Specification for Revisions to the Elective Surgery Information System for 1 July 2008

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Executive Summary

Each year the Department of Human Services (DHS) reviews the data elements and format of the Elective Surgery Information System (ESIS) This review seeks to ensure that the elective surgery waiting list data collection supports the Department's state and national reporting obligations, assists DHS planning and policy development, and incorporates appropriate feedback from data providers on improvements.

The revisions to the ESIS for 1 July 2008 include:

- An additional data item *Date of Birth Accuracy Flag* to provide means of identifying that the reported Date of Birth is an estimate.
- Amendment to the code set for the *Indigenous Status* data item.

ESIS reporting hospitals are now required to arrange for their software to be modified in accordance with these revised specifications.

Introduction

The need for ESIS modifications

From 1 July 2008, a change to the ESIS is necessary to assist Victorian health program monitoring, planning and policy development.

Additionally, DHS has been undertaking development of the Common Client Data Set (CCDS) which aims to create greater alignment of data provided by funded organisations that describes persons in receipt of DHS funded services. Where possible, the ESIS has been modified to align with the CCDS.

Comments from hospitals and software suppliers regarding the content of the document *Proposals for Revisions to the Elective Surgery Information System for 1 July 2008, November 2007* have been taken into account, and where possible these suggestions have been accommodated.

Please note that items presented in the *Proposals for Revisions to the Elective Surgery Information System for 1 July 2008* may be altered from their initial presentation in that document.

Distribution and contents of this document

This document has been distributed to all Victorian hospitals, software suppliers known to have Victorian clients, and to a range of industry bodies and DHS staff. It provides the following information:

- Amended, deleted and new concept definitions, data items and business rules.
- Amended file structures.

Victorian hospitals are required to arrange for their software to be modified in accordance with the revised specifications.

The *ESIS Manual*, *11th Edition, July 2008* will be distributed at a later date.

Any questions related to this document may be directed to the HDSS Help Desk on 9096 8141 or HDSS.Help-Desk@dhs.vic.gov.au.

Outcomes of the *Proposals for Revisions to the ESIS* process

In November 2007, the *Proposals for Revisions to the Elective Surgery Information System for 1 July 2008* were released. The release of this document generated good feedback and discussion in Health Services and at the Department of Human Services.

Proposal 1: Add a new data item to record the accuracy of the date of birth
This proposal has been accepted. Feedback from hospitals indicated that the documentation provided regarding this item did not accurately reflect DHS' intentions for implementing this data item. The data item specification has now been rewritten to better reflect the intention of this data item.

Mesh Blocks for Geocoding addresses
Additionally, hospitals were asked to provide feedback regarding replacement of SLA with mesh blocks for geocoding addresses. Thank you to everyone who commented on this issue. Your feedback is being summarised for future DHS use, and for the Commonwealth for information.

Thank you to everyone who participated in this process. Your feedback and discussion is invaluable, and provides DHS with greater insight into hospital processes, resulting in better outcomes for everybody.

Orientation to this document

As this document details revisions to an existing dataset, there are a few features that require explanation:

- New values and definitions relating to existing items are highlighted in orange
- Changes to existing items are highlighted in green
- Redundant values and definitions relating to existing items ~~are struck through.~~
- Page numbers representing cross-referencing to another section of the ESIS Manual are represented by a hash (#).
- Edits with changes are marked with an asterisk (*) when listed as part of a Data Item or after an Edit Table.
- New edits are denoted by ###.
- The complete edit description for changed and new edits is listed in 'Section 7'.
- The text is divided into the categories of 'Specification' and 'Administration' as presented in the *Elective Surgery Information System* Manual.
  - *Specification:* details the reporting requirements for the item.
  - *Administration:* provides additional information including the purpose for the collection of the data item and the source of the code set and definitions.

This document is structured in the same order as the ESIS Manual. Revisions to a Section of the Manual are detailed under the appropriate Section heading. Where a Section has been omitted from this document, there are no revisions to that Section of the ESIS Manual.

ESIS Manual Content Summary

Section 1: Introduction
Provides information on the development and purpose of the ESIS data collection, scope and coverage, contact details and a list of relevant abbreviations.

Section 2: Concept and Derived Item Definitions
Provides definitions of concepts that are the foundation of the ESIS collection and information that the Department derives from the data submitted.

