

## Auckland Regional Public Health Service

Rātonga Hauora ā Iwi o Tamaki Makaurau



Working with the people of Auckland, Counties Manukau and Waitemata

## Auckland Regional Public Health Service

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### **Submission from the Auckland Regional Public Health Service on the *EpiSurv* Minimum Datasets for Local and National Surveillance Consultation Document**

1. Thank you for the opportunity for the Auckland Regional Public Health Service to provide a submission on the EpiSurv Minimum Datasets for Local and National Surveillance consultation document.
2. This submission represents the views of the Auckland Regional Public Health Service (the Service). The Service provides public health services for the three district health boards in the Auckland region (Auckland, Counties Manukau and Waitemata District Health Boards), with the primary governance mechanism for the Service resting with Auckland District Health Board. This submission represents the views of the Service and does not necessarily represent the views of the three District Health Boards.
3. The Service understands that all submissions will be available under the Official Information Act 1982, except if grounds set out under the Act apply.
4. The primary contact point for this submission is:

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## Data usage categories applied to existing case report form data items

5. The Service supports the general approach taken by ESR to group case report form data items into categories based on how the information is likely to be used. Historically, much locally unnecessary case information has been collected by the Service under the belief that this information would be useful at a national level. Clearly categorising data items as either 'core surveillance', 'case management' or 'optional' (i.e. for local use) transparently identifies the intended audience for the information.
6. The Service also supports the general approach taken by ESR to identify a set of data items for core surveillance, and to use this dataset as the basis for an EpiSurv quality assurance programme. This will contribute to improved consistency of data collection around New Zealand, enable better inter-regional comparisons, and increase the value of the notifiable disease surveillance dataset for analysis.
7. While endorsing moves to improving quality of the core surveillance dataset, the Service also recognises that the benefits of quality improvements come at the cost of greater resource commitments at the point of data entry. In order to fully assess the likely resource impacts at a local level of re-categorising data items as core surveillance data, and therefore to judge whether to give this initiative full support, the Service would like to receive more detail on the nature of the proposed EpiSurv quality assurance (QA) programme (p5). For instance, will QA measures be primarily passive (at one extreme, QA measures may just provide feedback on data completeness) or active (at the other extreme, QA measures may impose restrictions on ability to close case report form or proceed in data entry until specific fields are completed)? What monitoring or auditing of our data collection is proposed, and what (if any) the privacy implications will this have for us?
8. The Service's concerns about the level of quality assurance oversight are based on its current practice in investigating, and collecting information on, enteric disease cases. Several data items categorised as core surveillance in the discussion document are currently collected on only a minority of enteric cases by the Service. The Service prioritises investigation of most sporadic enteric disease cases to those of high public health risk only, according to the following disease-specific criteria:

<b>Selected diseases*</b>	<b>Criteria for investigation (and complete data collection) of sporadic** cases</b>
Campylobacteriosis	Food handlers, health care workers only.
Giardiasis	Food handlers, healthcare workers, early childhood centre workers, children aged <5 years only.
Yersiniosis	None investigated.

\* All sporadic cases of other diseases recorded using the Enteric case report form (salmonellosis, shigellosis, cryptosporidiosis, VTEC, listeriosis, typhoid fever, paratyphoid fever and cholera) are fully investigated.

\*\* Note that this applies to sporadic cases only. Full investigation and data collection occurs of cases occurring in clusters or linked to a common source.

9. Therefore, information collected by the Service on enteric disease cases not identified as high risk is restricted to that provided by the notifier in the first instance, and is often limited to the case's name, address, age or date of birth, and diagnosis. Other data items identified in the discussion document as core surveillance data items, that are not likely to be consistently collected on enteric disease cases not identified as high risk, include the following:
- NHI number
  - Sex
  - Ethnicity
  - Date of onset
  - [Whether case] hospitalised
  - [Whether case] died
  - Water supply code (see below)
  - Overseas travel (entire section)
  - Source (entire section)

The Service does not consider that the benefits to our local disease control activities of complete collection of this information for non-high-risk enteric disease cases outweigh the resource costs in doing so. If full collection of this information was required of the Service for the purposes of development of a core surveillance dataset, this would have considerable resource implications that would need to be discussed with our funder.

10. The Service also has reservations about the categorisation of water supply code data items as core surveillance for all enteric disease cases. These data items are not routinely available, and Service staff involved in data entry do not have access to up-to-date lists of water supply codes by addresses. The Service recommends that, if these data items are to be considered part of the core, an electronic up-to-date list of water supply codes linked to addresses or geocodes should be integrated with the EpiSurv software so that the water supply code fields are populated automatically following entry of the case's current address or school/workplace address.
11. The Service considers that it will be difficult to maintain high-quality data collection of core surveillance data items that remain free-text fields, such as occupation, other specified ethnic group, and hospital name. The Service recommends that ESR consider, where feasible, introducing drop-down lists or some other form of standardised indexed list for these data items.
12. While not categorised as core surveillance data items, the Service recommends that similar standardised index lists be introduced for key disease management fields such as school or pre-school name. Such a list would need to be sufficiently dynamic to accommodate establishment, closure or name-changes of schools and pre-schools. In the absence of any national standard, local public health units may be innovating their own index lists; greater consistency would be achieved if a national approach was taken.

### **Changes to case report forms**

13. The Service supports all additions to case report forms proposed in the consultation document, with the exception of one comment on the TB Case Report Form. The 'time of onset' (underneath 'date of onset') isn't necessary for TB and would be very difficult to provide a meaningful and accurate answer.

14. The Service supports all alterations to existing case report form data items proposed in the consultation document.
15. ARPHS supports all deletions of existing case report form data items proposed in the consultation document.
16. The Service recommends that the following further alterations are made to the existing case report forms:
  - Include data item for nil or unknown NHI number (or retain an option to leave the NHI Number blank).
  - In Case Management section of Pertussis case report form, include question asking whether the case received two week course of erythromycin.
  - In Laboratory Criteria section of Tuberculosis case report form, enable multiple disease sites to be entered into each laboratory category (i.e. it is not unusual to have a case that is culture positive both in sputum and in another extrapulmonary site). At present, data can only be entered in one or the other field.
  - The current question about HIV testing in the Risk Factors section of the Tuberculosis case report form has little value, either for case management or for surveillance, because measuring the prevalence of HIV testing in TB patients is much less important than knowing the prevalence of TB/HIV co-infection. More useful information on TB/HIV co-infection would be collected if the question was reworded as “Does patient have HIV infection”. If this option is not acceptable, then the focus of the questions should be to guide researchers to the group of cases in whom HIV/TB co-infection is most likely, should a retrospective case review be performed (with supporting ethics committee approval) in the future. To rationalise the number of patient charts that would need to be reviewed, the first question should be retained as “Has HIV test been performed” but the next question reworded as “Patient has immunosuppressive illness” (i.e. deleting the word “other”). In that way, HIV positive patients would have “Yes” ticked for both these questions, and no chart review would be necessary for patients found to be HIV negative on testing (and with no other immunosuppressive illness).

## **Conclusion**

The Service supports the overall aim of the suggested changes to the EpiSurv Minimum Datasets for Local and National Surveillance consultation document. However, improving the completeness of data collection for enteric disease data items identified in the core surveillance dataset will have substantial resource implications for the Service. The Service believes that incorporating its suggested changes to the consultation document will improve the ease of data collection, its accuracy and the functionality and utility of the data collected.

Yours sincerely

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