





### STATE INJURY AND VIOLENCE PREVENTION PROGRAMS









### STATE INJURY AND VIOLENCE PREVENTION PROGRAMS

The State and Territorial Injury Prevention Directors Association is a national non-profit organization of professionals committed to strengthening the ability of state, territorial and local health departments to reduce death and disability associated with injury and violence. STIPDA is the only national nonprofit organization comprised of public health injury professionals representing all U.S. states and territories.

The Association of State and Territorial Health Officials is the national non-profit organization representing the state and territorial public health agencies of the United States, the U.S. Territories and the District of Columbia. ASTHO's members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy, and to ensuring excellence in state-based public health practice.

This compendium was made possible through funding from CDC's National Center for Injury Prevention and Control (Cooperative Agreement U50/CCU313903-07). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC. Information and data in each state example featured in this document were provided by state health department staff.

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### FOREWORD

Injury in the U.S. is endemic. Nationally, and in every state in the U.S., injury is the leading cause of death during the first three decades of life. More than 148,000 people died from injuries and violence in 2000; injuries and violence are the fourth leading killer in the U.S. This document, Making a Difference: State Injury and Violence Prevention Programs, presents examples of how state health departments are achieving impressive results preventing injuries and violence among their populations.

Millions of Americans also are injured and survive, only to be disabled, live with chronic pain or experience a profound change in lifestyle. More than 30 million people are treated for injuries in U.S. emergency departments each year; injuries account for over 35 percent of emergency department visits annually. Injuries cost an estimated \$260 billion annually.

These injuries - car crashes, falls, homicides, and other violent deaths, for example - are so common that they're often viewed as inevitable, as accidents. But when a public health approach is applied to the problems of injury and violence, these events can be predicted and, in most cases, prevented. In fact, each day, state health department injury and violence prevention programs utilize scientific methods like those used to prevent infectious and chronic disease in order to reduce injuries and save tens of thousands of lives.

Although only one prevention and impact example is presented for each state, collectively the examples illustrate the diversity of the issues faced by state health departments in preventing injury and violence, and show the equally multi-faceted responses that state programs have to this major public health problem.

It is important to note that the capacity of state injury and violence prevention programs differs significantly from state to state. Staff size and the types of injuries or violence addressed are just two examples of this variance. Funding levels and competing priorities often affect a state's capacity to most effectively respond to injury and violence.

The state activities described in this report make it clear: state injury and violence prevention programs save lives and money, and contribute significantly to the public's health and safety. We thank the many dedicated public health professionals who contributed to the development of this report, and hope you will find this report both useful and compelling.

Sincerely

Leah Devlin, DDS, MPH President Association of State and Territorial Health Officials



ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

### ASTHO

Trisha Keller, RN, MPF President State and Territorial Injury Prevention Directors Association





### INJURY AND VIOLENCE IN THE U.S.

### INJURY AND VIOLENCE AFFECT EVERYONE.

Whether a person dies from an injury or survives, family, friends, co-workers, employers, and the health care system also are affected.

### IN 2000, MORE THAN 148,000 PEOPLE DIED FROM INJURIES.

- · Unintentional injuries often called accidents kill more people up to age 34 in the U.S. than any other cause of death.
- Injury is the leading cause of death and disability among children and young adults.
- · Unintentional injuries and violent acts combined are among the top 10 killers of Americans in all age groups.

### AN EVEN GREATER NUMBER SURVIVE, ONLY TO EXPERIENCE DISABILITY, CHRONIC PAIN AND A PROFOUND CHANGE IN LIFESTYLE.

In 2000, almost 30 million people were treated for injuries in U.S. emergency departments.



### INJURY AND VIOLENCE PLACE A TREMENDOUS **BURDEN ON THE U.S. HEALTH CARE SYSTEM.**

- Violent and unintentional injuries cost an estimated \$260 billion annually (in 1995 dollars).
- The federal government pays almost \$9 billion annually for medical care of injured persons, mainly through Medicare and Medicaid.
- The federal government also pays over \$14 billion annually in disability and survivor benefits through Social Security Disability Insurance, Supplemental Security Income, and the Veterans Administration.

### LIKE DISEASES, INJURIES ARE PREVENTABLE.

- Injuries do not occur randomly; they often are predictable and preventable.
- State and local health departments use the same scientific methods to prevent injuries that have been used to prevent infectious and chronic diseases.
- Public health efforts to prevent injury and violence have been highly successful. For example, motor vehicle-related deaths have been reduced significantly in recent decades; hundreds of lives have been saved from residential fires thanks to smoke alarm distribution and fire safety education programs.
- With adequate resources, state health departments can effectively address injury and violence statewide and in local communities.

### Resources:

Website of the National Center for Injury Prevention and Control, www.cdc.gov/ncipc. National Center for Injury Prevention and Control. Injury Fact Book 2001-2002. Atlanta, GA: Centers for Disease Control and Prevention; 2001.



ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS









### THE TOLL OF INJURY AND VIOLENCE & THE BENEFITS OF PREVENTION

The costs of injury and violence in the U.S. are many, including physical, emotional and economic. But there are proven prevention measures that can save lives and money, and there are known protective factors that may lessen risks. *Here are some examples:* 