Section 3: Data Definitions
Details the specifications of data items relating to individual waiting episodes for reporting to ESIS. The data items are arranged in alphabetical order.

Section 4: Business Rules
Draws together business rules that incorporate a combination of two or more data items.

Section 5: Compilation and Submission
Specifies the required format of ESIS records submitted to HDSS. It includes details such as file naming conventions, file structures, reporting requirements and data security. This section also outlines the process of testing.

Section 6: Reports and Reconciliation
Details edit reports provided to each hospital, following the submission and processing of ESIS data and a guide to the reconciliation process of ESIS data with in-house data.

Section 7: Editing
Each ESIS edit message is listed in this section in numerical order. The entry for each edit message describes the problem and the remedy.

Section 8: Supplementary Code Lists
The supplementary code lists are comprised of reference files and code sets used in ESIS. Most code sets are short and are included in Section 3. The list of applicable reference files and code sets is listed below and files are available from the HDSS website at:
http://www.health.vic.gov.au/hdss/reffiles/index.htm

Abbreviations

CCDS	Common Client Dataset
DHS	Department of Human Services
DOB	Date of Birth
ESIS	Elective Surgery Information System
HDSS	Health Data Standards and Systems

Section Three: *Data Definitions*

Date of Birth

Revision Summary	Amend the reporting instructions for unknown Date of Birth to be consistent with advice in the new data item *Date of Birth Accuracy Code*.

Date of Birth *(Amended)*

Specification

Definition	Patient's Date of Birth.
Label	Date_Of_Birth
Field size	8 Layout DDMMCCYY
Reported in	Patient extract
Reported for	All patient level records.
Reported when	The patient is first registered on the waiting list for any episode.
Reporting guide	The Date of Birth must be on or before the Clinical Registration Date. **Unknown Date Of Birth:** ~~Estimate the year of birth and enter 0000 (zeros) in DDMM and the estimated year in CCYY.~~ ~~A date of '00MMCCYY' will not be accepted.~~ If the patient's Date of Birth is unknown, this should be estimated. If the patient's approximate age is known, then the Date of Birth should be estimated using the approximate age to calculate an estimated year of birth. Sentinel dates should not be used.
Edits	S082 Medicare Code '0' And Age Is Greater Than 180 Days S096 Date Of Birth Invalid S099 Clinical Registration Date Before Date Of Birth S409 Age Greater Than 105 Years
Related items	Section 3: *Medicare Number* and *Registration Date.*

Administration

Purpose	Used to derive age for demographic analyses.		
Principal data users	DHS		
Collection start	July 1997	***Version***	1 (Effective 1 July 1997)
Definition source	National Health Data Committee	***Codeset source***	N/A

Date of Birth Accuracy Code

Revision Summary	Introduction of a new data item *Date of Birth Accuracy Flag* to: • Improve data quality for the *Date of Birth* data item • Provide means of reporting that a Date of Birth is an estimate. This provides an alternative to health services using a default date specified by the individual service which is meaningless in a statewide context.
Implementation Information	Date of Birth Accuracy Flag may be defaulted to 'AAA' for all patients except those for whom the Date of Birth has been estimated. Where the Date of Birth has been estimated, ideally the accuracy of each segment of the date should be indicated. However, a default of 'EEE' will be acceptable. Therefore, a 'tick-box' system for this data item is considered sufficient. For systems using HL7, this data item would be included in the PID 32 segment. Where data is updated from other systems (for example, the patient administration system propagates data to the waiting list system) hospitals and vendors will need to develop and implement methods to ensure data is of known quality. Ideally, both systems will contain estimated date information. As this data item will be reported from 1 July 2008, hospitals are advised to commence collecting this item as soon as possible for new patients placed on the waiting list. For patients registered on the waiting list prior to 1 July 2008: • If the accuracy of the recorded Date of Birth is known, report according to the specification for this data item. • If the accuracy of the recorded Date of Birth is not known, report the Date of Birth Accuracy Flag as AAA—*Accurate*.

Date of Birth Accuracy Code *(New)*

Specification

Definition	A code representing the accuracy of the components of a date - day, month, year.		
Label	DOB_Accuracy_Code		
Datatype	Alpha	Form	Structured Code
Field size	3	Layout	AAA
Reported In	Patient extract		
Reported for	All patient level records.		
Reported when	The patient is first registered on the waiting list for any episode.		
Value domain	Value domain consists of a combination of three codes, each of which denotes the accuracy of one date component:		

Code	**Descriptor**
A	The referred date component is accurate
E	The referred date component is not known but is estimated
U	The referred date component is not known and not estimated.

