Florida Injury Prevention Advisory Council
2010 Action Plan Annual Report
Data Workgroup

June 30, 2011

Data Workgroup Members

- Michelle Akins - Department of Health, State Child Abuse Death Review Committee
- Nancy Tamariz - Agency for Health Care Administration
- Gillian Hotz - University of Miami, Jackson Memorial Hospital
- Michael Lo - Department of Health, Trauma Program Manager
- Joe Nelson - State Emergency Medical Services Medical Director
- Carl Schulman - University of Miami, Jackson Memorial Hospital
- Kyla Shelton - Office of Injury Prevention Liaison

Data Workgroup Strategies - 88% of Activities Completed (21/24)

1I: Obtain and format each data source in the Florida Injury Surveillance System
1J: Analyze injury data sources to complete required data reports and deliverables
1K: Monitor and evaluate opportunities for new or additional surveillance data sources
1L: Disseminate injury data to stakeholders
1M: Provide data consultation and guidance that supports injury prevention efforts of other goal teams

Strategy 1I - 100% COMPLETE

Between July and December, the five data sources in the Florida Injury Surveillance System were retrieved and formatted. The data sources include: Death Certificates, Hospital Discharge Data, Emergency Department Discharge Data, Crash Records, and Medical Examiner Drugs Identified in Deceased Persons Database.

Strategy 1J - 100% COMPLETE

Between March and December, five data reports/deliverables were completed to fulfill various grant requirements and complete various performance improvement measures.

Strategy 1K - 100% COMPLETE

1K(1): All Child Death Review

The Florida Department of Health has submitted a legislative proposal to amend §383.402 (1), F. S to expand the State Child Abuse Death Review Committee's authority related to the review of all child deaths in Florida on behalf of the children of Florida and the State Child Abuse Death Review Committee for the expansion of all child deaths reported to the Florida Abuse Hotline however it was not adopted. The

proposed amendment to the current Florida law would authorize the State Child Abuse Death Review Committee to review all child deaths that were reported to the Florida Abuse Hotline and to review all other child deaths based on the availability of resources. The State Committee has made this recommendation every year in the annual reports which can be located on the web site http://www.flcadr.org.

The amendment would also expand the membership of the State Child Abuse Death Review Committee in response to the broader scope of responsibility to include additional departmental/agency representatives and professional experts. Membership will be expanded to include the Department of Highway Safety, the Department of Health State Epidemiologist, The Office of Adoption and Child Protection, the Department of Juvenile Justice, a representative from the Florida Pediatric Society, a professional, licensed in a mental health field, who is knowledgeable concerning deaths of children, a social worker who is knowledgeable concerning deaths of children, a representative from the Florida Hospital Association, the Registrar for Vital Statistics, a perinatal expert, and a representative from the health insurance industry.

The State Child Abuse Death Review Committee recommended in their 2010 annual report the following:

"to amend §383.402 (1), F. S. to expand the State Child Abuse Death Review Committee's authority to review all child deaths in two phases. This will allow Florida to have a better understanding of why children die in Florida.

- Phase I - expand the State's child abuse death review process to include the review of all child deaths reported to the Florida Abuse Hotline.

- Phase II - expand the State's child abuse death review process to include the review of all child deaths.

Identifying the causes of and developing strategies to reduce avoidable child deaths is the essence of prevention. Regrettably, the State of Florida has not made much progress in accomplishing this goal. Since 1999, the State Committee has been articulating a need to better understand why children in our state die. The State Committee acknowledges there are individuals concerned that this process would be intrusive; however, that is not the case. Families will not be contacted or interviewed as result of this proposed legislative change. Of the states conducting some form of child death review, all have indicated that families are not impacted by these reviews. The child death review process is a review of records and reports, focusing on critical areas which include infant sleep related deaths, drowning, suicides, traffic crashes and poisoning.

The All Child Death Review process will allow the Florida Department of Health and other agencies to develop appropriate strategies to reduce the occurrence of Florida child deaths attributed to preventable situations. Recognizing the current economic limitations, the State Committee proposes that the Governor and Legislature support the expansion of child death review to include all child deaths reported to the Florida Abuse Hotline. Currently, 39 states have laws mandating a child death review process; four states have laws permitting child death review. Most programs (27) are coordinated by state health departments; others are found in social service agencies, attorney general's offices, universities or other settings. At the request of the State Committee, the Florida Department of Health has submitted a legislative proposal on behalf of the children of Florida for the expansion of all child deaths reported to the Florida Abuse Hotline. This is also a goal of the State Child Abuse Prevention and Permanency Plan adopted by the Governor's Advisory Council on Child Abuse Prevention and Permanency.

