

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the Healthiest State in the Nation

EMSAC Data Committee/ Meeting Minutes *In Person & Virtual*

June 14, 2023

1:30 pm– 3:00 pm

Committee Members Attending		State Office Staff Attending	
<ul style="list-style-type: none"> • John Simpson • Rodney Mascho • Anthony Tedesco • Patricia Byers 	<ul style="list-style-type: none"> • Ian Womack • Ken Devin (online) • Phyllis Hendry • Colin Johnson (online) 	<ul style="list-style-type: none"> • Brenda Clotfelter • Thomas DiBernardo 	<ul style="list-style-type: none"> • Sri Kiran Botta
Other In Person Attendees			
<ul style="list-style-type: none"> • Tizita Walde • Stephanie Lucce • Michael Rodriguez • Emily Myers • Salome Lofty • Gilbert Martin • Xavier Jones • Wil Sanchez • Bret VanDeman 	<ul style="list-style-type: none"> • Brett Justice • Pennie Eggers • Dustin Sheckler • Rick Clow • Bilie Williams • Steve Mason • John Gatlin • Andrew Brown 	<ul style="list-style-type: none"> • Paul Shannon • Stephen Cherry • Mike Carpenter • Bill Gorham • Mark Womach • Mike Fonte • Scott Egan • Paul Shannon 	<ul style="list-style-type: none"> • Maria Fernandez • Brian Berson • Evan Spence • Glenn Joseph • Tami Stafford • Robert Jorge • Karl Bennett • Shari Surdovel
Other Online Attendees			
<ul style="list-style-type: none"> • Charles Felton • Robert Ford 	<ul style="list-style-type: none"> • Toddy Hockert • Joanna Zarzycki 	<ul style="list-style-type: none"> • Smitha Madireddy • Prudvhi Alugubelli 	<ul style="list-style-type: none"> • Leyna Lacognata • Morgan Henson
Review/Approval of Prior Meeting Record			
<ul style="list-style-type: none"> • Motion by Dr. Byers and second by John Simpson to approve minutes for January 18, 2023. Passes unanimously. 			

Proposed State Plan Updates

Objective 1.1.C - By December 31, 2028, improve data submission quality, specifically fully validated submissions, from 38% in 2023 to 90%. (Data)

Objective 1.1.D - By December 31, 2028, increase the number of electronic patient care records (ePCR) submitted to the EMS Tracking And Reporting System (EMSTARS) from 79% in 2023 to 95%. (Data)

Objective 1.4.A - By December 31, 2028, increase Health Information Exchange (HIE) outcome data matching to EMS records from 21% in 2023 to 75%. (Data)

Objective 1.5.A - By December 31, 2028, increase the number of peer-reviewed EMS-related journal articles to which the Department contributed from 0 in 2023 to 25, in aggregate. (Data)

Objective 5.1.A By December 31, 2028, increase number of EMS research projects that the department participates from 3 in 2023 to 5. (Data)

Objective 5.2.B By December 31, 2028 increase the number of predictive analytical reports from 0 in 2023 to 10. (Data)

Objective 5.2.C By December 31, 2028 increase the number of collaborative programs with county health departments bi directionally exchanging bio-surveillance data with EMS providers, to identify emerging health threats from 2 to 67. (Data)

5

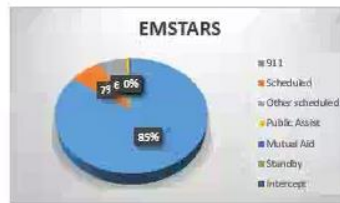


State Plan Updates



A. Identify all categories of EMS services that are provided by EMS agencies (not collected via EMSTARS) and develop recommendations for the statewide collection and reporting of aggregate data by December 2025

98%



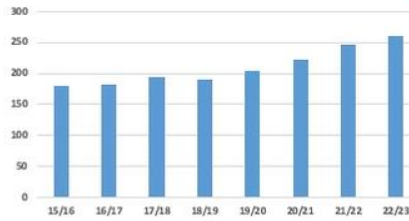
State Plan Updates



B. Increase % of EMS agencies submitting to state incident level repository to 100% by 12/30/25

83%

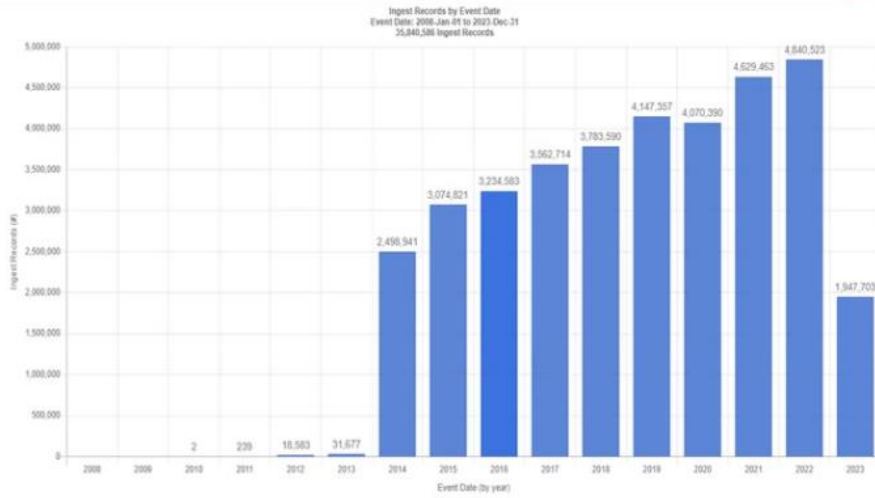
EMSTARS Agencies



314 Total Licensed Agencies
261 (+5 agencies) in EMSTARS
4 Pending
47 Aggregate



biospacial Event Counts by Year



8



- Data prior to 2014 is available in state repository for researchers.

