An Assessment of the Arkansas Department of Health Injury Prevention Section

Assessment conducted
August 1-5, 2011
by the
Safe States Alliance

BACKGROUND

Injury is the leading cause of death during the first four decades of life and the fifth leading killer in the United States overall. In the U.S. more than 180,000 people die from injury and violence each year. More than 2.8 million people are hospitalized due to an injury and over 29 million people are treated and released from an emergency department (ED) in the U.S. each year. The financial costs of injury and violence are staggering - an estimated $406 billion annually. These estimates do not include the emotional burden resulting from the loss of a child or other loved one, or the toll of severe disability, chronic pain, or a profound lifestyle change in the injured person and their family and friends.

Daily media reports describing unintentional and intentional injury events are commonplace. However, many people view injuries as "accidents" and therefore not preventable. When a public health approach is applied to the problem of injury and violence, injury events can be predicted, and in most cases prevented. In the U.S., the primary health jurisdictions are the state and local entities where such authority may be delegated by state law. It is frequently the responsibility of the state to provide guidance, technical assistance and financial support, whether directly or in partnership with both public and private entities to assure the state's residents live in a healthy and safe environment.

State health department injury and violence prevention (IVP) programs utilize a public health approach (surveillance, identification of risk and protective factors, intervention, and evaluation) to reduce injuries and save lives. Much of this work is done through coordination and collaboration between IVP programs within the state health department and with external partners and stakeholders. Unlike many other public health prevention activities where monitoring, intervention, and evaluation occur within the health sector (i.e. immunization against childhood diseases), IVP involves education, law enforcement, emergency medical services, traffic safety, fire safety, environmental health, and many other sectors. Additionally, community-based coalitions and organizations play a critical role in the development implementation and evaluation of IVP programs.

In the late 1980s, the then-Center for Environmental Health and Injury Control at the Centers for Disease Control and Prevention (CDC) began supporting state capacity for IVP. Some states built their programs without these grants, using funds from sources such as the Maternal and Child Health (Title V) Block Grant, the Preventive Health and Health Services Block Grant, state general or special funds, and private and foundation support. CDC's National Center for Injury Prevention and Control (NCIPC) currently supports 28 state health department base injury and violence prevention programs through its Core Violence and Injury Prevention Program (Core VIPP). The program's three primary objectives are to build and/or maintain a sustainable solid infrastructure for injury prevention and control; collect, analyze and use injury

data; and implement and evaluate interventions. NCIPC also supports research activities that assist states in the implementation of best practices.

In 1993, state health department IVP program directors recognized a need for a national organization of their peers, and the State and Territorial Injury Prevention Directors' Association (STIPDA) was organized. One of its publications, *Safe States: Five Components of a Model State Injury and Violence Prevention Program* served as a blueprint for describing a comprehensive program. Soon thereafter, STIPDA entered into a cooperative agreement with the NCIPC. In 1999, under the cooperative agreement, STIPDA developed a State Technical Assessment Team (STAT) project to support the assessment of state health department IVP programs. A team of technical experts is identified who have expertise and experience in developing and implementing state and local IVP programs. These experts demonstrate their leadership and expertise through involvement in national organizations committed to improving IVP programs.

In 2010, STIPDA changed its name to the Safe States Alliance to reflect its expanded focus to serve as the national voice in support of all state and local IVP professionals engaged in building a safer, healthier America. Safe States' vision is to be the recognized leader and driving force in understanding and preventing injuries and violence.

The STAT assembled in Little Rock, Arkansas on July 31, 2011. For the first two and half days, 29 presenters invited by the Arkansas Department of Health(ADH) provided in-depth briefings on the injury and violence prevention activities in Arkansas. Topics for review and discussion included the following:

- Infrastructure
- Data: Collection, Analysis and Dissemination
- Interventions: Design, Implementation and Evaluation
- Public Policy

Coordination and collaboration, training and technical assistance are crosscutting issues and addressed in each of the component areas. In addition, there is attention to eliminating health disparities in injury and violence outcomes. The forum of presentation and discussion allowed the team the opportunity to ask questions regarding the status of the Arkansas Injury Prevention & Control Branch and to clarify any issues identified in the briefing materials provided prior to the site visit, identify barriers and facilitators to change, and develop a clear understanding of how IVP activities are conducted in Arkansas.

Following the briefings by presenters from the ADH, public and private sector partners and stakeholders in the IVP community, the team assessed the status of the Arkansas Injury

Prevention & Control Branch with respect to the STAT standards, summarized its findings, and developed a set of recommendations for program improvement.

ACKNOWLEDGMENTS

The team would like to acknowledge the ADH for its support in conducting this assessment.

The team would like to thank all of the presenters for being candid and open regarding the status of injury and violence prevention in Arkansas. Each presenter was responsive to the questions posed by the team which aided the reviewers in their assessment.

Special recognition and thanks go to Dr. Paul Halverson, Bill Temple, Renee Patrick, Joe Martin, and Jim Brown, and the briefing participants for their well-prepared and forthright presentations. In addition, the team applauds the well organized, comprehensive briefing material sent to the team members.

List of Presenters

Name	Organization
Bill Temple	ADH – Injury Prevention & Control Branch
Renee Patrick	ADH – Injury Prevention & Control Branch
Paul Halverson	ADH – Director and State Health Officer
Donnie Smith	ADH – Center for Health Protection
Todd Maxson	ADH – Trauma Medical Consultant to ADH/Trauma Medical Director, Arkansas Children's Hospital
Austin Porter	ADH – Injury Prevention & Control Branch
Lynda Lehing	ADH – Health Statistics Section
Bettye Watts	ADH – Injury Prevention & Control Branch
Detrich Smith	ADH – Injury Prevention & Control Branch
Robert Brech	ADH – Office of Government Affairs
Andrea Ridgeway	ADH – Hometown Health Support Services Branch
John Senner	ADH – Center for Public Health Practice and Health Statistics Section
Dr. Steve Bowman	Johns Hopkins University
Marie Lewis	ADH - Trauma Registry
Kevin Ryan	Arkansas Center for Health Improvement
Don Adams	Arkansas Hospital Health Association – Rural and Mental Health Services
Cathy Flanagin	ADH – Preparedness and Emergency Response Branch
Joe Martin	ADH – Injury Prevention & Control Branch
Yousef Fahoum	Arkansas Brain Injury Association
Max Snowden	Arkansas Commission on Rape and Domestic Abuse

Bridget White	Arkansas State Police – Highway Safety Office
Karen Bonds	Arkansas State Police – Highway Safety Office
Ann Ruud	Arkansas Children's Hospital – Safe Kids
Greg Leding	Arkansas House of Representatives
Dr. Mary Aitken	Arkansas Children's Hospital – Injury Prevention Center
Beverly Miller	Arkansas Children's Hospital – Injury Prevention Program
Stephanie Williams	ADH – Center for Health Advancement
Bradley Planey	ADH – Family Health Branch
Dr. Bob West	ADH – Family Health Branch

The statements made in this report are based on the input received. All team members agree with the recommendations as presented.

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EXECUTIVE SUMMARY

Injuries and violence threaten the lives of Arkansas residents of all ages and is the leading cause of death for residents between the ages of 1 - 44. In 2007 alone, injury accounted for approximately 2,206 deaths, for an age-adjusted rate of 76.95 per 100,000 residents. In 2006, injury accounted for almost 17,900 hospitalizations with an economic burden of $412 million. In addition, the toll of injuries places a sizeable non-monetary burden on families and communities each year.

To address the burden of injuries, the ADH created the Injury Prevention & Control Branch as a direct result of the passage of the Trauma System Act of 2009. Prior to that time ADH received CDC funding for several injury prevention initiatives but were unable to build a robust and sustainable IVP program.

Although there is a strong childhood injury prevention focus in the state, there is a need for a comprehensive data driven program addressing the leading causes of injury and violence across the lifespan. A coordinated, data driven, evidence-informed IVP program is needed to reduce injury-related mortality, morbidity and disability.