	Toll of injury and violence	Opportunities for prevention
Child passenger safety <sup>j, 2</sup>	<ul> <li>Motor vehicle crashes are the leading cause of death among children in the U.S.</li> <li>Every <i>year</i>, more than 322,000 children will be killed or injured.</li> <li>Every <i>week</i>, more than 40 children are killed.</li> <li>Every <i>day</i>, 900 children are hurt.</li> </ul>	<ul> <li>Child safety seats reduce the risk of death by 70% for infants and 55 % for toddlers.</li> <li>Every \$45 child safety seat generates \$1,800 in benefits to society.</li> <li>Every \$30 booster seat generates \$2,000 in benefits to society.</li> </ul>
Home fires <sup>1,2,3</sup>	<ul> <li>The vast majority of fire deaths in the U.S. occur in the home.</li> <li>Every year, there are 3,400 deaths and 17,000 injuries.</li> <li>Every week, more than 365 people are killed or injured.</li> <li>Every day, there are nearly 1,100 residential fires.</li> <li>Every day, approximately 53 people are injured or killed.</li> <li>In 2002, residential fires caused more than \$6.1 billion in property damage.</li> </ul>	<ul> <li>Smoke alarms reduce the chance of dying in a house fire by up to 50%.</li> <li>Every \$30 smoke alarm generates \$870 in benefits to society.</li> </ul>
Traumatic brain injury <sup>45</sup>	<ul> <li>Each year in the U.S.:</li> <li>At least 1.4 million people sustain a TBI.</li> <li>Of them, about 50,000 die, and 80,000 to 90,000 experience permanent disability.</li> <li>Falls are the leading cause of TBI; rates are highest among children ages 0 to 4 and adults age 75 and older.</li> <li>Societal costs associated with bicycle-related head injury or death resulting from head injury are more than \$3 billion annually.</li> </ul>	<ul> <li>Bicycle helmets reduce head injuries and deaths by up to 85%.</li> <li>Every \$10 bicycle helmet generates \$530 in benefits to society.</li> </ul>

### THE TOLL OF INJURY AND VIOLENCE & THE BENEFITS OF PREVENTION Continued





### (ASTHO)

	Opportunities for prevention
nillion such	Protective factors may lessen the
nong women	likelihood of domestic/intimate partner
e U.S.	victimization or perpetration. These
nearly 2 million	factors exist at individual, relational,
0 deaths.	community, and societal levels. Less is
an is beaten in	known about protective factors, but the
	literature suggests some factors. For
ATTAC NO.	example, increased social support has
S. costs an	been significantly related to a reduced risk
ally.	of poor perceived mental health, poor
	physical health, anxiety, depression,
	symptoms of posttraumatic stress
a second s	disorder, and suicide attempts. Protective
	factors for perpetration include:
2001 L	<ul> <li>emotional health;</li> </ul>
	<ul> <li>connectedness with friends and adults</li> </ul>
- 1911.	in the community; and
	<ul> <li>high socioeconomic status.</li> </ul>
ber of U.S. child	Protective factors may lessen the risk of
are available	child maltreatment. Protective factors
e agencies, but	exist at individual, relational, community,
nsidered	and societal levels and include:
	<ul> <li>supportive family environment;</li> </ul>
n confirmed by	<ul> <li>nurturing parenting skills;</li> </ul>
agencies as	<ul> <li>stable family relationships;</li> </ul>
experienced	<ul> <li>household rules and monitoring of the</li> </ul>
ically abused,	child;
ed, and 5%	<ul> <li>parental employment;</li> </ul>
chologically	<ul> <li>adequate housing;</li> </ul>
10 10 24 1055	<ul> <li>access to health care and social</li> </ul>
dren were	services;
from	<ul> <li>caring adults outside family who can</li> </ul>
hese deaths were	serve as role models or mentors; and
physical abuse,	<ul> <li>communities that support parents and</li> </ul>
maltreatment	take responsibility for preventing
	abuse.





### THE TOLL OF INJURY AND VIOLENCE & THE BENEFITS OF PREVENTION

Continued

	Toll of injury and violence	Opportunities for prevention
	Direct costs (judicial, law enforcement, and health system responses to child maltreatment) are estimated at \$24 billion each year. The indirect costs (long-term economic consequences of child maltreatment) exceed an estimated \$69 billion annually.	
Suicide <sup>15,16,17,18</sup>	<ul> <li>In 2001:</li> <li>Suicide took the lives of 30,622 people.</li> <li>3,971 suicides were reported among young people ages 15 to 24; suicide is the third leading cause of death among this group.</li> <li>5,393 Americans over age 65 committed suicide.</li> <li>In 2002, 132,353 individuals were hospitalized following suicide attempts; 116,639 were treated in emergency departments and released.</li> <li>Males are four times more likely to die from suicide than females.</li> <li>Women report attempting suicide during their lifetime about three times as often as men.</li> </ul>	<ul> <li>Protective factors buffer people from the risks associated with suicide. A number of protective factors have been identified:</li> <li>effective clinical care for mental, physical, and substance abuse disorders;</li> <li>easy access to a variety of clinical interventions and support for help seeking;</li> <li>family and community support;</li> <li>support from ongoing medical and mental health care relationships;</li> <li>skills in problem solving, conflict resolution, and nonviolent handling of disputes; and,</li> <li>cultural and religious beliefs that discourage suicide and support self-preservation instincts.</li> </ul>

### THE TOLL OF INJURY AND VIOLENCE & THE BENEFITS OF PREVENTION Continued

<sup>14</sup> Department of Health and Human Services (DHHS) (US), Administration on Children, Youth, and Families (ACF). In focus: understanding the effects of maltreatment on early brain development. Washington (DC): Government Printing Office: 2001.

<sup>19</sup> Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (producer/Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2004). Available online from: URL: http://www.cdc.gov/ncipc/wisgam/default.htr(2004 June 21accessed).

<sup>16</sup> Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health [serial online]. 2004 May. Available online from: URL:

http://www.who.int/violence\_iniury\_prevention/violence/world\_report/wrvh1/en

<sup>17</sup> Anderson RN, Smith BL, Deaths: leading causes for 2001. National Vital Statistics Report 2003;52(9):1-86.