As stated in last year's [Child Abuse Death Review] annual report, a priority for the Centers for Disease Control and Prevention (CDC) and the Healthy People 2010 is that a child fatality review team reviews 100% of deaths of children aged 17 years and younger that are due to external causes. By monitoring the occurrence of all childhood deaths and performing an appropriate review when deaths occur, child death review teams have a unique ability to gather the detailed information that is necessary for effective injury/disease prevention activities. The benefits of a comprehensive all child death review process includes:

- A more thorough child death investigation by law enforcement and medical examiners
- Enhanced interagency cooperation
- Improved allocation of limited resources
- Consistency in the certification of the cause and manner of death, which would provide more accurate epidemiologic data as to risk factors that may play a role in the deaths of children in the State of Florida
- Consistency and congruence in data collection by incorporating elements from all existing death reviews
- Establishment of standards for accountability and partnerships with Fetal Infant Mortality Review, Pregnancy Affected Mortality Review, Child Abuse Death Review, Domestic Violence Fatality Review, and the Sudden Infant Death Syndrome program in Family Health Services Florida Department of Health
- Flexibility for local communities to conduct reviews
- Strict confidentiality protections which protect records by providing appropriate protections from public disclosure
- A thorough analysis of why children die that informs data driven prevention efforts

Finally, it is essential to protect the confidentiality of the parents and other surviving siblings, and any other protected records. Currently, Florida Statutes provide

confidentiality protections for all protected records received by the State or Local Committee. Confidentiality ensures that a family's feelings will be spared a public scrutiny as the State Committee carries out its work and that no family be further traumatized as a result of this process. To understand why one child dies may save the lives of countless others. Expanding child death reviews is one of the key prevention strategies in Florida's Five-Year Child Abuse Prevention and Permanency Plan."

1K(3): Miami-Dade County Data Linkage

Efforts continue in Miami-Dade County to incorporate linked death certificate date with medical examiner records for research and analysis. However, inconsistencies between the two data sources remain and additional linkages with law enforcement records continue to prove difficult. In addition, competing priorities are limiting the advancement of these efforts. Strategy 1K(3) will be discontinued until the full status and outlook of these efforts can be established.

1K(5): Trauma Registry Data

Integration and analysis of trauma patient data files received quarterly from Florida's 22 trauma centers have been challenging due to the multiple file formats in which the data are received. In 2010, the Office of Trauma hired a full-time Project Manager/Business Analyst to complete the gathering and documentation of business requirements necessary to identify interim and long-term solutions to this internal data integration problem that prevents the effective use of trauma registry data for injury surveillance, quality management, and outcomes evaluation, and prevents the linkage of trauma registry data to other data sets within the continuum of injury care, including pre-hospital records and the Brain and Spinal Cord Injury Central Registry. A Trauma Data Group was formed in 2010 to review and revise the Florida Trauma Registry Manual to conform to the National Trauma Data Standard. Other accomplishments of the Trauma Registry Project Team for 2010 include the following:

<u>Current State</u>

- Worked with each trauma center and software vendor to map all 2010 trauma registry data submissions to the reporting requirements of the current Florida Trauma Registry Manual, thereby finally standardizing all data files received.

<u>Interim Solution</u>

- Worked with the Bureau of EMS database integration expert to begin converting and uploading 2010 trauma registry data files to a data warehouse via the ETL (Extract, Transform, Load) process to integrate with pre-hospital data.

<u>Long-Term Solution</u>

- Held conference calls during 2010 with the Trauma Data Group to review and revise the current Florida Trauma Registry Manual to conform to the National Trauma Data Standard and associated XML schema for electronic data reporting.
- Issued a Request for Information (RFI) from potential software vendors and evaluated vendors' responses. Held product demonstrations with three vendors.
- Held conference calls with several states (Washington, New York, and North Carolina) for input regarding their vendor choices.
- Began drafting a business plan for a long-term software solution to accommodate the business needs of Florida Trauma Registry user.