State Plan Update



C. Develop an implementation plan to increase the number of automated data linkages between EMSTARS and other related databases by December 2025

C.1 Research and make a recommendation for the most up-to-date and accurate method of performing EMS to other EHR data linkage (deterministic vs probabilistic linkage; use of multiple imputation, etc.)

Current,

- Crash
- Essence
- HIE
- **Florida Stroke Registry – in progress**

Action Items:

Conduct Linkage Needs Assessment - no progress

Dr. Fish, Ian Womack, Brenda, John and Rodney

Develop Linkage Methodology

Develop implementation plans

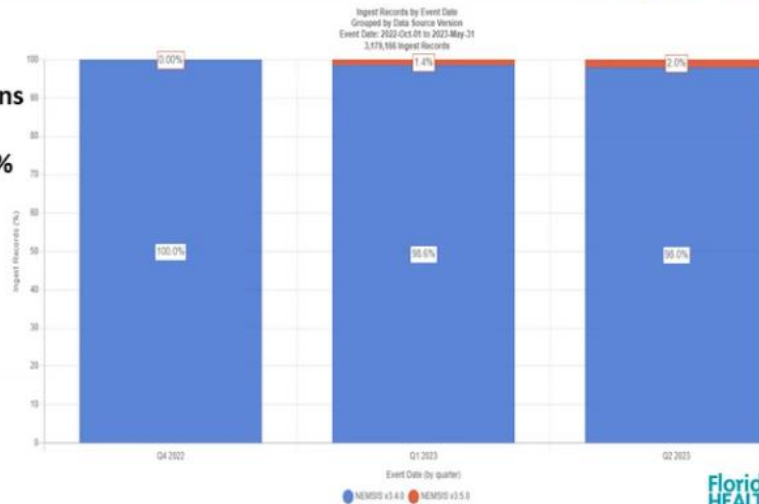


State Plan Updates



D. Of those EMS Runs submitted to EMSTARS; Increase % of NEMSIS V3.4 or higher to 95% by December 2025.

**2%
V3.5**



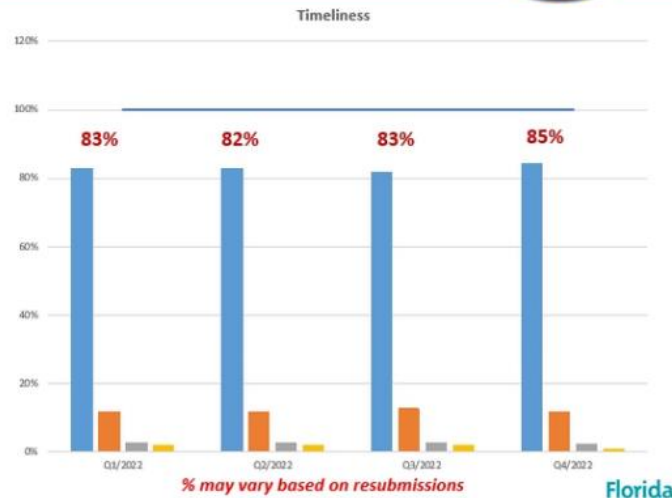
State Plan Updates



E. Increase % of V3 EMS emergency run reports received within 10 hours of the run to 85% by December, 2025

85%

Q4/2022



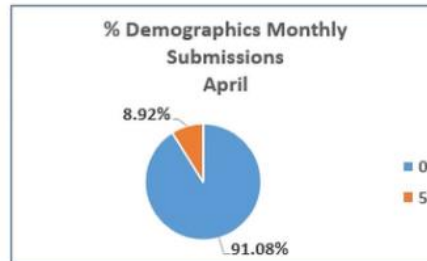
Florida HEALTH

State Plan Updates



E.1 Increase % of agency Demographic records resubmissions received every 30 days by December, 2025

- ✓ Defining measurements – complete
- ✓ Developing baseline – 8.92% as of 4/23
- ✓ Monitoring/Reporting on measurements – 4/23



Florida HEALTH

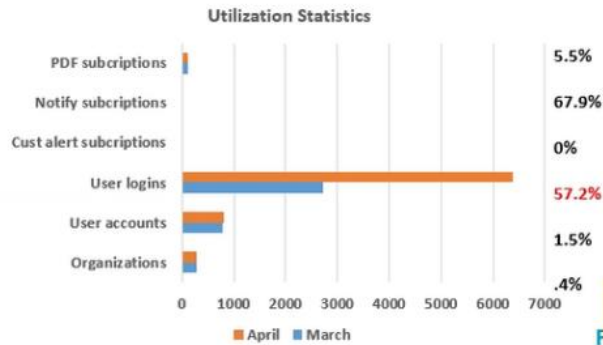
- Agencies should be working towards this being automatic in V3.5

FY 22/23 Objectives



- Continuing to utilize biospatal for repository and data accessibility
 - ❖ Increase provider utilization of Biospatial reporting from 10% to 50%

Accessibility Work in Progress



State Plan Update

Next Steps

- Await final approval of Strategic Plan & Committee Assignments
- Draft action plan to further accomplishment of strategic objectives assigned
- Review and finalize action plan
- Track/report on action plan

14



- As a committee, we will decide during working group as to which of the old measures we want to keep internal to the Data Committee even though it is no longer part of the state plan.
- We need to add Trauma Registry to planned link list.