The ADH leadership understands and appreciates the magnitude of injury and violence as a public health problem and has expressed commitment to building and sustaining an injury and violence prevention program. Funding from the Trauma System Act and the recent award of the CDC's Core Violence and Injury Prevention Program grant will be instrumental in building a viable IVP program.

Stakeholders interviewed during the STAT visit overwhelmingly indicated the need for ADH to provide leadership and coordination among internal and external IVP partners. The ADH should provide focus and visibility, reduce duplication and fragmentation, and improve the use of existing resources. The first step to developing a robust program is to hire a well qualified Injury Prevention Section Chief as well as program and surveillance staff, and to seek IVP training opportunities for existing and new staff, as appropriate.

Data surveillance, analysis, reporting, and dissemination are a fundamental component to effective public health practice. Injury and violence data resources in Arkansas are not yet fully developed or utilized. This limitation reduces the current capabilities to utilize injury and violence data in developing program priorities and interventions, identifying the full burden of injury in Arkansas, and effectively communicating this burden to important stakeholders and the public.

The availability of data is a core element of a successful injury and violence prevention program. However, data must be analyzed, interpreted and disseminated in a proper manner for it to have its real value. The Injury Prevention Section (IPS) has hired an injury epidemiologist to increase this capability, and has devoted resources to train this individual in the fundamentals of injury control. Current plans also call for the hiring of two data positions under Core VIPP funding.

At present, Arkansas utilizes only 4 of the 11 core data sets recommended for injury and violence surveillance in state health departments. Recent legislative funding to support the development of a statewide trauma system has provided resources for the establishment of a trauma registry to identify the key clinical and administrative issues associated with the use of designated trauma centers. The trauma registry has been developed and is currently undergoing testing to identify important issues in data sharing, data quality, and data accuracy. The trauma registry will be available for IPS use in a short period of time. With the development of the trauma registry, there was also the recognition of the desire to capture pre-hospital and emergency department (ED) data. Current efforts are underway to begin an ED surveillance system, with support for this effort originating from ample resources. Validating the data from the Emergency Medical Services (EMS) record surveillance system is in its infancy.

The ADH has had federal funding from several sources since the early 1990s to implement various injury prevention interventions. As is common in many states some of the injury prevention activities reported to the STAT that are being conducted at the local level are based on educating individuals to be safer, but may not be evidence-informed and may not be effective. There are many scientifically-evaluated, evidence-informed strategies that are proven effective in reducing injuries and violence. The IPS should be a resource to promote proven and promising interventions.

In the absence of a strong, centralized IVP program at ADH, Arkansas Children's Hospital (ACH) assumed the coordination of childhood injury prevention activities, and thus an identity as a statewide leader in this area. With the new funding and commitment of ADH executive leadership to establishing a comprehensive IVP program, there may be a challenge for IPS to be recognized in an injury prevention leadership role.

Arkansas has a strong tradition of protecting personal freedoms and limiting the size of state government and legislation mandating personal behaviors. Despite this, there is significant political and administrative support for injury and violence prevention in Arkansas and there have been many recent public health IVP successes.

In spite of these legislative successes and Dr. Halverson's support, there has been little leadership or coordination from ADH in the area of IVP across the state until this point. Additionally, despite the presence of resources, the Trauma System Act and the state personnel policies limit the further development of a strong program staff for statewide IVP within the

current fiscal and political environment. Given the lack of state IVP infrastructure, there has been limited Injury Prevention & Control Branch involvement in the development, review, monitoring and evaluation of IVP policies. However, there are established mechanisms for the IPS to work with policymakers to advance public health and IVP policies.

There is significant senior leadership, particularly through the state health official, Dr. Halverson, for policy approaches to IVP within the ADH. There is legislative support and potential champions who have been identified as supportive of public health, injury and trauma issues. Additionally, ADH works effectively with the House and Senate Committee on Public Health and Welfare.

The following recommendations reflect the voice of interviewees who graciously spent time with the STAT.

Infrastructure Recommendations

ADH should:

1. Develop the IPS which at a minimum:
    a) Uses national guidelines, standards, and proven and promising practices to customize approaches to local issues.
    b) Critical core state staff positions consisting of a full-time IP Section Chief, Core Program Manager, two Health Educators, Injury Epidemiologist, Data Analyst, and administrative support. Program realignment should be considered to relocate the Rape Prevention and Education (RPE) program within the IPS.
    c) Develop a plan for the expansion of the IPS, both in staffing and activity, over the next five years, based on the established priorities and work plan within a comprehensive IVP plan.
2. Assess staff's training needs by using the self-assessment tool developed by the National Training Initiative to evaluate strengths and weakness regarding the fundamental and basic principles of IVP from a public health perspective. Adequately train staff through formal training from nationally recognized programs that meets the core competencies for IVP.
3. Train Trauma Section staff on the concepts of IVP.
4. Develop an internal ADH department-wide coordinating group which will:
    a) Develop a unified vision for department-wide approaches to IVP and surveillance;
    b) Define the scope of the IVP program within the ADH;
    c) Use department procedures to establish agreements with Centers, Branches and programs related to IVP; and
    d) Identify opportunities for integration within existing programs.

5. Update the Arkansas Trauma Systems Rules and Regulations, Trauma Facility Standards for Public Education and Injury Prevention to mirror, at a minimum, the requirements from the American College of Surgeons Committee on Trauma as it applies to IVP.
6. Re-establish the Injury Community Planning Group (ICPG) and ensure representation from public and private partners with diverse interests in IVP, to guide and champion IVP as a public health priority.
7. Lead the development of the Arkansas Injury Surveillance and Prevention five-year plan. The plan should be data driven and address all components of a multi-faceted IVP program. All internal and external stakeholders should be involved in developing and implementing this plan.
8. Create internship opportunities for undergraduate and graduate students.

Data Recommendations

The Arkansas Injury Prevention & Control Branch should:

1. Mentor and develop the data knowledge, skills, and abilities of the injury epidemiologist so that this position would be the person known as the one of the state experts on injury data, analysis, dissemination and interpretation. Key components of this development should include:
    a. Continued mentoring from the primary state epidemiologists;
    b. Integration of the injury epidemiologist into other state-based data groups;
    c. Integration of the injury epidemiologist into the ACHI to allow for access to and increased knowledge of state data systems, and the development of the ability to link datasets; and
    d. Membership and participation in national organizations, including the Council of State and Territorial Epidemiologists (CSTE) and the Safe States Alliance.
2. Develop an Injury and Violence Data Users Group so that individuals fully and partially involved in administrating or analyzing data from surveillance systems pertinent to injury and violence data can discuss technical issues, develop common approaches, and support each other's efforts in making data useful for the IPS program.
3. Increase collaboration with the OHS in the Arkansas State Police. At a minimum, this should include:
    a. Becoming an active member of the Strategic Highway Safety Plan; and
    b. The establishment of two-way data sharing between the OHS and IPS.
4. Recognize and exploit the opportunity to integrate key injury and violence data elements into the developing ED data, trauma registry, and EMS data surveillance systems. Key data needs should be identified from national resources, such as the Data Elements for Emergency Department Surveillance and that National Trauma Data Bank.

5. Given that resources exist, exploit the ability to enhance injury and violence surveillance using the Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance System (YRBSS) mechanisms by adding questions appropriate to state and local needs.
6. Develop an Injury and Violence Surveillance Plan to identify a process to build the capacity of the IPS to use core data systems for program needs, including coroner/ME data, Uniform Crime Reports, and CDR data. The plan should also include alternative sources of intentional injury data focused on attempted suicide, child maltreatment, rape and sexual assault, and domestic violence. Strengths and weaknesses of available data should be assessed and data systems, if not yet developed, should be established preliminarily though pilot programs.
7. Expand links between the IPS and the Boozman College of Public Health via preceptorships and internships to utilize graduate students in program data activities.
8. Implement a formal evaluation of the functioning ED, EMS, and trauma registry, and other key injury and violence surveillance systems following the public health surveillance system evaluation criteria of the CDC.
9. Identify procedures for enabling access to the trauma registry, ED data, and EMS data systems by external agencies, partners, researchers, and the public.
10. With the establishment of high quality injury and violence surveillance mechanisms, use available data to regularly:
    a. Identify and support program development and priorities;
    b. Report on health disparities in injury and violence at the state and local level; and
    c. Disseminate data to internal and external partners and coalitions.