<sup>18</sup> Department of Health and Human Services: The Surgeon General's call to action to prevent suicide. Washington (DC): Department of Health and Human Services; 1999. Available online from: URL: http://www.surgeongeneral.gov/library/calitoaction/default.btm



<sup>1</sup> Ted R. Miller and Della Hendrie (2005). How should government spend the drug prevention dollar?: A buyer's guide. Book chapter in <u>Preventing Harmful Substance Use: The Evidence base for policy and practice</u>dited by T. Stockwell, P.J. Gruenewald, J.W. Toumbourou and W. Loxiey, John Wiley & Sons. From Children's Safety Network: Economics and Data analysis Resource Center February 2005.

<sup>8</sup> Karter MJ. Fire loss in the United States during 2002. Quincy (MA): National Fire Protection Association, Fire Analysis and Research Division; 2003.

<sup>4</sup> Langlois JA, Rutland-Brown W, Thomas KE. Traumatic Brain Injury in the United States: Emergency Department Visits, Hospitalizations and Deaths. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Control and Prevention; 2004.

<sup>3</sup> Performance Plan, Centers for Disease Control and Prevention, 2000.

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<sup>4</sup> National Center for Injury Prevention and Control Costs of Intimate Partner Violence Against Women in the United States Atlanta (GA): Centers for Disease Control and Prevention; 2003.

<sup>3</sup> American Institute on Domestic Violence. http://www.aidv-usa.com/Statistics.htp://

2002;11(5):465-76.

\* Blum RW, Ireland M. Reducing risk, increasing protective factors: findings from the Caribbean Youth Health Survey. Journal of Adolescent Health 2004;35(6):493-500.

<sup>10</sup> Helse L, Garcia-Moreno C, Violence by intimate partners. In: Krug E, Dahlberg LL, Mercy JA, et al., editors. World report on violence and health. Geneva (Switzerland): World Health Organization; 2002, p. 87–121.

rtment of Health and Human Services (DHH5) (US), Administration on Children, Youth, and Families (ACF). Child maltreatment 2003 [online]. Washington (DC): Government Printing Office: 2005. [ cited 2005 April 5]. Available from: URL: www.acf.hhs.gov/programs/cb/publications/cm03.pdf

<sup>12</sup> Fromm S. Total estimated cost of child abuse and neglect in the United States--statistical evidence. Chicago (IL): Prevent Child Abuse America (PCAA); 2001. [cited 2005 Jan 1]. Available from: URL: www.preventchildabuse.org/learn\_more/research\_docs/cost\_analysis.pdf

<sup>13</sup> Department of Health and Human Services (DHHS), Administration on Children, Youth, and Families (ACF). Emerging practices in the prevention of child abuse and neglect. Washington (DC): Government Printing Office; 2003.



### (ASTHO)





### **COST OF INJURY HOSPITALIZATIONS AND FATAL INJURIES IN THE U.S.**

The total cost of injury hospitalizations and fatalities in the U.S. is \$1.1 trillion for all ages and injury intents (based on incidence for the year 2000, in 2003 dollars). This breaks down as follows:

- Medical: \$86.8 billion
- Productivity: \$242.7 billion
- · Quality of Life: \$787.7 billion

Hospital injuries are 53% of the \$1.1 trillion, and fatal injuries are 47%. (Non-admitted injuries are not included in the \$1.1 trillion).

### Total Annual Cost of Fatal and Hospital Admitted Injuries in the U.S. (in 2003 dollars)

	Incidence	Medical	Productivity	Quality of Life	Total Cost
<b>Fatal</b> (1991 - 2001)	191,000	\$2,445,500,000	\$170,971,100,000	\$352,364,700,000	\$525,781,200,000
Hospital Admitted (2000)	1,846,000	\$84,362,200,000	\$71,743,200,000	\$435,418,400,000	\$591,523,800,000
Total	2,036,000	\$86,807,800,000	\$242,714,200,000	\$787,783,000,000	\$1,117,305,000,000

Medical includes spending on hospital and professional services, rehabilitation, prescriptions, home health care, medical equipment, and funeral expenses.

Productivity (Work Loss) includes wages, fringe benefits and household work for adults. It is the present value of a lifetime's worth of wage and household work that children will be unable to do as adults if they are killed or permanently disabled; these earnings include fringe benefits.

Quality of Life places a dollar value on the pain, suffering, and lost quality of life that children and their families experience due to death and injury.