EMS Data in
the Florida
Stroke
Registry:
Past and
Future

Hannah Gardener, ScD
Director of the Biostatistics Core of
the Florida Stroke Registry
Assistant Professor, Department of
Neurology
University of Miami Miller School of
Medicine

The Florida Stroke Registry (FSR)



Established and Founded by Ralph L Sacco MD, MS



FSR ADVISORY COMMITTEE

- JOSE G ROMANO MD
CO-CHAIR
 - TATJANA RUNDEK MD PHD
CO-CHAIR
 - PETER ANTEVY, MD
 - AL BROTONS, EMT-P
 - WILLIAM SCOTT BURGIN, MD
 - TERESITA CASANOVA, MD
 - DIANNE FOSTER (AHA)
 - ANTONIO GANDIA, MD
 - RICARDO HANEL, MD, PHD
 - JONATHAN HARRIS, MD
 - TARA HYLTON, MPH (DOH)
 - ANGUS JAMESON, MD
 - GERARD JOB, MD
 - NILS MUELLER-KRONAST, MD
 - BRIJESH MEHTA, MD
 - MAX MOKIN, MD
 - TERRY NEILL, MD
 - PAUL PEPE, MD
 - DAVID ROSE, MD
 - CHARLES SAND, MD
 - KENNETH A SCHEPPKE, MD
 - DILEEP YAVAGAL, MD
- FSR EXECUTIVE COMMITTEE

FLORIDA STROKE REGISTRY ORGANIZATIONAL CHART



Overview of the FSR: Funding and Milestones

Florida
Puerto Rico
Collaboration to
Reduce Stroke
Disparities
(FL-PR CReSD)



Florida
Stroke Registry
(FSR)

[Florida state
statute 395.30381](#)



- + 1 of 13 states awarded the **CDC** Paul Coverdell National Acute Stroke Registry (3 years funding)
- + FSR mission: To drive an effective system of stroke care in Florida

2012

2017

2018

2019

2020

2021

2022

2023

- + Quality improvement, ID and address disparities

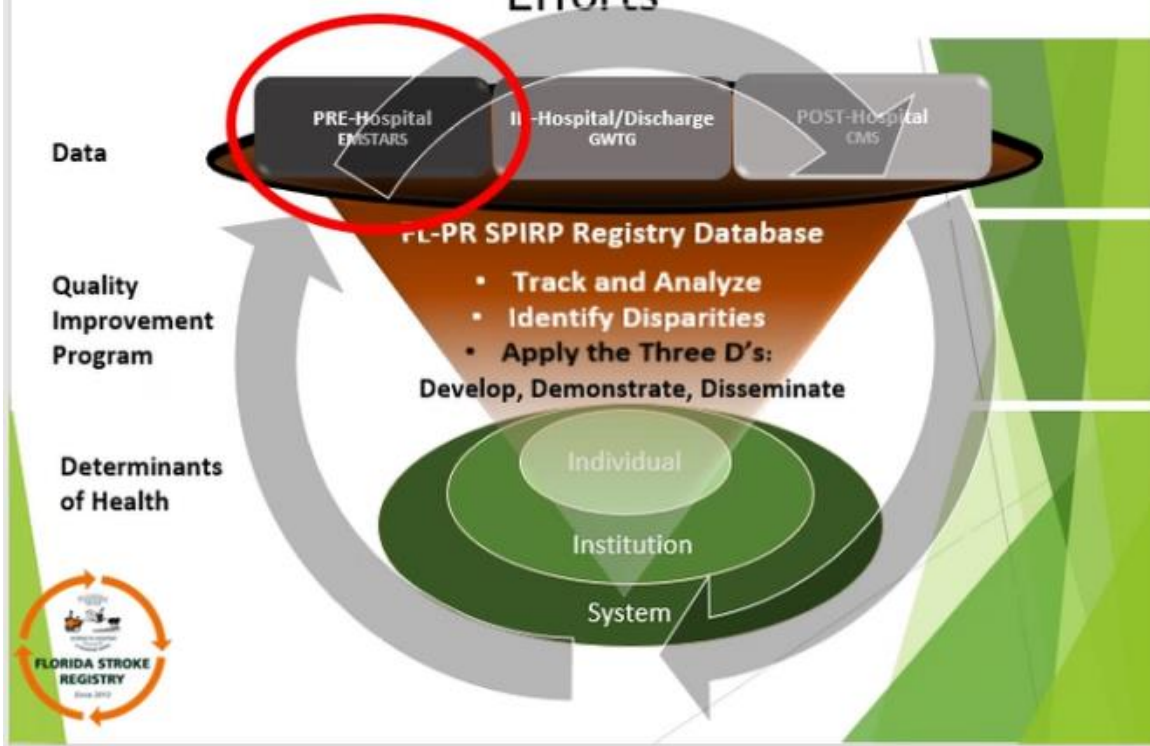
- + Enhance the FSR data infrastructure (collecting pre and post hospital stroke data)
- + Encourage EMS/hospital collaboration
- + Increase FSR stakeholders to include multidisciplinary membership
- + Facilitate establishment of local stroke coalitions



Coverdell: Drive A Complete Stroke System of Care

- ▶ Improve our understanding and implementation of stroke care and prevention opportunities in Florida
 - ▶ Expand data collection from pre-stroke interactions with healthcare providers to post-hospital transitions of care and long-term outcomes
 - ▶ Prioritize the continuum of stroke care, including pre-hospital and post-hospital systematic data collection
- ▶ Elucidate opportunities for stroke prevention in the community and improved recovery post-stroke

PRE-Hospital Data Collection Enhancement Efforts



Published in final edited form as:
Prehosp Emerg Care. 2019; 23(4): 439-446. doi:10.1080/10903127.2018.1525458.

The Need to Prioritize Education of the Public Regarding Stroke Symptoms and Faster Activation of the 9-1-1 System::

Findings from the Florida-Puerto Rico CReSD Stroke Registry

Hannah Gardener, ScD¹, Paul E. Pepe, MD, MPH², Tatjana Rundek, MD¹, Kefeng Wang, MS¹, Chuanhui Dong, PhD³, Maria Ciliberti, MPH¹, Carolina Gutierrez, PhD³, Antonio Gandia, MD³, Peter Antevy, MD⁴, Wayne Hodges, RN⁵, Nile Mueller-Kronast, MD⁶, Charles Sand, MD⁷, Jose G. Romano, MD¹, and Ralph L. Sacco, MD¹

¹University of Miami Miller School of Medicine, Miami, FL

²The University of Texas Southwestern Medical Center, Dallas, TX

³Mount Sinai Medical Center, Miami, FL

⁴Joe DiMaggio Children's Hospital, Hollywood, FL

⁵University of Florida Health-Jacksonville, Jacksonville, FL

⁶Delray Medical Center, Delray Beach, FL

⁷St. Joseph's Hospital, Tampa, FL

Abstract

Objective: Demographic differences (race/ethnicity/sex) in 9-1-1 emergency medical services (EMS) access and utilization have been reported for various time-dependent critical illnesses along with associated outcome disparities. However, data are lacking with respect to measuring the various components of time taken to reach definitive care facilities following the onset of acute stroke symptoms (i.e., stroke onset to 9-1-1 call, EMS response, time on-scene, transport interval) and particularly with respect to any differences across ethnicities and sex. Therefore, the specific aim of this study was to measure the various time intervals elapsing following the first symptom onset (FSO) from an acute stroke until stroke hospital arrival (SHA) and to delineate any race/ethnicity/sex-related differences among any of those measurements.