Intervention Recommendations

IPS should:

1. Conduct a more comprehensive needs assessment of the IVP workforce in Arkansas, beyond the hospital and EMS personnel, to include regional HHI support staff and county health department staff.
2. Work with partners to develop a compendium of evidence-informed strategies specific to injury and violence topic areas.
3. Serve as a clearinghouse to disseminate information about identified proven and promising strategies and IVP training opportunities to the IVP workforce in Arkansas.
4. Implement proven and promising IVP strategies that are comprehensive and go beyond awareness and information dissemination activities to approach behavioral, social, and environmental change.

5. Actively seek opportunities for IPS to work with internal programs and external stakeholders on IVP issues, including the review of statewide educational and media materials to portray appropriate IVP messages.
6. As appropriate, ensure that the full range of evaluation components—formative, process, impact, and outcome evaluation—are an integral part of the prevention strategies from the beginning.
7. Utilize accepted conceptual models (i.e., Haddon Matrix, social ecological model, Spectrum of Prevention) to identify intervention opportunities and/or develop future interventions. Establish mechanisms to ensure fidelity to evidence-informed protocols.
8. Work with ACH to ensure that training to locals includes not only information about evidence-informed strategies, but also information about activities and interventions that are NOT effective.
9. Ensure that attention is given to implementing IVP strategies into a culturally appropriate framework of norms, values, roles, literacy levels, and practices.
10. Explore opportunities to expand partnerships among public and private entities to address under-served populations in Arkansas.
11. Identify key stakeholders at the local level and provide funding for them to attend formal IVP training that has been mapped to the core competencies for IVP adopted by the Safe States Alliance and Society for the Advancement of Violence and Injury Research (i.e., Johns Hopkins Summer Institute: Principles and Practices in Injury Prevention).

Policy Recommendations

ADH should:

1. Work closely with the state personnel committee to communicate the need for strong IVP program infrastructure within the state health department, including but not limited to, immediately hiring a well-qualified Section Chief with strong experience in IVP and leadership and management.
2. Utilize its state agency relationships to promote aggressive enforcement of IVP laws through direct senior-level communication and formal partnerships with state police, as well as through the media. Additionally, ADH should ensure leadership and organization for the enforcement of injury and violence related policies at the state level (i.e., monitor and support implementation of related daycare regulations, Medicaid transportation standards, suicide risk awareness training, soccer goal safety guidelines, etc).

The IPS should:

1. Immediately utilize resources within the Core VIPP grant to hire an experienced, well-qualified staff member charged with managing internal relationships, the ICPG and other external partnerships, and develop and oversee policy approaches to IVP, in lieu of a second data analyst.
2. Seek training and technical assistance from associations and agencies with expertise in public health and IVP policy such as Safe States Alliance, CDC, the Directors of Health Promotion and Education and the Society for the Advancement of Violence and Injury Research. The IPS should also continue to participate in national activities such as the NCSL/CDC Workshop.
3. Identify and provide training for local partners and HHI Coalition members for policy approaches to injury prevention and control (i.e., Shaping Policy for Health™).
4. Form a Policy Committee of the ICPG to develop and strategically disseminate a policy agenda. Develop a media and legislative packet for all priority areas, utilizing national and state resources and templates, that includes:
    a. Fact sheets with data on deaths, disability and associated costs as well as proven and promising practices.
    b. A one page brief that describes the IVP program, its goals, objectives, capacities and history for dissemination to the ADH, key stakeholders, partners and policy makers; and
    c. A standard report on the status of IVP to be distributed annually.
5. Conduct a scan of all laws and formal and informal policies related to identified policy priorities at the state and local level that address IVP and interventions, and identify gaps and opportunities to work with advocacy groups to support needed policy changes.
6. Work with the ADH Office of Governmental Affairs to proactively provide input into department legislative priorities and draft and review legislation as appropriate.
7. Convene regular meetings, press conferences, and seminars to keep partners, policymakers, and the public informed about issues of importance in injury and violence.
8. Identify and actively participate in relevant state associations (such as Arkansas Public Health Association, Arkansas Chapter of the American Academy of Pediatrics, Arkansas Emergency Nurses Association, etc), commissions, task forces, boards and the ACHI to advance the policy agenda and IVP.
9. Prioritize evaluating the impact of legislation, such as the primary seat belt law and GDL system in partnership with key stakeholders such as the OHS and the Arkansas State Police.
10. Support law enforcement at program levels to enhance enforcement through national campaigns (i.e., *Click it or Ticket*, etc) and other strategic enforcement initiatives.

INFRASTUCTURE

Standard

- In the state health department, there is a designated, functioning, core program which is responsible for providing leadership and coordination for injury and violence prevention.
- Staffing is adequate to conduct a statewide injury and violence prevention program.
- The injury and violence prevention program takes action to obtain funding that is both adequate to support its core functions – data collection/ analysis/ dissemination, intervention design/implementation/evaluation and public policy work – and commensurate with the nature and scope of the injury problem in the state.

Status

Arkansas Department of Health held a CDC Core VIPP grant between 1999 and 2005 that resulted in a state plan for injury prevention and a number of injury prevention initiatives. After CDC injury funding ended, few other resources were allocated (state or federal) to injury prevention within ADH. As a result, the injury prevention program within ADH saw a decrease in personnel that resulted in limited IVP efforts and planning. In 2009, ADH established an Injury Prevention & Control Branch following the passage of the Arkansas Trauma System Act. The Trauma System Act of 2009 has the potential to have a significant positive impact on mortality and morbidity from injury in Arkansas.

Existing IVP activities are located in multiple ADH branches including Chronic Disease, Family Health, Lifestage Health, and Preparedness and Emergency Response. Several other agencies/organizations such as the Arkansas Commission on Child Abuse, Rape and Domestic Violence; Highway Safety Office of the Arkansas State Police; Injury Prevention Center at ACH; Department of Human Services, Division of Aging; the University of Arkansas for Medical Sciences (UAMS) Department of Geriatrics; and the Department of Human Services' Division of Aging and Adult Services are also involved in injury prevention activities. Thus, Arkansas has IVP efforts occurring, but with little communication or collaboration among stakeholders. As a result, there exists a patchwork of categorically funded activities rather than coordinated, data driven, evidence-informed efforts that enhance and support each other.

With CDC funding, the state developed a draft Injury Prevention Plan in 2005. However, this plan was never finalized. Other state plans that relate to IVP include the Highway Safety Plan and the Arkansas Strategy for Suicide Prevention. Additionally the Maternal and Child Health (MCH) Block Grant has both national and state injury-related performance measures.

Arkansas's Hometown Health Improvement (HHI) Initiatives currently exist in every county around the state. Additionally, there are between four and five HHI support staff which are typically health educators in each of the five regions. HHI coalitions are doing powerful and unique work to improve the health of those in their communities. These partnerships include improving the health and quality of life in communities, reducing preventable illness and injury, coordinating community health services more effectively, and using available health care resources more efficiently. The Trauma System Act also provides resources for HHI coalitions to expand IVP activities.

The ADH leadership understands and appreciates the magnitude of IVP as a public health problem and has expressed commitment to develop and strengthen their focus on IVP and to develop and strengthen their injury surveillance efforts. Significant dedicated funding for IVP has been allocated from the Trauma System Act and the recent award of the CDC Core VIPP will be used to develop a strong, functioning core program within the health department responsible for providing statewide leadership and coordination.