### **10 LEADING CAUSES OF DEATH BY AGE GROUP - 2002**

. 1					Age Groups						1
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Congenital Anomalies 5,623	Unintentional Injury 1.641	Unintentional Injury 1,175	Unintentional Ilijury 1,542	Unintentional Injury 15,412	Unintentional Injury 12,569	Unintentional Injury 16,710	Malignant Neoplasms 49,637	Malignant Neoplasms 93,391	Heart Disease 576,301	Heart Disease 696,947
2	Short Gestation 4,637	Congenital Anomalies 530	Malignant Neoplasms 537	Malignant Neoplasms S35	Homicide 5,219	Sutcide 3,046	Malignant Neoplasms 16,085	Heart Disease 37,570	Heart Disease 64,234	Malignant Neoplasms 391,001	Malignant Neoplasms 557,271
3	SID5 2,295	Homicide 473	Congenital Anomalies 199	Suicide 260	Suicide 4,010	Homicide 4,489	Heart Disease 13,688	Unintentional Injury 14.675	Chronic Low. Respiratory Disease 11,280	Cerebro- vascular 143,293	Cerebro- vascular 162,672
4	Maternal Pregnancy Comp. 1,708	Malignant Neoplasms 402	Homicide 140	Congenital Anomalies 218	Malignant Neoplasms 1,730	Malignant Neoplasms 3,872	Suicide 6,851	Liver Disease 7,216	Diabetes Mellitus 10,022	Chronic Low. Respiratory Disease 108,313	Chronic Low. Respiratory Disease 124,816
5	Placenta Cord Membranes 1,028	Heart Disease 165	Heart Disease 92	Homicide 216	Heart Disease 1,022	Heart Disease 3,165	HIV 5,707	Suicide 6.308	Cerebro- vascular 9,897	Influenza & Pneumonia 58,826	Unintentional Injury 105.742
6	Unintentional Injury 1946	influenza & Pneumonia 110	Benign Neoplasms 44	Heart Disease 163	Congenital Anomalies 492	HIV 1,839	Homicide 3,239	Cerebro- vascular 6,055	Unintentional Injury 8.345	Alzheimer's Disease 58,289	Diabetes Mellitus 73,249
7	Respiratory Distress 943	Septicemia 79	Septicemia 42	Chronic Low. Respiratory Disease 95	Chronic Low. Respiratory Disease 192	Diabetes Mellitus 642	Liver Disease 3,154	Diabetes Mellitus 5,496	Uver Disease 6,097	Diabetes Mellitus 54,715	influenza & Pneumonia 65,681
8	Bacterial Sepsis 749	Chronic Low. Respiratory Disease 65	Chronic Low. Respiratory Disease 41	Cerebro- vascular 58	HIV 178	Cerebro- vascular 567	Cerebro- vascular 2,425	HIV 4,474	Suicide 3,618	Nephritis 34,316	Alzheimer's Disease 58,866
9	Circulatory System Disease 667	Perinatal Period 65	Influenza & Pneumonia 38	influenza & Pneumonia 53	Cerebro- vascular 171	Congenital Anomalies 475	Diabetes Meliitus 2,164	Chronic Low, Respiratory Disease 3,475	Nephritis 3,455	Unintentional Injury 33.641	Nephritis 40,974
10	Intrauterine Hypoxia 583	Benign Neoplasms 60	Cerebro- vascular 33	Septicemia 53	Diabetes Meilitus 171	Liver Disease 374	Chronic Low. Respiratory Disease 1,008	Viral Hepatitis 2,331	Septicemia 3,360	Septicemia 26,670	Septicemia 33,865

Source: National Vital Statistics System, National Center for Health Statistics, CDC. Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC

Resources

Children's Safety Network: Economics and Data Analysis Resource Center, March 2005, (This fact sheet has been updated to include hospital admitted suicides and assaults of unknown method)



### (ASTHO)





### NATIONAL ESTIMATES OF THE 10 LEADING CAUSES OF NONFATAL INJURIES **TREATED IN HOSPITAL EMERGENCY DEPARTMENTS, UNITED STATES, 2003**

		Age Groups									
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Unintentional	Uninterritorial	Unintentional	Unintentional	Unintentional	Dnimentional	Unintentional	Unintentional	Unimentional	Unintentional	Unintentional
	Fall	Fall	Fall	Fall	Struck by/Against	Fail	Fall	Fall	Fall	Fail	Fail
	122,276	865.209	670,107	678.897	973,073	754.691	812,270	739,365	563.973	1.822,157	7,895.385
2	Unintentional	Unintentional	Unintentional	Unintentional	Uniotentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional
	Struck by/Against	Struck by/Against	Struck by/Against	Struck by/Against	MN-Occupant	Overexertion	Overexertion	Overexertion	Overexertion	Struck by/Against	Struck by/Against
	33,132	364,168	411,733	593,148	916:330	694,464	657,267	436,494	193,361	194,435	4,422,252
3	Unintendional Fine/Butin 11:506	Onenterritorial Other InterStorg 154,954	Unintentional Cut/Pierce 125,350	Unintentional Overexertion 278,182	Unimentional Full 866.078	Unintentional Struck by/Against 675,770	Unintentional Struck by/Against 594,628	Unintentional Struck by/Against 390,563	Unintentional Struck by/Against 191,370	University of the University o	Unintentional Overexertion 3,324,641
4	Uninternitional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional
	Other Bite/String	Foreign Body	Pedal Cyclist	Cut/Pierce	Overexertion	MV-Occupant	MV Occupant	MV-Dccupant	MV-Giccapant	Overexertion	MV Occupant
	13,543	108,037	113,513	158,011	746,386	629,739	\$72,631	353,415	186,101	168,995	\$.026,595
5	Unintentional Cut/Pierce 7,731	Unintentional Cut/Pierce 85,140	Universite String	Unintentional Pedal Cyclist 141,252	Unintentional Cut/Pierce 493,032	Unintentional Cut/Pierce 441,956	Unintentional Cut/Pierce 391,061	Unintentional Cut/Pierce 273,232	Unintentional Cut/Pierce 143,244	Unintentional Cut/Pierce 116,915	Unintentional Cut/Pierce 2,235,869
6	Uninternoral	Unintentional	Unintentional	Unintentional	Other Assault*	Other Assault*	Other Assault*	Unintentional	Oninteritional	Unanderittignial	Other Assault*
	MV-Occupint	Overexertion	Overexertion	Uni/Unspecified	Struck by/Against	Struck by/Against	Struck by/Against	Other Specified	Other line filing	Onliver Bitla Sching	Struck by/Against
	7,713	67,227	76,045	117,463	436,395	270,689	218,136	141,179	65,117	77, 181	1,247,857
7	Unintentional	Unintentional	Unintentional	Other Assault*	Unrementionfail	Unintentional	Unintentional	Unimentational	Unintentional	Unintentional	Ummersteinet
	Foreign Body	Poisoning	MV-Occupert	Struck by/Against	Other Sine Soling	Other Bris:Sting	Other Specified	Other EthelShing	Other Specified	Poisoning	Od Bho/Sang
	7,465	62,661	21,653	116,873	164-502	141,176	175,356	105,804	51,566	46.581	100L451
8	Unintentional	Shorternoral	Unintentional	Unintentional	Unintentional	Unintentional	Unintendional	Other Assault*	Unintentional	Unintentional	Unintentional
	Paisoning	Feedbarn	Other Transport	MV Occupant	Unit/Unspecified	Other Specified	Diner Hile/Smig	Struck by/Against	Poisoning	Other Transport	Other Specified
	6,095	54,537	51,878	108,609	164,325	138,591	143,566	101,341	34,436	46,507	763,029
9	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional
	Overexertion	Unk/Unspecified	Dog Bite	Other Transport	Other Specified	Other Transport	Potening	Poisoning	Unix/Unspecified	Unk/Unspecified	Unk/Unspecified
	5,975	50,343	49,285	64,821	148,112	102,373	106,914	85,187	32,529	45,837	688,779
10	Unintentional	Unintertional	Unintentional	Unimentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional	Unintentional
	Unik/Unspecified	MV-Occupant	Foreign Body	Other Illia/Ssing	Other Transport	Unk/Unspecified	Foreign Body	Other Transport	Other Transport	Other Specified	Other Transport
	5,703	43:495	48,816	62.926	137,327	97,096	89,692	63,781	32,097	36,156	619,544