Methods: The Florida-Puerto Rico Stroke Registry (FLPRSR) is an on-going, voluntary stroke registry of hospitals participating in the *Get with the Guidelines-Stroke* initiative. The study population included patients treated at Florida hospitals participating in the FLPRSR between 2010 and 2014 who had called 9-1-1 and were managed and transported by EMS. In total, 10,481 patients (16% Black, 8% Hispanic, 74% white) had complete data-sets that included birthdate/year, sex, ethnic background, date/hour/minute of FSO and date/hour/minute of EMS response, scene arrival and SHA.



What we knew

- ▶ There are race/ethnic disparities in acute stroke care in the hospital
- ▶ Disparities in care may begin at first contact with EMS
- ▶ Time from symptom onset to medical treatment predicts stroke mortality and disability
- ▶ EMS transport is associated with shorter arrival time, shorter time to CT, shorter door-to-needle times
- ▶ Race/ethnic and sex differences in EMS use reported in GWTG: Women>Men, Whites>Hispanics
 - ▶ Even after adjusting for stroke symptoms



Goal

- ▶ Disparities in EMS care may impact both stroke care at the hospital and stroke outcomes, and may account for race/ethnic disparities in these outcomes
- ▶ Goal: Examine whether there are race/ethnic differences in EMS contact times
- ▶ Novelty: First study to link EMSTARS with GWTG-S data

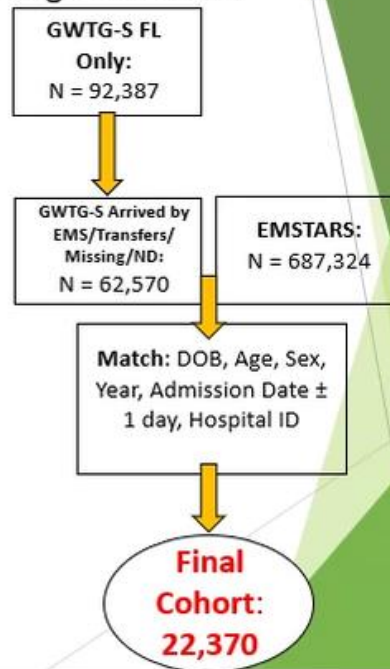


PRE-Hospital Data Collection Enhancement Efforts

EMS-AHCA Linkage

The image shows a screenshot of an EMS form titled "Get With The Guidelines 4 Stroke 10 Best Practice Public Eye Form". Below it is the "Emergency Medical Services Tracking and Reporting System" document, Version 3, which includes a map of Florida and the text "EMS Data Standards". A circular logo for the "FLORIDA STROKE REGISTRY" is also visible.

Merge Flowchart



Study Population

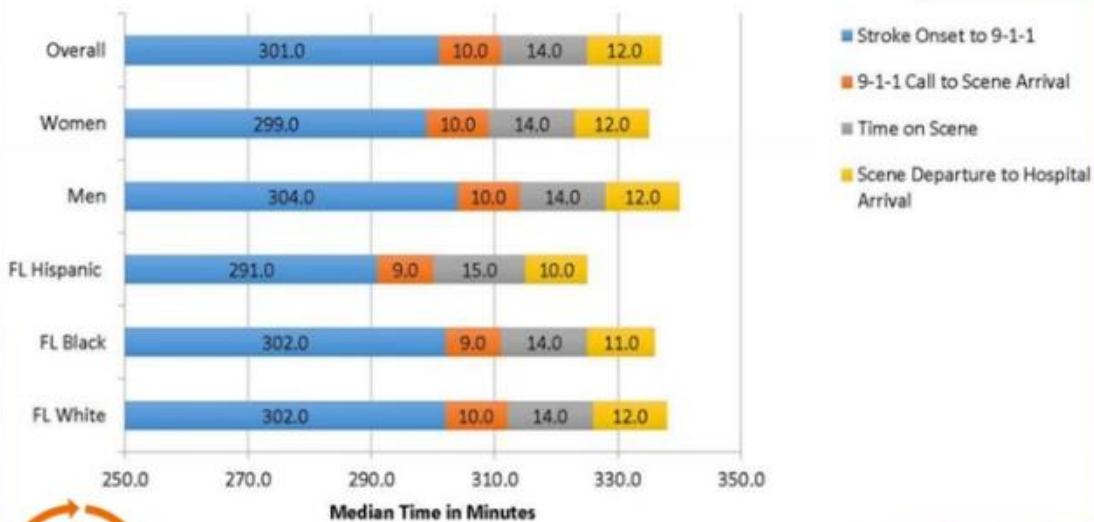
- ▶ **10,481 Stroke Cases**
 - ▶ Called 9-1-1
 - ▶ Transported directly to a stroke facility
 - ▶ Data available on demographics and stroke severity
 - ▶ Data available on time of symptom onset, time to 9-1-1 call, time arrived on scene, time left scene, arrival time at hospital
 - ▶ Excluded outliers: FSO to 9-1-1 call (two days), 9-1-1 call to EMS arrival on-scene (>100 minutes), EMS time on scene with patient (>60 minutes) and scene departure to hospital arrival (>140 minutes)
- ▶ 16% Black, 8% Hispanic, 74% White, 51% Women
- ▶ Symptom onset to hospital arrival: 339 (5 hours, 39 minutes) with an interquartile range (IQR) of 284 to 442
 - ▶ White: 340, Black: 337, Hispanic: 327 minutes