The IPS staff members have learned their jobs primarily through on-the-job training and participation in national conferences and meetings and have expertise in related areas; however aside from the injury epidemiologist, staff members have had no formal training in injury prevention. The National Training Initiative for Injury and Violence Prevention developed a set of core competencies for practitioners in injury and violence prevention. These competencies provide a basis for professional development and give direction for injury prevention training and education. Several training programs have been mapped to the core competencies and offer specific instruction in the competency areas such as the Johns Hopkins Summer Institute: Principles and Practices in Injury Prevention.

Stakeholders interviewed during the STAT visit overwhelmingly indicated the need for ADH to provide leadership and coordination of internal and external IVP partners. The ADH should provide focus and visibility, reduce duplication and fragmentation, and improve the use of existing resources.

The ADH is to be commended for pursuing the creation of a dedicated IVP program and having adequate funding to create a comprehensive program that will address state and community needs. Arkansans will benefit from having the Injury Prevention & Control Branch focus on providing leadership, visibility, and statewide implementation of comprehensive, evidence-informed solutions.

Strengths

- Arkansas has a state mandate for the IPS that includes language that allows creating capacity to track and describe the epidemiology and health statistics of injury deaths and disabilities.
- The state budget mandates significant funds be allocated for the primary prevention of injury and violence.
- ADH executive leadership supports the Injury Prevention & Control Branch and has provided national leadership in advancing public health IVP efforts in other states.
- The Trauma Advisory Committee (TAC) recognizes that IVP is critical to a successful trauma system and has an Injury Prevention Sub-committee.
- ACH is a committed partner with a demonstrated expertise in childhood injury prevention principles.
- HHI coalitions exist in every county and are dedicated to advancing the health of their local communities. Additionally, through the Trauma System Act, resources are available to support local HHI support staff time and to provide implementation funds for IVP efforts.
- The Trauma System Act requires designated trauma facilities to implement public education and IVP programs. ADH has the capability to integrate a public health approach to IVP into the hospital systems.
- ADH was awarded a CDC Core VIPP grant.
- Partners recognize the importance and credibility of ADH taking a leadership role in statewide IVP.

Challenges

- The IPS lacks a well-qualified and experienced Section Chief. ADH requires approval from the Legislative personnel committee for new staff positions. The fiscal environment of state government inhibits recruitment of qualified individuals.
- Given the limited staffing, no central point of contact exists for internal and external stakeholders and consumers seeking information on IVP and surveillance activities.
- There is a need for workforce development and training on IVP to build the management and leadership skills of staff.
- The IVP requirements within the trauma rules are vague.
- There is limited internal and external communication, collaboration and coordination of efforts.
- Communication with the local health departments is not well established.
- ADH does not recognize the role that they can play in intentional injury prevention.

Recommendations

ADH should:

1. Develop the IPS which at a minimum:
    a) Uses national guidelines, standards, and proven and promising practices to customize approaches to local issues.
    b) Critical core state staff positions consisting of a full-time IP Section Chief, Core Program Manager, two Health Educators, Injury Epidemiologist, Data Analyst, and administrative support. Program realignment should be considered to relocate the Rape Prevention and Education (RPE) program within the IPS.
    c) Develop a plan for the expansion of the IPS, both in staffing and activity, over the next five years, based on the established priorities and work plan within a comprehensive IVP plan.
2. Assess staff's training needs by using the self-assessment tool developed by the National Training Initiative to evaluate strengths and weakness regarding the fundamental and basic principles of IVP from a public health perspective. Adequately train staff through formal training from nationally recognized programs that meets the core competencies for IVP.
3. Train Trauma Section staff on the concepts of IVP.
4. Develop an internal ADH department-wide coordinating group which will:
    a. Develop a unified vision for department-wide approaches to IVP and surveillance;
    b. Define the scope of the IVP program within the ADH;
    c. Use department procedures to establish agreements with Centers, Branches and programs related to IVP; and
    d. Identify opportunities for integration within existing programs.
5. Update the Arkansas Trauma Systems Rules and Regulations, Trauma Facility Standards for Public Education and Injury Prevention to mirror, at a minimum, the requirements from the American College of Surgeons Committee on Trauma as it applies to IVP.
6. Re-establish the Injury Community Planning Group (ICPG) and ensure representation from public and private partners with diverse interests in IVP, to guide and champion IVP as a public health priority.
7. Lead the development of the Arkansas Injury Surveillance and Prevention five-year plan. The plan should be data driven and address all components of a multi-faceted IVP program. All internal and external stakeholders should be involved in developing and implementing this plan.
8. Create internship opportunities for undergraduate and graduate students.

DATA COLLECTION, ANALYSIS, & DISSEMINATION

Standard

- Consistent with the Consensus Recommendations for Injury Surveillance in State Health Departments, the injury and violence prevention program conducts surveillance of the 14 recommended conditions, based on the 11 core data sets, in order to identify injury priorities, risk factors, and populations at risk.
- The injury and violence prevention program conducts research to support effective program implementation.
- The injury and violence prevention program maintains specific data collection activities that support program development and reflect state and local priorities.
- The injury and violence prevention program collaborates with other agencies and groups to ensure the quality of their data, improve their utility for prevention purposes, and provide assistance in the development of data.
- The injury and violence prevention program regularly monitors and reports disparities in injury outcomes.
- The injury and violence prevention program disseminates data to relevant coalitions and partners, including other health department programs and all levels of government (state and local).

To develop these capacities, an IVP program must have skilled staff, computer hardware and software, networked online data systems, and other resources. The capacities listed here are necessary to maintain even after grant funding expires.

An injury surveillance unit may not have to be physically or administratively housed within the state injury and violence prevention program, but ties should be close enough so that the IVP program is adequately served by these recommended surveillance capacities.

Status

Data surveillance, analysis, reporting, and dissemination are a fundamental component to effective public health practice. Injury and violence data resources in Arkansas are not yet fully developed or utilized. This limitation reduces the current capabilities to utilize injury and violence data in developing program priorities and interventions, identifying the full burden of injury in Arkansas, and effectively communicating this burden to important stakeholders and the public.

At present, Arkansas utilizes only 4 of the 11 core data sets recommended for injury and violence surveillance in state health departments. The vital records and hospital discharge data

(HDD) are the two primary data sources used by the IPS. Both are housed within the ADH and IPS personnel have reasonable access to these data. The HDD also include E-code information. The BRFSS and YRBSS data systems also exist within the ADH, but are sporadically accessed and analyzed for injury and violence programmatic efforts.

A key burden is injury from motor vehicle crashes. Traffic records housed in the Office of Highway Safety (OHS) in the Arkansas State Police identify injuries from fatal and non-fatal crashes. This office follows national standards in the maintenance and reporting of crash data. However, there is no current IPS involvement with crash data or with the Highway Safety Plan that guides injury prevention efforts related to motor vehicle crashes.

Recent legislative funding to support the development of a statewide trauma system has provided resources for the establishment of a trauma registry to identify the key clinical and administrative issues associated with the use of designated trauma centers. The trauma registry has been developed and is currently undergoing testing to identify important issues in data sharing, data quality, and data accuracy. The trauma registry will be available for Injury Prevention & Control Branch use in a short period of time. With the development of the trauma registry, there was also the recognition of the desire to capture pre-hospital and ED data. Current efforts are underway to begin an ED surveillance system, with support for this effort originating from ample resources. The development of an EMS record surveillance system is also in its infancy.

Other recommended data systems are either not developed for surveillance purposes [i.e. coroner/medical examiner (ME) reports, child death review (CDR) reports] or not recognized for their injury and violence prevention program value (i.e. Uniform Crime Reports from the state police, and National Occupant Protection Use Survey).

Access to several state-based data systems is possible through the Arkansas Center for Health Improvement (ACHI). This center is based in UAMS and has legislative authority to obtain state data systems and the capability to analyze and link data sets. This represents a particularly valuable resource for the ADH, but its potential is not yet fully realized, and there has been little IPS involvement with ACHI.

The availability of data is a core element of a successful IVP program. However, data must be analyzed, interpreted and disseminated in a proper manner for it to have its real value. The Injury Prevention & Control Branch hired an injury epidemiologist to increase this capability, and has devoted resources to train this individual in the fundamentals of injury control. Current plans also call for the hiring of two data positions under Core VIPP funding.

