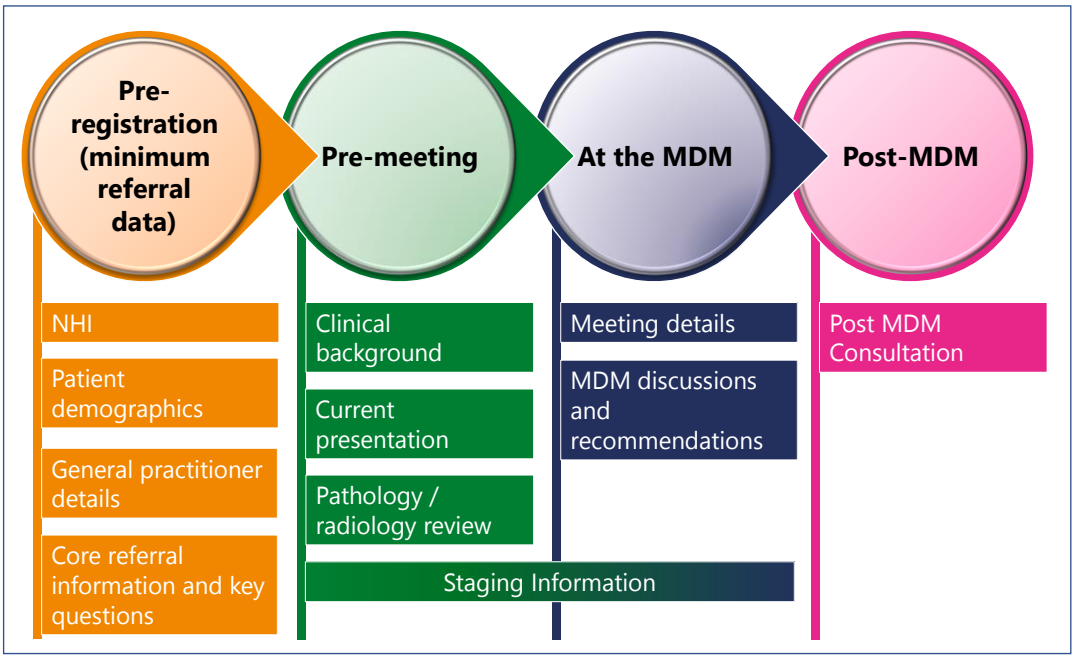
There is no set timeframe for the adoption of this standard, however these requirements should be included within any Request for Proposal (RFP) or similar process to procure an MDM IT system and should be met by any new MDM IT system implemented by the sector. HISO will work with the Cancer Control 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** See also: • HISO 10005:2008 Health Practitioner Index Data Set: **www.health.govt.nz/publication/hiso-100052008-health-practitioner-index-hpi-data-set** • HISO 10006:2008 Health Practitioner Index Code Set: **www.health.govt.nz/publication/hiso-100062008-health-practitioner-index-hpi-code-set**		
Data type	Alphanumeric	**Representational class**	Identifier
Field size	6	**Representational layout**	NNAAAA
Data domain	HPI 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

Name	MDM relevance
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