\* The "Other Assault" category includes all assaults that are not classified as sexual assault. It represents the majority of assaults

Source: National Electronic Injury Surveillance System-All Injury Program operated by the U. S. Consumer Product Safety Commission

Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC.

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### **OVERVIEW OF STATE INJURY AND VIOLENCE PREVENTION PROGRAMS**

Injuries (or accidents, as they are commonly called) and violence often are viewed as random acts of fate or something out of anyone's control. Car crashes, falls, drownings, fires, suicides, homicides, and other violent deaths are perceived - and explained - as the worst of luck, being in the wrong place at the wrong time.

But viewing these tragedies through a public health lens yields a different picture. This process starts by posing and answering basic epidemiologic questions, such as: Who has the problem? What causes it? When and where does it occur? The information gleaned from such questions changes the seemingly random acts of fate into events that can be better understood, predicted and, in most circumstances, prevented.

Each day, state health department injury and violence prevention programs apply a public health approach and, with limited resources, achieve results that reduce injuries and save tens of thousands of lives. To help guide these programs in their work and development, the State and Territorial Injury Prevention Directors Association has identified five core components of state injury and violence prevention programs. The components reflect the multiple, complex causes of injury and the equally diverse, interrelated

solutions that are needed. They are:

- collecting and analyzing injury data;
- designing, implementing and evaluating interventions;
- building a solid infrastructure for injury prevention;
- providing technical support and training; and affecting public policy.

Each component includes collaboration and coordination, which are essential to every aspect of an injury or violence prevention program.

Taken together, these components represent what currently is known and understood about creating and sustaining effective state injury and violence prevention programs. The core components work together to create effective state injury and violence prevention programs. Each piece is critical. When all five components are in place and functioning well, a program is most likely to fulfill its potential to reduce injury and violence.

Some state programs are able to address all five components, others only one. Most are somewhere in between. The capacity of state health department injury and violence prevention programs varies widely, in part due to factors such as funding and health department priorities. Despite the enormous toll of injury and violence, dedicated and ongoing federal or state funding to respond to these problems does not exist as it does for other major public health priorities. With adequate resources, the effect of state health department injury and violence prevention programs could be even greater.

Resource

State and Territorial Injury Prevention Directors Association. Safe States, 2003 Edition. Atlanta (GA): State and Territorial Injury Prevention Directors Association; 2003.



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STATE AND TERRITORIAL INIURY PREVENTION DIRECTORS ASSOCIATION



### GLOSSARY

### An overview of injury and violence terminology

Injury and violence prevention is a diverse and growing field, and so is some of its terminology. This is especially true for violence-related terms, which can vary in their meaning and use from program to program and state to state. To provide some consistency in the terms used in this document, STIPDA developed a list of working definitions for common terms used in the descriptions of the state health department programs highlighted herein. From among these terms, STIPDA then identified preferred terms for use in this document that were determined to best encompass the work and programs of the state injury and violence prevention programs presented in this document without altering the description of a state's program intent or activities.

It is important to note that all definitions provided in this glossary are for the purposes of this document only. The definitions for these terms can vary among federal, state and local laws and these legal definitions may be different than the definitions provided in this glossary. The glossary definitions below are not meant to change or be substituted for law.

### **Terms and definitions**

Injury is the physical damage that results when a human body is suddenly subjected to energy in amounts that exceed its threshold of tolerance (e.g. burns) or it can be the result of the lack of one or more vital elements (e.g. drowning). Injuries traditionally have been regarded as random, unavoidable "accidents." In the last few decades, a better understanding of the nature of injuries has led to the view that injuries -- both unintentional and intentional -- are largely preventable events. Injuries are defined by intent:

- Unintentional injuries include motor vehicle crashes, poisoning, drowning, falls, fires, and burns/scalds.
- Intentional injuries are those caused by violence and include homicide, suicide, sexual violence, child maltreatment, and elder violence.

Violence is defined as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation." Violence can be divided into self-directed (as in suicide), interpersonal (child, partner, elder, acquaintance, stranger) and collective (war and gangs).

Sexual violence is an overarching term that represents behaviors that may otherwise fall under the categories of sexual abuse, sexual assault and other sexual violations. Sexual violence can apply to persons of all ages and genders, and does not imply an existing relationship, as perpetrators can include those who are known or unknown by the victim. According to the 2002 CDC document Sexual Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0,<sup>2</sup> sexual violence is divided into five categories:

- completed sexual acts
- attempted sexual acts

- one of above four categories)

Sexual acts in each of these five categories can be those to which the victim does not consent, is unable to consent (e.g., due to age, illness), or refuses to consent (e.g., due to physical violence or threats). The sexual acts may be perpetrated by persons well-known (e.g., partners or spouses), not as well known (e.g., acquaintances) or unknown (e.g., strangers) to the victim. Victims include adults, adolescents and children. For the purposes of this document, sexual violence will be used when appropriate as an overarching term. Specific terms such as rape or sexual assault will be used when specifically used in a program title or funding source, or when citing specific statistics.