The IPS program does not currently conduct injury prevention research to support program implementation, does not largely support data collection activities (relying upon other agencies

for that purpose), does not yet monitor injury and violence data quality, and has limited experience with monitoring, reporting, and disseminating injury and violence data.

Strengths

- Access to four established core data sets (vital statistics, HDD, Fatal Analysis Reporting System, BRFSS/YRBSS) with standard quality controls and the availability of E-code data in the HDD.
- Recognition by the executive leadership of the value of data as the foundation for program activities, and demonstration of the need to address the current dearth of data capabilities by devoting resources for a full-time injury epidemiologist and the development of missing data systems.
- A trauma registry is currently under development and being tested for completeness and validity. The trauma registry will be inclusive of all designated centers from Levels I through IV, and include data from both in and out of state trauma centers serving Arkansas residents. Data will be available for assessment in a short period of time.
- Plans have been set in motion to develop a surveillance system for ED and EMS data.
- Capability to add key and core IVP data elements to the emerging ED, EMS, and trauma registry surveillance systems.
- The ACHI provides a unique and valuable resource to access, analyze, and interpret large, state-based data systems, including several data systems with direct importance for injury and violence surveillance. The center also has the knowledge and skills to link datasets.
- Capability to use local health department administrators for the dissemination and interpretation of key injury and violence indicators at the local level.

Challenges

- Several of the eleven core datasets identified in the document, "Consensus Recommendations for Injury Surveillance in State Health Departments," are not being utilized for injury and violence prevention activities in Arkansas. Selected core data (Uniform Crime Reports and National Occupant Protection Use Survey) are available but have not been pursued. Other core surveillance systems are not yet available in Arkansas and will take some time before they may become viable systems (i.e. those focused on ED data, CDR, EMS, and coroner/ME reports).
- Data sharing arrangements between external state agencies and IPS have not been identified and developed. Data sharing between the OHS and IPS has not been established. Access to and use of data available through the ACHI has not been pursued.
- Due to the recent establishment of the Injury Prevention & Control Branch, available personnel have limited experience in injury epidemiology methods, database analysis

strategies, and database linkage capabilities. Further, available personnel have not yet gained full involvement with the assessment and analysis of HDD and BRFSS data.

- Very limited prior IPS program experience in using data to support program implementation, dissemination, and reporting on key injury and violence issues, including the disparity in injury and violence among sub-groups of the Arkansas population.
- No prior IPS program experience in using and interpreting data at local levels, both analytically and programmatically.

Recommendations

The Arkansas Injury Prevention & Control Branch should:

1. Mentor and develop the data knowledge, skills, and abilities of the injury epidemiologist so that this position would be the person known as the one of the state experts on injury data, analysis, dissemination and interpretation. Key components of this development should include:
    a. Continued mentoring from the primary state epidemiologists;
    b. Integration of the injury epidemiologist into other state-based data groups;
    c. Integration of the injury epidemiologist into the ACHI to allow for access to and increased knowledge of state data systems, and the development of the ability to link datasets; and
    d. Membership and participation in national organizations, including the Council of State and Territorial Epidemiologists (CSTE) and the Safe States Alliance.
2. Develop an Injury and Violence Data Users Group so that individuals fully and partially involved in administrating or analyzing data from surveillance systems pertinent to injury and violence data can discuss technical issues, develop common approaches, and support each other's efforts in making data useful for the IPS program.
3. Increase collaboration with the OHS in the Arkansas State Police. At a minimum, this should include:
    a. Becoming an active member of the Strategic Highway Safety Plan; and
    b. The establishment of two-way data sharing between the OHS and IPS.
4. Recognize and exploit the opportunity to integrate key injury and violence data elements into the developing ED data, trauma registry, and EMS data surveillance systems. Key data needs should be identified from national resources, such as the Data Elements for Emergency Department Surveillance and that National Trauma Data Bank.
5. Given that resources exist, exploit the ability to enhance injury and violence surveillance using the BRFSS and YRBSS mechanisms by adding questions appropriate to state and local needs.
6. Develop an Injury and Violence Surveillance Plan to identify a process to build the capacity of the IPS to use core data systems for program needs, including coroner/ME

data, Uniform Crime Reports, and CDR data. The plan should also include alternative sources of intentional injury data focused on attempted suicide, child maltreatment, rape and sexual assault, and domestic violence. Strengths and weaknesses of available data should be assessed and data systems, if not yet developed, should be established preliminarily though pilot programs.

7. Expand links between the IPS and the Boozman College of Public Health via preceptorships and internships to utilize graduate students in program data activities.
8. Implement a formal evaluation of the functioning ED, EMS, and trauma registry, and other key injury and violence surveillance systems following the public health surveillance system evaluation criteria of the CDC.
9. Identify procedures for enabling access to the trauma registry, ED data, and EMS data systems by external agencies, partners, researchers, and the public.
10. With the establishment of high quality injury and violence surveillance mechanisms, use available data to regularly:
    - Identify and support program development and priorities;
    - Report on health disparities in injury and violence at the state and local level; and
    - Disseminate data to internal and external partners and coalitions.

INTERVENTION DESIGN, IMPLEMENTATION, AND EVALUATION

Standard

- The injury and violence prevention program collaborates with internal and external stakeholders, reflective of the state's diverse populations, to promote the development, implementation and evaluation of injury prevention interventions.
- The injury and violence prevention program's interventions address a wide range of populations and injuries.
- The selection and design of interventions is informed by needs assessments, asset assessments, and data on disparities in morbidity, mortality, and risk factors.
- The injury and violence prevention program staff adopts effective or promising approaches and considers feasibility and acceptability when developing intervention plans.
- Attention is given to fitting injury prevention interventions into a culturally appropriate framework of norms, values, roles, and practices.
- All injury prevention interventions are designed to include plans for multi-faceted evaluation and dissemination of evaluation findings.
- A comprehensive intervention approach is utilized at state, local, and community levels.
- The state injury and violence prevention program supports and monitors injury prevention activities at the local level.
- The injury and violence prevention program identifies, selects and establishes collaborative agreements with agencies and individuals to implement injury prevention interventions.
- The injury and violence prevention program facilitates the development of state interventions and intervention components that complement the injury and violence prevention program's goals and objectives.
- Progress in achieving the objectives of the state injury prevention plan or agenda is monitored by state injury prevention staff and stakeholders.

Status

The ADH had federal funding from CDC from the early 1990s through 2008 to implement various injury prevention interventions, including residential fire safety and child passenger safety. Additionally, ADH has funding from the Health Resources and Services Administration (HRSA) for the Emergency Medical Services to Children (EMSC) program, and had funding through 2010 for a Traumatic Brain Injury (TBI) Awareness Project. The ADH also had funding from the Robert Wood Johnson Foundation to implement the Common Ground Violence Prevention Initiative. As federal funding ended, few other state or federal resources were allocated to IVP within ADH, resulting in limited engagement of IVP activities.

With the exception of efforts addressing falls among older adults, most recently ADH has financially supported the ACH to conduct childhood injury prevention activities. This partnership has expanded childhood injury prevention efforts across the state. As a result, ADH has played only a limited role in providing statewide planning and coordination for IVP efforts.

The STAT heard evidence that there are IVP activities being conducted by internal partners at ADH (i.e., strength training for older adults, training of dentists to recognize signs of child maltreatment); however, there have been limited attempts to collaborate among internal programs at ADH on IVP efforts.

With the passage of the Trauma System Act in 2009 and the recent award from the CDC for the Core VIPP, the IPS has a unique opportunity to select interventions based on evidence-informed research.

As is common in many states and communities, some of the injury prevention activities reported to the STAT that are being conducted at the local level were those that are based on educating individuals to be safer, but may not be evidence-informed and may be ineffective.

It is important that the IPS support and monitor IVP activities at the local level. The STAT heard evidence about plans to disseminate funds to HHI to increase IVP activities at the local level.