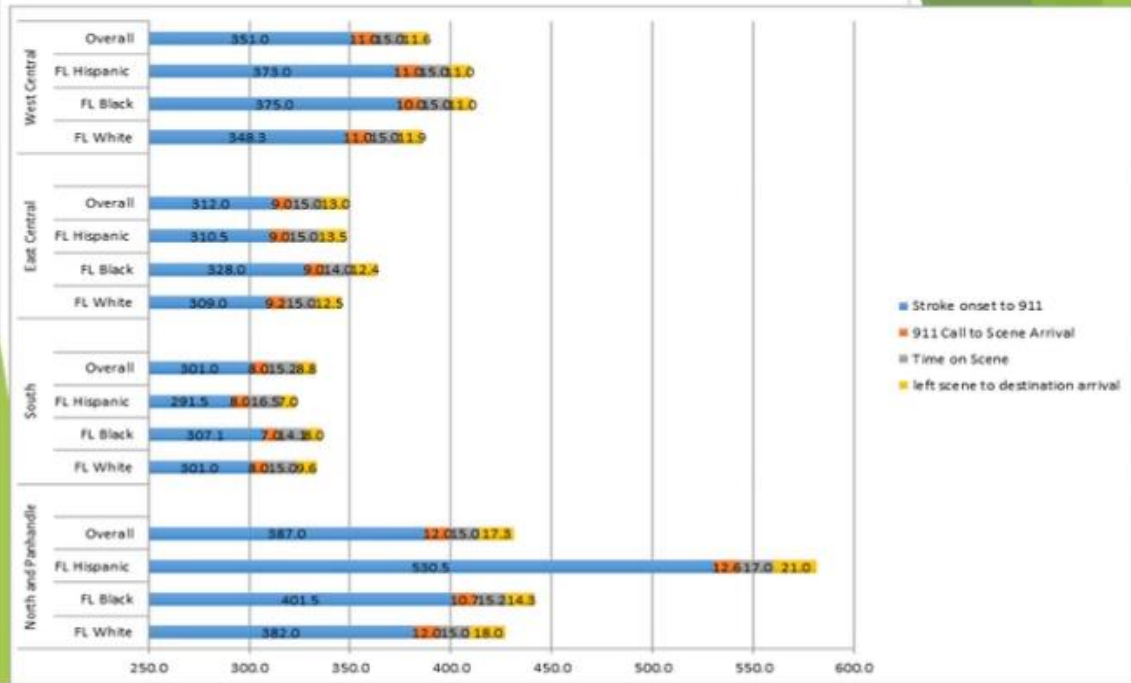
Time Line:



Disparities in EMS

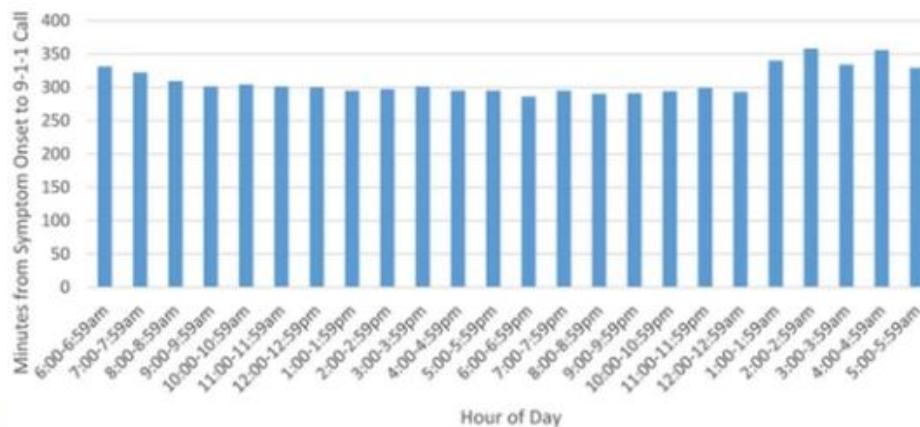


Regional Analyses



Impact of Hour of the Day

Median Minutes Elapsed from Stroke Symptom Onset to 9-1-1 System Activation, Stratified by Time of Day



Time elapsed from FSO to the 9-1-1 call was slightly longer between 1:00 am to 7:00 am, with median timespans approximately 5.5 to 6 hours during those hours compared to ~5 hours for all other hours of the day. Total EMS time intervals (9-1-1 response to SHA) remained relatively consistent throughout the daily cycle.

Conclusions

- ▶ The short race/ethnic differences observed in time spans from symptom onset to hospital arrival among EMSTARS patients were not clinically-significant.
- ▶ Following acute stroke onset, time elapsed for EMS response and transport is relatively short compared to the lengthy intervals elapsing between symptom onset and 9-1-1 system activation, regardless of demographics.
- ▶ Calls for an urgent reappraisal and re-invention of public education and interventions regarding identification of acute stroke symptoms as well as stressing the importance of making 9-1-1 calls immediately following onset of those symptoms.
- ▶ Exploration of innovative strategies to improve public education regarding stroke symptoms and immediate 9-1-1 system activation are strongly recommended.
 - ▶ Interventional programs should be tailored in culturally-specific ways
- ▶ Data limitations: Linkage of datasets was not optimal, only a third of patients were linked
 - ▶ Study sample likely represented more of an ideal situation



Conclusions

- ▶ Rapid stroke recognition by the patient, family, friends and the public with immediate EMS activation are the main barriers causing delays in stroke care, regardless of racial/ethnic background, sex or EMS system interface
- ▶ Reasons that demographics could impact time to activate 9-1-1:
 - ▶ Lack of medically-related public education, language barriers, communication sources, cultural perspectives, domestic circumstances, socio-economic barriers, prior experiences with the healthcare system, financial issues/barriers, cultural stoicism versus cultural proclivity to call for help.