Violence against women (VAW) is a broad term used to reflect various forms of physical violence, sexual violence and threats of physical and/or sexual violence. To counter the misconception that a woman is abused only if she has broken bones or other physical injuries, a 2000 MMWR report<sup>3</sup> from a CDC workgroup tasked with developing uniform definitions for defining and measuring violence against women suggested the use of the expanded term violence and abuse against women (VAAW) to reflect a larger spectrum of maltreatment that includes the three components of VAW and stalking and psychological/emotional abuse.

The terms VAW and VAAW have some limitations. Physical violence, sexual violence and/or psychological/emotional abuse also are inflicted on children or adolescents under age 16, so the term "women" does not apply. Likewise, VAW and VAAW often are not applicable to a host of youth-oriented violence prevention programs, which may target both females and males, since males are victims and perpetrators of these forms of maltreatment. The terms also do not reflect the reality of maltreatment experienced by



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abusive sexual contact that is non-penetrative (e.g., intentional touching) non-contact sexual abuse (e.g., voyeurism, exposure to pornography) unspecified sexual violence (inadequate information available to categorize it in





### **GLOSSARY** Continued

men. According to the National Violence Against Women Survey, approximately 300,000 women and 90,000 men are forcibly raped each year.<sup>4</sup> Therefore, for this publication, VAW or VAAW were used only if the highlighted program focused exclusively on women and/or if the terms were used in a program title or funding source. The overarching term sexual violence was used instead when appropriate.

Domestic violence has long been used to define a pattern of abusive behaviors used by an individual in order to exert power and control over another individual in the context of an intimate relationship, whether the partners are married or not married, living together, separated or dating. However, this term does not adequately convey the violence that occurs between partners outside the home. Intimate partner violence has been used in recent years as an updated term for domestic violence. Some programs use the term domestic/intimate partner violence, and for this publication, this combined term will be used when appropriate. The term domestic violence will be used if it is part of a state's program title or funding source. Both of these terms have specific application because they imply a relationship between the victim and perpetrator.

**Rape** is defined as forced vaginal, oral or anal penetration.<sup>4</sup> It is a type of sexual assault, and sexual assault is included under the broad term sexual violence.

Sexual assault is a generic term that can be used to describe any sexual contact to which the victim does not consent, is unable to consent (e.g., due to age, illness), or refuses to consent (e.g., due to physical violence or threats).<sup>2</sup> The act may be accomplished by force sufficient to cause physical injury, or there may be no lasting physical injury, but the psychological damage done by this intimate violation may be substantial. Rape is a type of sexual assault. It is important to note that the definition of sexual assault varies among federal, state and local laws.

Child maltreatment, often referred to as child abuse, is a general term used to describe all forms of child abuse and neglect, including physical abuse, sexual abuse, neglect and emotional abuse. There is no one commonly accepted definition of "child abuse and neglect." The federal government defines child abuse and neglect in the Child Abuse Prevention and Treatment Act as "the physical and mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened."<sup>5</sup> Each state provides its own definition of child abuse and neglect.<sup>6</sup>

Youth violence "typically involves children, adolescents, and young adults between the ages of 10 and 24. The young person can be the victim, the perpetrator, or both. Youth violence includes aggressive behaviors such as verbal abuse, bullying, hitting, slapping, or fist fighting. These behaviors have significant consequences but do not generally result in serious injury or death. Youth violence also includes serious violent and delinquent acts such as aggravated assault, robbery, rape, and homicide committed by and against youth." 7

Elder maltreatment, often referred to as elder abuse, is a general term that encompasses "any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult. The specificity of laws varies from state to state, but broadly defined, abuse may be physical abuse, emotional abuse, sexual abuse, exploitation (of funds, property or assets), neglect, or abandonment."8

<sup>1</sup> Krug EG et al., eds. World report on violence and health. Geneva, World Health Organization, 2002.

<sup>2</sup> Basile KC, Saltzman LE. Sexual violence surveillance: Uniform definitions and recommended data elements. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2002.

<sup>3</sup> Centers for Disease Control and PreventionBuilding data systems for monitoring and responding to violence against women: recommendations from a workshop. MMWR 2000;49(No. RR-11):[inclusive page numbers].

<sup>4</sup> Tjaden P, Thoennes N. Full report of the prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey. Washington, DC: U.S. Department of Justice; 2000. Publication No.: NJC183781.

<sup>5</sup> Child Abuse Prevention and Treatment Act (CAPTA) as amended by Keeping Children and Families Safe Act of 2003, 42 U.S.C. § 5106(g) (2003).

<sup>6</sup> See, 2003 Child Abuse and Neglect Statute Series Statutes-at-a-Glance: Mandatory Reporters of Child Abuse and Neglect, National Center on Child Abuse and Neglect: National Clearinghouse on Child Abuse and Neglect Information, National Adoption Clearinghouse (2003).

<sup>7</sup> Website for Center for Disease Control and Prevention's National Center for Injury Prevention and Control. http://www.cdc.gov/ncipc/factsheets/yvoverview.htm.

<sup>8</sup>Website for National Center on Elder Abuse. http://www.elderabusecenter.org; see FAQs about elder abuse.



ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

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# ALABAMA Department of Public Health

ISSUE Suicide is the second leading cause of death due to injury in Alabama; second only to motor vehicle crashes. Alabama's fatality rate for suicide in 2001 was 11.34 deaths per 100,000 population, higher than the same U.S. rate of 10.70 deaths per 100,000 population.

## PROGRAM OVERVIEW

The Department of Public Health's Injury Prevention Program played an in-

tegral role in developing a statewide response to the problem of suicide in Alabama. In 2002, program staff helped form the Alabama Suicide Prevention Task Force, which was convened in response to former Surgeon General Dr. David Satcher's Call to Action to Prevention Suicide 1999. The task force brought together more than 40 participants from public and private agencies, including public health, mental health, law enforcement, the judicial system, education, social work, hospitals, ministries, and academia. Suicide survivors also participated in the task force.