The ACH has conducted an online needs assessment survey of hospitals and EMS providers across the state to obtain information about injury prevention activities and training. There are plans to repeat the needs assessment in the future to obtain additional information, as well as broaden the distribution to include HHI.

Trained and high-caliber staff are a key element of an injury prevention program, contributing to the success of interventions as well as the program's overall strength and longevity. Though passion and interest are important, they are insufficient criteria for staffing effective IVP programs. The ACH has developed an IVP course, which will be provided to HHI and injury prevention staff at local hospitals.

Strengths

- The passage of the Trauma System Act of 2009 provides substantial funding for the Injury Prevention & Control Branch, with dedicated funding for implementation of IVP strategies.
- The IPS has the ability to fund and guide IVP strategies to HHI, which has the potential to result in HHI being more engaged in IVP at the local level.

- There is injury prevention expertise among senior staff at ACH, and IPS has a strong collaborative relationship with this entity.
- The potential to have integrated injury and violence data could yield direction on selecting areas to focus intervention strategies.
- The ACH has integrated IVP into the pediatric residency program at UAMS. Because of expertise and a variety of training modalities, ACH has the capability to provide childhood IVP training, as well as training on specific injury and violence topics.

Challenges

- There has been a lack of sustained IVP intervention activities at ADH.
- The ADH lacks an injury prevention identity among stakeholders and clients served by ADH.
- There has been little attention devoted to violence prevention at ADH over the years.
- There is a lack of training on IVP principles at the state and local level.
- There has historically been a lack of internal coordination and collaboration among ADH programs on IVP issues.
- In the absence of a strong, centralized IVP program at ADH, the ACH assumed the coordination of childhood injury prevention activities, and thus an identity as the statewide leader in this area. With the new funding and commitment of ADH executive leadership to establishing a comprehensive IVP program, there may be a challenge for IPS to be recognized in a leadership role.

Recommendations

IPS should:

1. Conduct a more comprehensive needs assessment of the IVP workforce in Arkansas, beyond the hospital and EMS personnel, to include regional HHI support staff and county health department staff.
2. Work with partners to develop a compendium of evidence-informed strategies specific to injury and violence topic areas.
3. Serve as a clearinghouse to disseminate information about identified proven and promising strategies and IVP training opportunities to the IVP workforce in Arkansas.
4. Implement proven and promising IVP strategies that are comprehensive and go beyond awareness and information dissemination activities to approach behavioral, social, and environmental change.
5. Actively seek opportunities for IPS to work with internal programs and external stakeholders on IVP issues, including the review of statewide educational and media materials to portray appropriate IVP messages.

6. As appropriate, ensure that the full range of evaluation components—formative, process, impact, and outcome evaluation—are an integral part of the prevention strategies from the beginning.
7. Utilize accepted conceptual models (i.e., Haddon Matrix, social ecological model, Spectrum of Prevention) to identify intervention opportunities and/or develop future interventions. Establish mechanisms to ensure fidelity to evidence-informed protocols.
8. Work with ACH to ensure that training to locals includes not only information about evidence-informed strategies, but also information about activities and interventions that are NOT effective.
9. Ensure that attention is given to implementing IVP strategies into a culturally appropriate framework of norms, values, roles, literacy levels, and practices.
10. Explore opportunities to expand partnerships among public and private entities to address under-served populations in Arkansas.
11. Identify key stakeholders at the local level and provide funding for them to attend formal IVP training that has been mapped to the core competencies for IVP adopted by the Safe States Alliance and Society for the Advancement of Violence and Injury Research (i.e., Johns Hopkins Summer Institute: Principles and Practices in Injury Prevention).

PUBLIC POLICY

Standard

- The injury and violence prevention program has access to local, state and federal policy-makers to achieve injury and violence prevention program goals.
- The injury and violence prevention program monitors the effectiveness of existing state and local policies and disseminates findings.
- The injury and violence prevention program reviews proposed legislation.
- The injury and violence prevention program collaborates with all appropriate partners, reflective of the state's diverse populations, to develop and promote policies related to selected injury and violence prevention issues.
- The injury and violence prevention program participates in the process of policy development to support injury and violence prevention.

Status

Arkansas has a strong tradition of protecting personal freedoms and limiting the size of state government and legislation mandating personal behaviors. Despite this, there is demonstrated political and significant administrative support for IVP in Arkansas and there have been many recent public health IVP successes. In the legislature, this is demonstrated by a strong suite of motor vehicle policies, including the 2009 passage of Trauma System Act, Graduated Driver's Licensing (GDL) system, and primary seat belt laws. The Trauma System Act specifically recognizes injury prevention as a critical piece of a successfully functioning trauma system. Additionally in 2011, statutes were passed requiring:

- Home safety measures related to carbon monoxide detectors;
- Intentional injury prevention related to educating parents about Shaken Baby Syndrome and providing in-service training on teen suicide awareness and prevention for licensed educational personnel; and
- Unintentional injury prevention related measures to strengthen recreational injury prevention and motor vehicle related policies.

Within the ADH, this is evidenced by the State Health Officer's national and state leadership in advancing IVP through the Association of State and Territorial Health Officials 2010 Presidential Challenge on Injury and Violence Prevention, and the significant involvement of the senior ADH leaders in working closely with the state legislature to develop and fund the Injury Prevention & Control Branch through the Trauma System Act.

There is no state regulation prohibiting the IPS from communicating with policy makers, and the State Health Officer has direct access to the Governor's Office and the State Legislature. There are state regulations prohibiting state employees from lobbying policy makers; however IPS can provide education/information to legislators when asked and after getting approval to do so from ADH management. There are established mechanisms for the IPS to work with policymakers to advance public health and IVP policies including:

- A required bi-annual report and testimony to the Joint House and Senate Committee on Public Health, Welfare and Labor through the Trauma System Act on the status of IVP activities;
- The formal process for reviewing proposed legislation within deadlines; and
- Opportunities to identify and advance needed legislation related to IVP.

Additionally, state health department leaders and three members of the Arkansas Legislature recently attended a workshop entitled "Preventing Injuries to Save Lives and Money" which was coordinated by the National Conference of State Legislators (NCSL) and the CDC. As a result of this meeting, an action plan will be developed with specific goals and objectives for advancing IVP policies within Arkansas.

In spite of these legislative successes and Dr. Halverson's support, there has been little leadership or coordination from ADH in the area of IVP across the state until this point. Additionally, despite the presence of resources, the Trauma System Act and the state personnel policies limit the further development of a strong program staff for statewide IVP within the current fiscal and political environment. Given the lack of state IVP infrastructure, there has been limited Injury Prevention & Control Branch involvement in the development, review, monitoring and evaluation of IVP policies. While there are regular opportunities for communication among directors, branch chiefs and programs, it is unclear whether the time is used to identify and advance policies that will have multiple health and safety impacts.

Without leadership from the IPS, the ACH has filled a void in developing partnerships, messages and materials to advance childhood IVP, including a resource guide for state policy makers covering existing laws, statistical information and best practice recommendations for preventing injuries related to all-terrain vehicles (ATV), increasing booster seat use, addressing concussion and youth sports, and describing existing motor vehicle-related policies.

The IPS has not conducted a scan of policies at the state and local level that address IVP, nor identified gaps and opportunities to work with advocacy groups to identify needed policy changes. For example, currently there are few regulations or laws in place regarding ATVs and their riders, which pose a significant risk of injury in Arkansas, particularly to young riders.

However, partnerships currently exist with organizations and agencies with strong advocacy components and histories of addressing childhood injury prevention policy at the state level.

There are 35 Senators and 100 Representatives in the Arkansas General Assembly, which meets in odd number years for a minimum of 60 days, with the authority to extend the session if necessary. The legislature also meets in fiscal session in even-numbered years, beginning in February. The fiscal session lasts up to 30 days and can be extended to 45 days, but no longer than 45 days. Also, the governor can call a special session during the interims between regular sessions. Representatives are limited to three terms of two years each and Senators are limited to two terms of four years each. While this provides only a small window of opportunity to get legislation passed, it allows a great deal of time between legislative sessions to lay important groundwork on potential legislation.