Next Steps

- ▶ Replicate this study in an updated linked dataset with more EMS data inclusion
- ▶ Have race, ethnicity, sex, or geographic disparities emerged over time?
- ▶ Has the time from stroke onset to 911 call decreased over time?
- ▶ Examine the independent effects of race/ethnicity and EMS contact times with stroke care at the hospital and stroke outcomes.



Thank you BEMO

- ▶ Ability to reevaluate the trends in 911 activation and time to arrival
- ▶ Translate data into action
- ▶ Strengthen data inter-operability
- ▶ Support community outreach and health literacy for stroke education

V3.5 Implementation

**Are you
ready for
V3.5?**

16

Florida
HEALTH

V3.5 Implementation



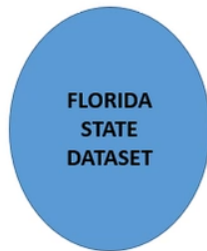
**Update to the Florida
Data Dictionary with
business rules for
NEMESIS 3.5**

- ✓ Completed Updated Data Dictionary to include Iteration 1 and 2 Business Rules – May 2023
- ✓ Working with Vendors to ensure V3.5 readiness
- ✓ Developed V3.5 Implementation Toolkit for EMS agencies for transition

Florida
HEALTH

State Data Set

EMS agencies and their software vendors must obtain information about their state's EMS data requirements in order to properly configure their patient care reporting software. This provides a consistent format in which to share NEMSIS V3 state-specific information.



- Custom data elements
- State Required Elements
- State-recognized certification/licensure levels
- State-permitted procedures
- Medications
- Protocols
- EMS agencies
- Facilities (such as hospitals)

Vendors of local-level systems are expected to build into their systems the ability to process StateDataSet files as part of your configuration

Florida
HEALTH

Updates to State Data Set

Facilities

- Updates received from AHCA and updated as follows:
 - biospatial – each Monday
 - NEMSIS – Monthly
 - Contact Data Staff for questions

Procedures and Medications

- Updates to Procedures/Medications posted on NEMSIS website monthly
 - Agency identifies recommended modifications/additions
 - Submit to Data Staff for EMS SME review
- Notification of updates

19

Florida
HEALTH

Implementation of Florida V3.5 Business Rules



A vendor system **MUST** be capable of performing Schematron validation on a NEMESIS XML document using multiple Schematron files (such as national, state, and local Schematron files). A system **SHOULD** process national rules **first**.

A vendor system that collects and sends data **MUST** validate each record (agency demographic report or patient care report) when it is finalized (when data entry is completed by **an EMS professional**) and any time it is **subsequently modified**. The system **MUST** present natural language assertion text to the user in order for action to be taken on failed assertions.

A vendor must determine record validity based on severity levels in the following way: • [FATAL]: • [ERROR]: • [WARNING]:



V3.5 Implementation

Vendor State of Readiness

Vendor	# of Agencies		NEMESIS v3.5	Florida V3.5 Validated
ESO Solutions	98		Yes	Target July
Zoll	53		Yes	
Image Trend, Inc.	33		Yes	In progress
Documed	15		No	
EMSCharts, Inc.	10		Yes	
SafetyPad	8		No	
American Medical Response	7		No	
Digitech	7		Yes	Yes
EPR Systems USA Inc	5		Yes	Yes
Truamasoft LLC	5		Yes	
Emergency Reporting	4		No	
EMS Consultants Ltd.	4		No	
Cloud PCR LLC	2		No	
Metro pcr - Saffire Software	2		Yes	Yes
Stryker formerly Physio-Control (Sansio)	2		No	
Creatie EMS - non compliant to Florida	1		No - In Compliance Testing	
FIREHOUSE Software, A Xerox Solution	1		No	
Beyond Lucid			Yes	Yes

V3.5 Implementation Trauma Triage Criteria

V3.4
CDC Trauma
Criteria
eInjury.03
eInjury.04



V3.5
CDC Trauma
Criteria
eInjury.03
eInjury.04
With Custom
elements for
field value
extensions



V3.5.1
CDC Trauma
Criteria
eInjury.03
eInjury.04
Extended
field values
included in
elements

V3.5.1 Next Release

ACS Trauma Triage Criteria changes

- eInjury.03 – Trauma triage criteria for Red boxes
- eInjury.04 – Trauma triage criteria for Yellow boxes

22

Florida
HEALTH

Trauma Alert Criteria (305-6-4)

Page 2 of 2

Adult Trauma Alert

Any one of the following:

- Active airway assistance required beyond the administration of oxygen
- HR < 30 without radial pulse
- Systolic BP < 50
- Best Motor Response = 4 or total GCS < 12
- 2nd or 3rd degree burns on > 10% of body
- Amputation proximal to wrist or ankle
- Penetrating injury to head, neck, or torso
- Two or more long-bone fracture sites (humerus, radius/ulna, femur, tibia/fibula)
- Paralysis, loss of sensation, or suspected spinal cord injury

Or any two or more of the following:

- RR > 30
- Sustained HR > 120 beats/minute
- GCS Best Motor Response = 5
- Major degloving injury or flap avulsion > 5"
- Gunshot wound to extremity
- One long-bone fracture from hip to foot
- Age < 55
- Ejected/struck from vehicle (including ATV, motorcycle, moped, or truck bed)
- Steering wheel or dashboard impact
- Dislocated or paramedic

Pediatric Trauma Alert

Any one of the following:

- Active airway assistance required beyond the administration of oxygen
- Any airway adjunct including manual jaw thrust, suctioning, or others to assist ventilation
- Altered mental status
- Paralysis, loss of sensation, or suspected spinal cord injury
- Faint or nonpalpable radial or femoral pulse
- Systolic BP < 50
- Open long-bone fracture, multiple fractures or dislocation sites
- Major degloving or flap avulsion
- 2nd degree or 3rd degree burns on > 10% of body
- Amputation proximal to wrist or ankle
- Penetrating injury to head, neck, or torso

Or any two or more of the following:

- Suspected amnesia, or LOC
- Systolic BP < 90
- Palpable carotid or femoral pulse but no radial or pedal pulse
- Suspected closed long-bone fracture
- Or judgment of EMT, paramedic, or other healthcare professional

Submitted by EMS committee Approved by Medical director Peter Gianino M.D.