This data element contains three positional components (DMY) that reflect the order of the date components in the format (DDMMYYYY) of the reported *Date of Birth*.

Component	**Descriptor**
1st – D	Refers to the accuracy of the day component.
2nd – M	Refers to the accuracy of the month component
3rd - Y	Refers to the accuracy of the year component

Reporting guide Any combination of the values A, E, U representing the corresponding level of accuracy of each date component of the reported date.

Where possible, report the accuracy of each date component. However, where software systems allow the collection of a binary value for Date of Birth Accuracy (that is the system has an 'Estimated Date of Birth' check box or similar) values such as 'AAA' and 'EEE' will be acceptable.

It is understood that the Date of Birth Accuracy Code will be reported as *'AAA'* unless the date has been flagged as an estimated date. It is not necessary to validate the Date of Birth provided by every patient unless there is a reasonable suspicion that the date provided is not correct. Where there is a question over the date provided, or where the patient is unable or unwilling to provide their date of birth, the date should be estimated and flagged as such.

If the date of birth is provided by a reliable source (for example the patient or close relative) and is known as accurate then the date accuracy indicator should be reported as *'AAA'*.

If the patient's approximate age is known, then the Date of Birth should be estimated using the approximate age to calculate an estimated year of birth. Sentinel dates should not be used. The Date of Birth Accuracy code would be reported as *'UUE'*, that is the day and month are 'unknown' and the year is 'estimated'.

A Year component value of *U – Unknown* is not acceptable.

Where the date part is accurate or estimated, the date part cannot be '00'.
Where the date part is unknown, the date part may be '00' or 'NN'.

Examples:

Valid combinations include:
DOB Accuracy = 'AAA', DOB = '03/11/1956'
DOB Accuracy = 'EEE', DOB = '03/11/1956'
DOB Accuracy = 'UUE', DOB = '00/00/1945'
DOB Accuracy = 'UUE', DOB = '01/01/1945'

Invalid combinations include:
DOB Accuracy = 'AAA', DOB = '00/00/1956'
DOB Accuracy = 'AAA', DOB = '00/06/1956'
DOB Accuracy = 'EEE', DOB = '00/00/1956'
DOB Accuracy = 'UUE', DOB = '00/00/0000'
DOB Accuracy = 'UEE', DOB = '00/00/1956'

Edits *###* Invalid Date of Birth Accuracy code

Related items Section 2: *Age*
Section 3: *Date of Birth*

Administration

Purpose Required to derive age for demographic analyses and for analysis by age at a point of time.

Principal data users Multiple internal and external research users.

Collection Start	2008-2009		
Definition source	NHDD (DHS modified)	Value Domain source	NHDD 294429

Indigenous Status

Revision Summary	Code values change as follows: • 5 changes to 1 • 6 changes to 2 • 7 changes to 3 • 2 changes to 4 The wording of the code descriptions have changed slightly but the meaning is unchanged. Codes 8 and 9 remain unchanged. This change aligns the ESIS with the DHS Common Client Data Set

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Indigenous Status *(Amended)*

Specification

Definition

An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.

Label

Indigenous_Status

Field size

N/A

Valid values

Code from Indigenous Status codeset

Reported in

Patient extract

Reported for

All patient level records

Reported when

The waiting list episode is first registered and whenever the field is updated. This field should be updated on each occasion that any other demographics are updated.

Code set

Code	***Descriptor***
1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin
~~2~~	~~Not indigenous – *Not* Aboriginal or Torres Strait Islander origin~~
~~5~~	~~Indigenous – Aboriginal but not Torres Strait Islander origin~~

~~6~~	~~Indigenous - Torres Strait Islander but not Aboriginal origin~~
~~7~~	~~Indigenous - Aboriginal and Torres Strait Islander origin~~
8	Question unable to be asked
9	Patient refused to answer

Reporting guide

A person of Aboriginal descent is a person descended from the original inhabitants of Australia.

The Torres Strait Islands are the islands directly to the north of Cape York, between Cape York and New Guinea.