Strengths

- There is a funded legislative mandate for the IPS through the Trauma System Act, which also established strengthened motor vehicle safety policies including a primary seat belt law and GDL legislation in 2009. Additionally, in the 2011 session, there were a significant number of policies that were passed related to IVP. These recent successes have generated momentum and identification of legislative champions.
- There is significant senior leadership and passion, particularly through the state health official, Dr. Halverson, for policy approaches to IVP within the ADH.
- There is legislative support and potential champions who have been identified as supportive of public health, injury and trauma issues. Additionally, ADH works effectively with the House and Senate Committee on Public Health, Welfare and Labor as evidenced by the state's participation in the recent NCSL/CDC meeting and Representative Greg Leding's interview with the team.
- There are established mechanisms for the IPS to communicate with policymakers including legislatively required reports to the House and Senate Committee on Public Health, Welfare and Labor.
- The health department monitors legislation and provides opportunities for programs to review and comment on proposed bills, as well as to draft new legislation.

Challenges

- There is a lack of staff capacity within the IPS to promote, monitor, review, develop and evaluate public policies. Additionally, this limits opportunities to bring together programs within the ADH to identify shared policy priorities to advance the health and safety of Arkansas' residents.
- There is concern about suboptimal enforcement of existing and new laws related to IVP leading to limited effectiveness of these policies.

- Despite having a motor vehicle death rate higher than the national average and recent successes in strengthening motor vehicle-related policies, the occupant safety laws and the GDL system do not comply with nationally recommended best practices.
- Motorcycle helmets are required only for riders aged 20 and younger and there is no bicycle helmet law.
- A culture of "protecting personal freedoms and limiting state government" exists in Arkansas. This presents challenges when trying to develop an adequate staff and infrastructure, as well as providing statewide leadership in addressing certain IVP-related polices.
- The structure of the state legislature and its calendar pose challenges to the IPS. Due to term limits, one-third of the legislature changes every two years, which increases the need for ongoing development of relationships and education of policymakers on the importance of IVP policies. Additionally, policy sessions of the legislature meet only in alternating years, which limit the opportunities to advance policies to reduce injuries and violence within the state.

Recommendations

ADH should:

1. Work closely with the state personnel committee to communicate the need for strong IVP program infrastructure within the state health department, including but not limited to, immediately hiring a well-qualified Section Chief with strong experience in IVP and leadership and management.
2. Utilize its state agency relationships to promote aggressive enforcement of IVP laws through direct senior-level communication and formal partnerships with state police, as well as through the media. Additionally, ADH should ensure leadership and organization for the enforcement of injury and violence related policies at the state level (i.e.: monitor and support implementation of related daycare regulations, Medicaid transportation standards, suicide risk awareness training, soccer goal safety guidelines, etc).

The IPS should:

1. Immediately utilize resources within the Core VIPP grant to hire an experienced, well-qualified staff member charged with managing internal relationships, the ICPG and other external partnerships, and develop and oversee policy approaches to IVP, in lieu of a second data analyst.
2. Seek training and technical assistance from associations and agencies with expertise in public health and IVP policy such as Safe States Alliance, CDC, the Directors of Health

Promotion and Education and the Society for the Advancement of Violence and Injury Research. The IPS should also continue to participate in national activities such as the NCSL/CDC Workshop.

3. Identify and provide training for local partners and HHI Coalition members for policy approaches to injury prevention and control (i.e., Shaping Policy for Health™).
4. Form a Policy Committee of the ICPG to develop and strategically disseminate a policy agenda. Develop a media and legislative packet for all priority areas, utilizing national and state resources and templates, that includes:
5. Fact sheets with data on deaths, disability and associated costs as well as proven and promising practices.
6. A one page brief that describes the IVP program, its goals, objectives, capacities and history for dissemination to the ADH, key stakeholders, partners and policy makers; and
7. A standard report on the status of IVP to be distributed annually.
8. Conduct a scan of all laws and formal and informal policies related to identified policy priorities at the state and local level that address IVP and interventions, and identify gaps and opportunities to work with advocacy groups to support needed policy changes.
9. Work with the ADH Office of Governmental Affairs to proactively provide input into department legislative priorities and draft and review legislation as appropriate.
10. Convene regular meetings, press conferences, and seminars to keep partners, policymakers, and the public informed about issues of importance in injury and violence.
11. Identify and actively participate in relevant state associations (such as Arkansas Public Health Association, Arkansas Chapter of the American Academy of Pediatrics, Arkansas Emergency Nurses Association, etc), commissions, task forces, boards and the ACHI to advance the policy agenda and IVP.
12. Prioritize evaluating the impact of legislation, such as the primary seat belt law and GDL system in partnership with key stakeholders such as the OHS and the Arkansas State Police.
13. Support law enforcement at program levels to enhance enforcement through national campaigns (i.e., *Click it or Ticket*, etc) and other strategic enforcement initiatives.

THE STATE TECHNICAL ASSESSMENT TEAM
BIOGRAPHICAL INFORMATION

Team Leader
Susan Hardman
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Susan Hardman served as the New York State Department of Health's Director of the Bureau of Injury Prevention from 1998- 2011. She has worked in the field of injury and violence prevention for over 24 years with an interest in moving research to action by translating evidence-based and promising research findings for public health practitioners in the field. Susan began her career working with partners and stakeholders to establish a multidisciplinary statewide bicycle safety program. Currently the NYS injury program focuses on surveillance of injuries and violence with an emphasis on policy development, as well as programs in traffic safety, fall prevention in older adults and childhood injury and violence prevention. Susan currently is a Public Health Advisor in the CDC's Office of State, Tribal, Local and Territorial Support in Atlanta, Georgia.

Infrastructure
Tomi St. Mars, MSN, RN, CEN, FAEN
Injury Prevention Section Manager
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Tomi St. Mars has 25 + years of professional experience that includes EMS, emergency nursing, traffic safety and injury prevention. As manager for Arizona's Injury Prevention/Child Fatality Review section within the department of health, Tomi facilitates several stakeholders' groups challenging them to address injury concerns using data and collaboration at the local level. Tomi has a deep appreciation for building relationships and networks that support the injury prevention, health and safety needs of Arizonans. A firm disbeliever in duplication of effort, she connects people, ideas and resources across communities. Tomi consulted on the development and updating of Indian Health Service's Safe Native American Passenger (SNAP) program and is a section editor for Injury Prevention with the Journal of Emergency Nursing. Tomi earned her Master's degree in Nursing (healthcare systems) from the University of Arizona and her undergraduate Bachelor of Science in Nursing from Grand Canyon University. In 2007, Tomi was inducted into the Academy of Emergency Nursing.

Data
Tom Songer, PhD, MSc, MPH
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Dr. Tom Songer is an assistant professor in the Department of Epidemiology, Graduate School of Public Health, University of Pittsburgh. Dr. Songer's research interests have focused on the epidemiology and costs of injuries and chronic disease. He has been involved in the conduct of several research projects, including work on identifying the motor vehicle crash risks for persons

with diabetes, identifying the injury risks faced by wheelchair users in motor vehicle transportation settings, and the medical costs of child maltreatment. He has received research support for these and other projects from the NIDDK, NIDDR, and CDC. Dr. Songer leads the injury training concentration area in the Department of Epidemiology, and teaches the primary introductory course in epidemiology for the school, and offers courses in injury epidemiology and injury prevention and control. In the past, Dr. Songer has been involved with the National Training Initiative, and worked on the development and publication of the core competencies for injury and violence prevention professionals. Dr. Songer has served on several NIH, AHRQ, and CDC review panels, and currently serves as the co-chair for the Injury Community Planning Group for the State of Pennsylvania.