National Guideline for the Field Triage of Injured Patients

RED CRITERIA
High Risk for Serious Injury

Injury Patterns	Mental Status & Vital Signs
<ul style="list-style-type: none"> Penetrating injuries to head, neck, torso, and proximal extremities Skull deformity, suspected skull fracture Suspected spinal injury with new motor or sensory loss Chest wall instability, deformity, or suspected flail chest Suspected pelvic fracture Suspected fracture of two or more proximal long bones Crushed, degloved, mangled, or pulseless extremity Amputation proximal to wrist or ankle Active bleeding requiring a tourniquet or wound packing with continuous pressure 	<p>All Patients</p> <ul style="list-style-type: none"> Unable to follow commands (motor GCS < 6) RR < 10 or > 29 breaths/min Respiratory distress or need for respiratory support Room-air pulse oximetry < 90% <p>Age 0-9 years</p> <ul style="list-style-type: none"> SBP < 70mm Hg + (2 x age in years) <p>Age 10-64 years</p> <ul style="list-style-type: none"> SBP < 90 mmHg HR > 160 <p>Age 65 years</p> <ul style="list-style-type: none"> SBP < 110 mmHg or HR > SBP

Patients meeting any one of the above criteria should be transported to the highest-level trauma center available within the geographic constraints of the regional trauma system

YELLOW CRITERIA
Moderate Risk for Serious Injury

Mechanism of Injury	EMS Judgment
<ul style="list-style-type: none"> High-Risk Auto Crash <ul style="list-style-type: none"> Partial or complete ejection Significant intrusion (including roof) <ul style="list-style-type: none"> > 12 inches occupant side OR > 18 inches any side OR Need for extrication for entrapped patient Child (Age 0-9 years) unrestrained or in unsecured child safety seat Vehicle telemetry data consistent with severe injury Rider separated from transport vehicle with significant impact (eg, motorcycle, ATV, horse, etc.) Pedestrian/bicyclist rider thrown, run over, or with significant impact Fall from height > 10 feet (all ages) 	<p>Consider risk factors, including:</p> <ul style="list-style-type: none"> Low-level falls in young children (age < 5 years) or older adults (age > 65 years) with significant head impact Anticoagulant use Suspicion of child abuse Special, high-resource healthcare needs Pregnancy > 20 weeks Burns in conjunction with trauma Children should be triaged preferentially to pediatric capable centers <p>If concerned, take to a trauma center</p>

Patients meeting any one of the YELLOW CRITERIA WHO DO NOT MEET RED CRITERIA should be preferentially transported to a trauma center, as available within the geographic constraints of the regional trauma system (need not be the highest-level trauma center)

Implemented in Florida Custom Elements

Implemented in eInjury.03 & eInjury.04

V3.5 Major Changes



24

Florida
HEALTH

Data Quality Focus

- Quality First Award
- Data Quality Score



Quality First Award

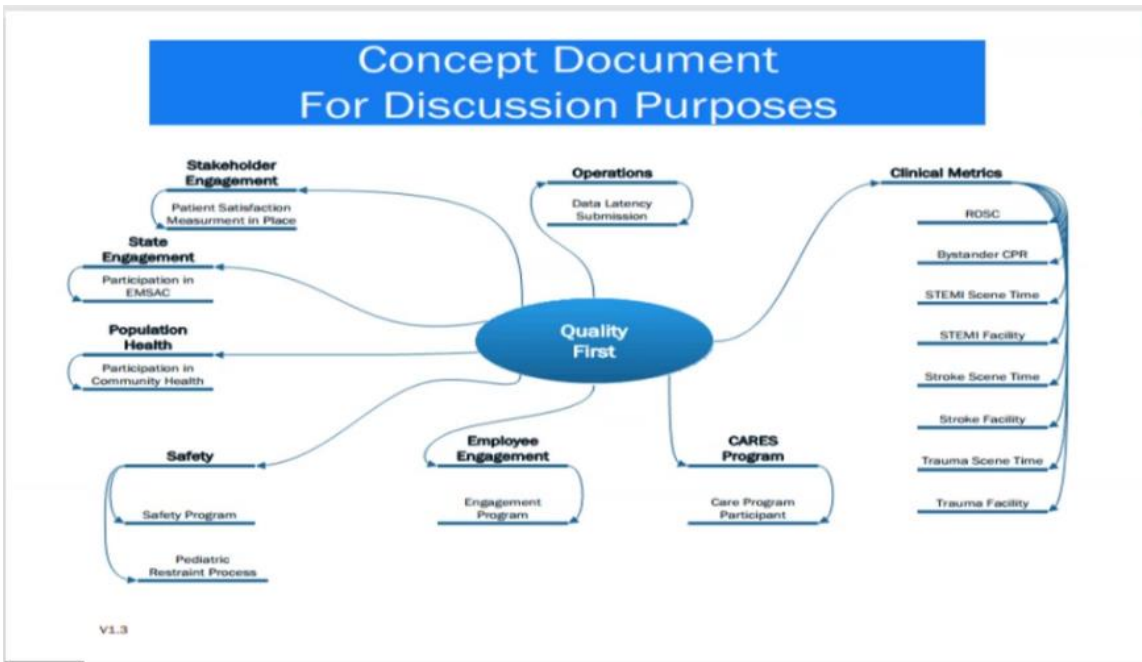
Purpose: Recognition of agencies in the State of Florida that demonstrate exceptional quality in their healthcare services. It signifies an agency's commitment to providing highquality healthcare services and highlights their dedication to improving patient outcomes and community health.