Planned Accomplishments for 2011

- Complete the ETL process for converting and uploading 2010 trauma registry data to the pre-hospital data warehouse.
- Analyze 2010 trauma registry data for the 2010 Florida Trauma System Annual Report to be published in Fall 2011.
- Complete business plan and present to DOH IT Governance on June 14, 2011.
- Complete Florida Trauma Registry Manual and XML schema revisions and begin the administrative rule development process to implement these revisions.
- Begin planning the Invitation-to-Negotiate (ITN) process for procuring a long-term trauma registry software solution in 2012.

1K(6): Data Integration and Evaluation Team

The Division of Emergency Medical Operation's Data Integration Evaluation Team was not formally active in 2010. However, data integration efforts have occurred among various team members such as Trauma and Emergency Medical Services. To date, no team-specific projects have been established.

1K(7): Emergency Medical Services Tracking and Reporting System (EMSTARS)

As of June 2011, there are 131 agencies submitting records through EMSTARS which represents 48% of Florida licensed EMS agencies. The state repository has over 3.8 million incidents reported.

Improvements in the data analysis, linkage and reporting capabilities of EMS data are being developed through the implementation of the EMSTARS Data Mart. The 2nd iteration of the EMS Data Mart is nearing completion and includes the initial linking of Agency for Healthcare Administration data (Emergency Department, Hospital Inpatient Discharge, and Rehabilitation data) data. This solution will be deployed in July 2011 and will provide a fully functional data mart that can be used to support the analysis and decision-making requirements of the business.

Florida continues to be a "stand out" state with its participation in the national program, National EMS Information System (NEMSIS). Florida has over 3 million incident records in the national database. Florida ranks number two in number of records submitted to NEMSIS.

Changes to the current NEMSIS Version 2.2.1 national data collection and reporting requirements are underway. The new version, NEMSIS 3.0, will be finalized and released during the months of July 2011 – October 2011. Florida continues to monitor the new changes and will assess the impact this may have to ensure that an appropriate state level implementation strategy is developed for the transition to NEMSIS 3.0.

1K(8): Emergency Management Tracking Tool

Through a grant from the U.S. Department of Health and Human Services (HHS) the Florida Department of Health's Bureau of Preparedness and Response implemented the Communications and Patient Tracking Solution Project. On April 1, 2009, Intermedix Corporation was awarded a three year contract to implement their EMResource and EMTrack web-based applications throughout the state. The Communications and Patient Tracking (CPTS) Work Plan is available at http://www.doh.state.fl.us/demo/BPR/PDFs/FDOH_CPTS_Work_Plan_and_Attachments.pdf

EMResourceTM and EMTrackTM will facilitate the exchange of information between emergency medical service providers, hospitals, health care entities, 911 dispatch centers and emergency operations centers. By sharing information, Intermedix will help facilities efficiently manage patients and resources and allow for pre disaster planning.

EMResource tracks key hospital and health care system resources and information on a daily basis in a real time environment. EMTrack tracks the location of patients and their condition as well as other important information. Together these tools will increase Florida's preparedness and response to public health emergencies and support the day-to-day information sharing needs of emergency medical services, hospitals, and health care providers.

Source: http://www.doh.state.fl.us/demo/BPR/emsystems.html

Strategy 1L - 66% COMPLETE

In 2009, the Office of Injury Prevention shared current injury data presentations during at least seven meetings and fulfilled at least 80 ad-hoc data requests. In addition, 13 injury-specific fact sheets and county-level profiles were developed and published to

the office website throughout the year. Each of the 13 fact sheets contains GIS maps indicating levels of injury burden among rural and non-rural counties.

1L(4) and 1L(7): Data Analysis Request Form and Poisoning Analysis

These activities were incomplete due to Kyla Shelton, Injury Epidemiologist being involved in the grant writing process for the CDC Core Violence and Injury Prevention 2011-2016 grant applications and preparing for maternity leave at the end of 2010.

1L(6): Florida CHARTS

The Office of Injury Prevention continues to support the data expansion efforts of Florida CHARTS. For example, in 2010, data was provided to update injury portions of the Child and Adolescent Health, Minority Health, and Pregnancy and Young Child Profiles. In July 2009, the CHARTS team began adding non-fatal data to Florida CHARTS. In fact, two of the health profiles now contain non-fatal injury hospitalization data in addition to fatal injury data.

Strategy 1M - 66% COMPLETE

Data consultation and guidance was provided in the form of injury fact sheets, ad-hoc data request, and technical assistance. A formal solicitation method was not developed in 2010, but will be developed and implemented in 2011 with corresponding activities added to the 2011 Action Plan.