The task force developed Alabama's first statewide suicide prevention plan, which builds upon many of the key recommendations of the Surgeon General's report. The plan was published in 2004 using grant funds that the state health department's Injury Prevention Program received from CDC's National Center for Injury and Prevention and Control. The plan was disseminated widely across the state to help interested agencies, individuals, families, and communities to plan, implement and seek resources for programs to decrease suicide in Alabama.

One of the main goals of the state plan is to raise public awareness that suicide is a public health problem and that many suicides are preventable. To meet this goal, the Suicide Task Force:

- developed a suicide prevention website hosted by the Alabama Department of Public Health that provides information and resources for persons at risk for and groups working to prevent suicide;
- organized a Suicide Prevention Awareness Week to announce the state's suicide prevention plan and to kick off media activities:
- held a proclamation ceremony at the beginning of the awareness week that included the Governor, the State Health Officer, and the Commissioner of Mental Health as event spokespersons;
- sponsored billboards featuring a suicide hotline number: and
- released paid radio spots and public service announcements featuring Dr. Satcher discussing Alabama's suicide problem.

### **PROGRAM RESULTS**

achievements:

- Alabama developed its first state suicide prevention plan.
- promotion activities.

## **IMPACT OF ADDITIONAL FUNDING**

Despite an increase in awareness of the burden of suicide in Alabama and crisis services available, suicide continues to be a leading cause of injury death. The Alabama Suicide Prevention Plan calls for implementation of prevention programs, training, educational programs, surveillance, and research to reduce suicide in the state. Additional funding for suicide prevention would enable the state's Injury Prevention Program and its prevention partners to implement more comprehensive, consistent and coordinated suicide prevention efforts.



The Alabama Suicide Prevention Task Force's awareness-building efforts include the following

 Hits to the suicide prevention website increased significantly during the month leading up to the proclamation ceremony, the month of ceremony and initial media efforts, and the month following awareness-building activities. The average of 65 hits per month during the six months prior to the awareness campaign increased to 509 hits during the intervention month, with an average of 136 hits leading up to and following the month of

> Alabama Department of Public Health **Division of Injury Prevention**

> > http://www.adph.org/injuryprevention/ 201 Monroe Street, Suite 986 Montgomery, AL 36130-3017 (P) 334-206-5571 • (F) 334-206-5534

# ALASKA **Department of Health and Social Services**

ISSUE Injury is the third leading cause of death for Alaskans overall and the leading cause of death for ages 1-44. There are approximately 4.800 injury hospitalizations in Alaska every year. Residential fire is one cause of these deaths and hospitalizations. Human loss and suffering from residential fires often are preventable when homes have a working smoke alarm and when home occupants follow basic fire safety and prevention procedures. Functional smoke alarms and basic home fire safety and prevention procedures are particularly important in rural Alaska, where many communities have little or no fire-fighting resources.

### PROGRAM OVERVIEW

The Alaska Department of Health and Social Services' Injury Surveillance and

Prevention Program implements a program to reduce death and injuries due to residential fire in rural Alaska. The program is funded by a grant from CDC's National Center for Injury Prevention and Control. The program focuses on increasing smoke alarm use in homes of residents at risk for residential fire and providing fire safety and prevention education to them. Highlights include:

- Rural communities at risk for residential fire are identified by analyzing residential fire incidence rates and community demographics. For example, communities with young children and older adults are particularly at risk for injury from residential fire.
- The Injury Surveillance and Prevention Program works directly with community agencies as well as through regional partners, who in turn expand the program's reach by traveling to villages in their area to conduct prevention activities. Program partners include local fire departments, Head Start programs, village public safety officers, and tribal councils.
- Program partners conduct door-to-door canvassing and make home visits to inspect existing smoke alarms, install new alarms with long-life lithium batteries as needed and fire safety and prevention education.
- The educational component is designed to increase knowledge and encourage behaviors that promote home fire safety and prevention. The information includes home fire escape planning and practice, smoke alarm maintenance, safe cooking methods, dealing with children and fire, safer smoking in the home, and safe use of electricity, home heating equipment and combustibles.
- Similar prevention education is conducted by program staff and partners through community and school presentations.

### **PROGRAM RESULTS**

From 2002-June 2005, the program:

- gained participation from 57 communities;
- canvassed 6.046 homes;
- installed 4,433 smoke alarms; and
- documented 22 lives saved.

### **IMPACT OF ADDITIONAL FUNDING**

Increased funding for the Injury Surveillance and Prevention Program would enhance the program's core functions and capacity to curb the tide of preventable injuries in Alaska. With additional funding, the program could purchase and distribute smoke alarms to other remote and rural communities in need. Additional funding also would provide program staff and its prevention partners with enhanced training to address the injury and violence prevention needs of at-risk populations in communities throughout Alaska

> Alaska Department of Health and Social Services **Injury Surveillance and Prevention Program**



The program has reached many at-risk homes with life-saving smoke alarms and information.

http://www.hss.state.ak.us/dph/chems/injury\_prevention 3601 C Street. Suite 222 Anchorage, AK 99503 (P) 907-269-5221 • (F) 907-269-2041

# ARIZONA **Department of Health Services**

ISSUE Arizona's drowning rate for children ages 0-4 years is the second highest in the U.S., and well above the national rate, due in part to the state's warm weather, long summers and the presence of about 300,000 residential swimming pools. In nine percent of Arizona drownings, the child survived, but with some degree of brain damage.

### **PROGRAM OVERVIEW**

The Drowning Prevention Coalition of Central Arizona has worked to reduce

water-related incidents and deaths in Maricopa County (the metropolitan Phoenix area) for about 15 years. This community-wide organization is comprised of municipal fire departments, hospitals, state and county health departments, community organizations, parents of drowning victims, pool builders, and suppliers of pool safety equipment.