In Victoria, the community of Torres Strait Island people is small and the community of people of Aboriginal and Torres Strait Island people is smaller again, therefore code ~~6~~ 2 ~~Indigenous-~~Torres Strait Islander but not Aboriginal origin and code ~~7~~ 3 ~~Indigenous-~~Aboriginal and Torres Strait Islander origin would not be widely used.

Code 8 *Question unable to be asked* should only be used under the following circumstances:

- When the patient's medical condition prevents the question of Indigenous Status being asked; or
- In the case of an unaccompanied child who is too young to be asked their Indigenous Status.
- Where registration for a waiting list episode occurs without the patient being present and cannot be determined from the information supplied. In this case it is expected that Indigenous Status will be updated prior to or at admission.

This information must be collected for every admitted patient episode and updated each time the patient represents to the hospital for admission.

Systems must not be set up to input a default code.

Rather than asking every patient about his or her indigenous status, first ask the patient. 'Were you born in Australia?'

- If No, the patient should be asked 'What country were you born in?
- If Yes, the patient should be asked Are you of Aboriginal or Torres Strait Islander origin?

If the patient answers Yes to being of Aboriginal or Torres Strait Islander origin, then ask further questions to record correctly the person's indigenous status.

Patient is baby or child

The parent or guardian should be asked about the indigenous status of the child. If the mother of a newborn baby has not identified as being of Aboriginal or Torres Strait Islander descent, hospital staff should *not* assume the baby is non-Aboriginal; the father may be of Aboriginal or Torres Strait Islander descent.

For further information refer to the Principles of recording Aboriginal Status in Victoria, available on the internet at:

http://www.health.vic.gov.au/koori/

Episodes registered before 1 July 2005
For episodes registered prior to 1 July 2005, if the patient's indigenous status is already stored in the reporting organisation's PMI, then report the existing value (assuming it is valid). For those patients where no value has been recorded, report code 8 *Question unable to be asked*. Indigenous Status should then be updated on the next occasion the patient's other demographic details are updated.

Edits *S425 Indigenous Status Invalid

Administration

Purpose To:

- Enable planning and service delivery, and monitoring of indigenous health at state and national level.
- Facilitate application of specific funding arrangements.

Principal data users Koori Health Unit (Public Health, DHS).

Funding, Health and Information Policy Branch (Metropolitan Health and Aged Care Services, DHS).

Collection start	July 2005	***Version***	1 (Effective 1 July 2005) 2 (Effective 1 July 2008)
Definition source	NHDD	***Codeset source***	NHDD (DHS modified)

Section 5: *Compilation and Submission*

Guidelines for patients remaining on the waiting list on 30 June 2008

All ESIS extracts with an Extract End Date **prior to 30 June 2008** should be reported in the 2007-2008 format.

ESIS extracts with an Extract End Date **after 30 June 2008** must be reported in the 2008-2009 format according to the amended reporting requirements outlined in this document.

See *Date of Birth Accuracy Flag* on page 6 for information on reporting this data item for patients registered prior to 1 July 2008.

Extract Structure

Patient Extract *(Amended)*

Revision Summary	Alter the Patient Extract structure to include the new data item *Date of Birth Accuracy Code*.

Note	Data Item	Label	Field size	Layout/Code Set
M	Patient Identifier	Patient_Identifier	10	XXXXXXXXXX
M	Date Of Birth	Date_Of_Birth	8	DDMMCCYY
M	Date of Birth Accuracy Code	DOB_Accuracy_Code	3	NNN
M	Indigenous Status	Indigenous_Status	N/A	Code from code set
M	Sex	Sex	N/A	Code from code set
1	Medicare Number	Medicare_Number	11	NNNNNNNNNNN or blank
M	Medicare Suffix	Medicare_Suffix	Between 1 and 3 characters.	AAA, AA, A'A, AA', A, A-A, AA-
M	Postcode	Postcode	N/A	Code from code set
M	Locality	Locality	N/A	Code from code set

Section 7: *Editing*

Amended Edit

S425 Indigenous Status Invalid *(Amended)*

Effect REJECTION

Problem An Indigenous Status code has not been reported or the code specified does not exist in the Indigenous Status code set.

Modify for amended codeset.

Remedy Correct or allocate the Indigenous Status and resubmit.

Refer: Section 3: *Indigenous Status*.

New edit

Invalid Date of Birth Accuracy code (*New*)

Effect REJECTION

Problem This record's Date of Birth Accuracy code is null or invalid.

Remedy Check Date of Birth Accuracy for valid format and values.