Program

Shelli Stephens Stidham
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Shelli Stephens-Stidham, M.P.A., is the Director of the Injury Prevention Center of Greater Dallas (IPC) in Dallas, Texas. The IPC has adopted the World Health Organization (WHO) Safe Communities model as an approach for working in communities to engage residents in injury prevention. In 1996, the IPC assisted Dallas in becoming the first WHO designated Safe Community in the United States; Dallas was re-certified by the WHO in 2007. Ms. Stephens Stidham has 28 years of experience in public health, including 22 years in injury and violence prevention. She is the past-president of the Safe States Alliance (formerly the State and Territorial Injury Prevention Directors Association). She is co-chair of the National Training Initiative for Injury and Violence Prevention (NTI), and served on the committee that developed core competencies for injury and violence prevention professionals. She is a member of the American Public Health Association, Society for the Advancement of Violence and Injury Research (SAVIR), Texas Public Health Association, Texas Governor's EMS & Trauma Advisory Council (GETAC), and serves on the External Advisory Committee for the University of North Carolina Injury Prevention Research Center.

Policy

Amber Williams
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Amber Norris Williams is the Executive Director of the Safe States Alliance (formerly STIPDA). As the Executive Director of Safe States Alliance, Ms. Williams provides direction and leadership to achieve Safe States Alliance's mission, strategic plan and annual operating plans, and serves as an advocate for Safe States Alliance's interests with federal organizations and other partners and stakeholders. Amber is a frequent speaker on various injury prevention and organizational development topics and has provided testimony to the Senate Health, Education, Labor and Pensions Committee on childhood injury prevention. Amber began her career in injury prevention at a local health department in the metro Atlanta area, and has also worked at the state level in Georgia to build community-based childhood injury prevention coalitions. She joined Safe States Alliance's staff in 2003 and served as the Acting Executive Director between

2006 and 2007. Ms. Williams has a B.S.Ed in Health Promotion & Education from the University of Georgia.

Floater
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Dwayne Smith is the Injury Prevention Manager at AnMed Health, a 573-bed hospital and Level II Trauma Center in Anderson, South Carolina. In this role, he has established numerous community-based injury prevention initiatives, including Safe Kids Anderson County, a Safe Communities highway traffic safety program, a traffic fatality review team, a pedestrian safety task force, and more. He has over 20 years experience as a Health Educator, including the past 16 years in a variety of injury and violence prevention roles at state and local health department levels and at a large metropolitan health department. His primary interests surround pediatric injury prevention efforts. Since 1999, programs under his guidance have been credited with helping prevent fatal injuries to at least 17 local children. Dwayne earned his B.S.Ed. and M.Ed. in Health Promotion & Behavior from the University of Georgia. He is South Carolina's original and longest serving child passenger safety technician, and was recently credentialed as a Master Certified Health Education Specialist.

Administrative Assistant
Sarah Hinkel-Young
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Sarah Hinkel-Young joined the State of Florida's Office of Injury Prevention in August of 2010 as the CDC Injury Prevention Grant Manager. She has two Bachelor of Science degrees in Biomedical Health and Business Management, and a Masters of Business Administration in Nonprofit Management. She previously worked for AMIkids Inc., a national nonprofit where she was lead evaluator and grant writer for 57 local programs.

Observer
Linda DeGutis, DrPH, MSN
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Dr. Degutis is currently Director of the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention (CDC). Prior to this, she was Associate Professor of Emergency Medicine and Public Health at Yale University. She was the Research Director for the Department of Emergency Medicine, and also served as Director of the Yale Center for Public Health Preparedness at Yale School of Public Health. In addition, she directed the Connecticut Center for Public Health Workforce Development. A native of Chicago, IL, Dr. Degutis received her BS from DePaul University in Chicago, and her MSN and DrPH from Yale University. She was a Robert Wood Johnson Foundation Health Policy Fellow, and worked in the office of the late Senator Paul Wellstone (D-MN). Dr. Degutis' research interests have focused on injury, alcohol and other drug problems, and trauma, with a particular interest in policy issues. Recently, she collaborated on projects related to developing a research agenda for

public health systems and services research, and initiatives with HHS in the area of quality improvement in public health. Her research has been funded through several federal agencies and the Robert Wood Johnson Foundation. She was President of the American Public Health Association, a member of the APHA Executive Board, and served two terms as chair of the Executive Board. Currently, Dr. Degutis serves on the Robert Wood Johnson Health Policy Fellowship Advisory Board, and the editorial boards of the journals Injury Prevention, and Disaster Medicine and Public Health Preparedness. In addition, she served as the Co-Chair of the Connecticut Coalition to Stop Underage Drinking, and worked on a number of community-based efforts focused on improving public health through coalition development and action.

Observer
Judy Monroe, MD, FAAFP
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Judith A. Monroe is Director of the Office for State, Tribal, Local and Territorial Support. In this role she provides critical leadership improving and supporting the public health system. Prior to assuming this position, Monroe served as the Indiana State Health Commissioner 2005 - 2010. She has held several national public health leadership positions and is a past president of the Association of State and Territorial Health Officials and served as vice chair on the Board of Directors for the Public Health Accreditation Board.

Under Monroe's leadership as Indiana State Health Commissioner, Indiana improved its obesity ranking from most obese in 2003 to 28th in 2009 (obesity decreased by 14.7 percent in youth and 3 percent in adults); cigarette consumption decreased nearly 25 percent, smoking among high school students dropped 21 percent and among middle school students dropped 46 percent. In 2007, the Indiana General Assembly passed a bill to increase the cigarette tax and all revenue went to health-related programs. As a result, childhood immunizations improved and the percentage of uninsured residents declined. In addition, colon cancer screening increased 34.5 percent; cancer incidence, heart disease, and all causes of mortality decreased significantly. Monroe focused on preparedness, preventing medical errors and quality improvement, in addition to health promotion and prevention. She partnered with Purdue University and led the design and implementation of the Indiana Public Health System Quality Improvement Project to strengthen local public health capacity, infrastructure, and public health system performance. Monroe received her undergraduate degree from Eastern Kentucky University and medical degree from the University of Maryland. She completed her residency in family medicine at the University of Cincinnati. Following her residency, she fulfilled a four-year National Health Service Corps commitment by practicing in rural Tennessee and then joined the faculty in the Department of Family Medicine at Indiana University.

Prior to being named the Indiana State Health Commissioner, she directed the Family Medicine Residency Program and Primary Care Center at St. Vincent Hospital in Indianapolis. She has received multiple awards for her teaching, clinical and leadership skills. Most recently, she was presented the MVP Award by Peyton Manning on behalf of the Peyton Manning Children's Hospital for her work to improve the health of children, the 2010 McGovern Award, and the Governor's Distinguished Service Medal from Governor Mitch Daniels.

ACRONYMS LIST

- ACH – Arkansas Children's Hospital
- ACHI – Arkansas Center for Health Improvement
- ADH – Arkansas Department of Health
- ASTHO - Association of State and Territorial Health Association
- ATV – All-Terrain Vehicle
- BRFSS – Behavioral Risk Factor Surveillance System
- CDC – Centers for Disease Control and Prevention
- CDR – Child Death Review
- Core VIPP – Core Violence and Injury Prevention Program
- Death Certificate – Vital Statistics
- ED – Emergency Department
- EMS – Emergency Medical Services
- EMSC – Emergency Medical Services - Children
- FARS – Fatal Analysis Reporting System
- GDL – Graduated Drivers Licensing
- HDD – Hospital Discharge Data
- HHI – Hometown Health Initiative
- HRSA - Health Resources and Services Administration
- ICPG – Injury Control Prevention Group
- IPS – Injury Prevention and Control Section
- IVP – Injury and Violence Prevention
- MCH – Maternal Child Health
- ME – Medical Examiners
- NCIPC – National Center for Injury Prevention and Control
- NCSL - National Conference of State Legislators
- OHS – Office of Highway Safety
- Safe States – Safe States Alliance
- STAT – State Technical Assessment Team
- TAC – Trauma Advisory Council
- TBI – Traumatic Brain Injury
- UAMS – University of Arkansas Medical School
- YRBSS – Youth Risk Behavioral Surveillance System