Overview of the award evaluation process: Each year, during the months of April and May, the EMS Section within the Bureau of Emergency Medical Oversight will gather information about every agency in the State of Florida related to this award. The gathered data will be evaluated to confirm the agencies that are eligible to receive this recognition.

Eligibility and Evaluation: Every agency authorized and registered with the FDOH is automatically considered. Pre established parameters have been developed under which agencies will be evaluated. Two types of awards, Gold and Silver

26

Florida
HEALTH



- Review by Chair John Simpson as to the importance of this quality initiative. Motion by Ian Womack to accept quality first initiative/award second by Patricia Byers. Discussion as to whether criteria is set in stone. Perhaps add PECC next time. Passes unanimously.



DATA QUALITY SCORE

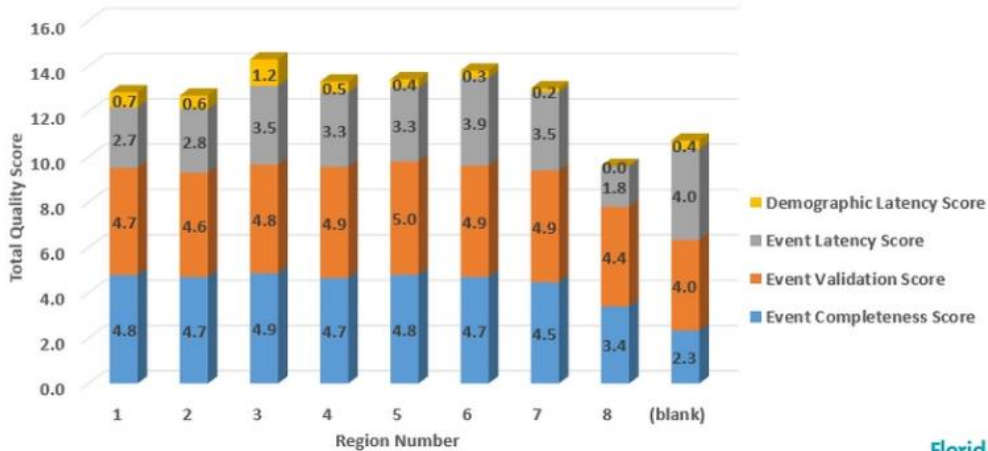
- ✓ Each quality metric has its own measures to calculate the metric score.
- ✓ All metric scores are used to calculate the overall Data Quality Score
- ✓ Data Quality Score can be viewed by state, region, county, agency

COMPLETENESS	TIMELINESS	ACCURACY	RELEVANCE
<p>Data Submission Completeness Measure – based on predictive avg. call volume</p> <ul style="list-style-type: none"> ratio of submitted records received to the expected number of records to be submitted to Biospatial <p>GT = 90% - 5 89-80 – 4 79-69 – 3 68-50 - 2 LT 50 - 1</p>	<p>Submission Timeliness Measure</p> <ul style="list-style-type: none"> % received within 10 hrs of event <p>Lt 11 = 5 11-24 = 4 25-36 = 3 37-48 = 2 49-72 = 1 Gt 72 = 0</p> <ul style="list-style-type: none"> % of monthly demographic submissions <p>At least 1 – 5 Else 0</p>	<p>Business Rule Adherence Measure</p> <ul style="list-style-type: none"> 100% fully validated - 5 >75% fully validated – 4 >50% fully validated - 3 % 1-5 warnings - 2 % GT 5 – 1 warnings 100 % err - 0 	<p>Business Rule Adherence to “select” Performance Measure and their associated elements</p> <ul style="list-style-type: none"> Similar to the Accuracy but focuses on measuring accuracy of elements within the selected performance measures Can be expanded to clinical

28

Data Quality Score

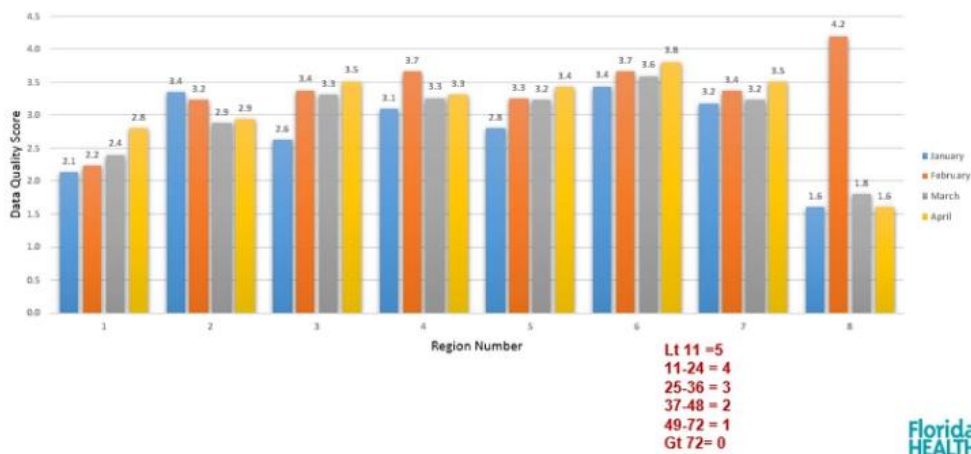
April Total Data Quality Score (max 20)



29

- Question whether the end user has direct impact on these concept points. Yes.
- Question about issues between vendor validation score versus biospatial validation score. The vendor should be basing their score on the state schematron.
- Automated submittal of demographics was configured based on changes. If no changes, still needs to be submitted. Talk to your vendors.

Event Latency Score By Region, Month



30



Open Discussion/ New Business/Public Comment

- Closing comments by John Simpson.

Adjourn/Next Meeting

- Adjourn at 14:55. Next meeting will be week of October 3rd in Destin FL.