The coalition has taken a multi-faceted approach that includes improved surveillance, prevention education and media campaigns, and policy change.

Surveillance. The coalition partnered with the Arizona Department of Health Services to establish a surveillance system to identify the factors surrounding water-related incidents among young children. The coalition enlisted the help of firefighters -- who typically are the first responders to emergency calls in Maricopa County -- to report all water-related 911 emergency calls and complete a standard case report to document the circumstances of each incident. ADHS staff then analyzes the data and prepares summary reports.

**Prevention.** The coalition's drowning prevention awareness and education efforts have included:

- Prevention messages that focus on the importance of adequate pool barriers such as fences and proper supervision of children:
- Door-to-door canvassing by firefighters, particularly in neighborhoods where drownings have occurred, to provide prevention information;
- Annual observance of an awareness-raising "April Pools Day";
- A website that includes annual drowning statistics, prevention information, media coverage of drowning incidents, and messages from parents of drowning victims;
- Generating coverage from local broadcast and print media, which have intensified their coverage of child drowning in recent years;
- Pro-bono development of two TV spots with messages about the consequences of not having proper pool barriers; the messages ran on local Phoenix cable channels in the summer of 2004; and
- Distribution of free pool fences through the United Phoenix Firefighters Association.

Policy change. The coalition also has urged municipalities to pass stricter laws requiring a barrier to a swimming pool.

**PROGRAM RESULTS** The improved surveillance system helped the coalition and its partners to better understand the causes of child drowning in the metropolitan Phoenix area. Specifically:

- The largest number of drowning incidents occurs at home, in the family pool.
- In cases where the child dies or is injured, the most commonly noted factor was an absence of or an inadequate barrier (as opposed to lack of supervision).
- In cases where a child survives without injury during warm months, lack of supervision was more commonly noted.
- outcome.

The coalition reports that its prevention efforts also have had an impact. Although there has been a 61 percent increase in the number of children living in Maricopa County since 1990, the count of serious pool-related incidents among young children has remained relatively unchanged. Drowning rates among young children in 2002, 2003 and 2004 were among the lowest in the past 20 years.

### **IMPACT OF ADDITIONAL FUNDING**

Additional funding would allow media campaigns to expand into other areas of the state where older children and adults typically drown in rivers and lakes. Additional funding could also be used to develop policy, including local and state ordinances for pool fences or other protective devices. While the modest decrease in child drowning rates reported above is encouraging, few local jurisdictions require retroactive placement of pool barriers, and more widespread use of pool barriers remains a long-term goal in Arizona.



In cold months, the absence of or an inadequate pool barrier is the predominate factor, regardless of the child's

### **Arizona Department of Health Services Injury Prevention Project**

http://www.azdhs.gov/phs/owch/injuryprev.htm 150 North 18th Avenue. Suite 320 Phoenix, AZ 85007-3248 (P) 602-364-3190 • (F) 602-364-3569

## ARKANSAS Division of Health

ISSUE Arkansas consistently ranks in the top third percentile in the U.S. for deaths due to numerous causes of injury and violence. Many different entities in Arkansas collect injury information, but there is no centralized entity for data collection in the state. There is a corresponding lack of a central coordinating entity for injury and violence prevention data and analysis, an essential foundation for the prioritization and development of targeted prevention activities.

### PROGRAM OVERVIEW

The Arkansas Division of Health's Injury Prevention Program was established in

1999 through a five-year, capacity-building grant from CDC's National Center for Injury Prevention and Control. The Injury Prevention Program then helped create the Arkansas Injury Prevention Coalition, an alliance of state agencies, non-profit organizations and other key stakeholders interested in the prevention of injuries. The coalition shares and develops resources, supports collaborative injury prevention activities and provides a forum for informing the public about injury and its prevention.

To address the common need for coordinated data and analysis, coalition members analyzed multiple injury-related databases and the Injury Prevention Program published the results in the document *Injury in Arkansas: A State Pro-file.* The document includes summaries of promising prevention strategies and highlights the state's resources and opportunities for injury prevention. Funding for the document was provided by the Injury Prevention Program through its CDC funding.

Over 700 copies of the state profile were distributed to federal and state policymakers, state agency department directors, the University of Arkansas for Medical Sciences College of Public Health, Emergency Medical Services providers, local Hometown Health Improvement Coalitions, the University of Arkansas Cooperative Extension Services 4-H programs, print and broadcast media, and other key stakeholders.

### PROGRAM RESULTS The Arkansas Division of Health's Injury Prevention Program has helped build the state's capac-

ity in two key areas - data and infrastructure.

- By bringing together partners with access to numerous injury and violence data sources, the program made significant strides in meeting the need for coordinated data collection and analysis.
- The state profile has provided a springboard for further collaboration and priority setting. The Injury Prevention Program, through collaboration with the Arkansas Injury Prevention Coalition, has drafted the state's first datadriven strategic plan for preventing injury and violence.
- To address some of the strategic plan's priorities such as reducing injuries from motor vehicle crashes, drownings and residential fires, the Injury Prevention Program is offering mini-grants to coalition members to develop pilot prevention projects.
- The establishment of the Arkansas Injury Prevention Coalition resulted in the development of many new partnerships. For example:
  - The Arkansas Rural and Volunteer Firefighters Association and the Arkansas Cooperative Extension Service joined forces for agricultural injury prevention education.
  - The Arkansas Poison Control Center partnered with the Arkansas Division of Health's Hometown Health Improvement Coalitions and the Rural and Volunteer Firefighters Association to disseminate prevention information around the state.
  - The Consumer Product Safety Commission began working with the Injury Prevention Program to prevent residential fire-related injuries.

## IMPACT OF ADDITIONAL FUNDING

Additional funding would enable the state's Injury Prevention Program to analyze and publish additional and updated injury and violence data. Ongoing and systematic review and analysis of the many data sources are necessary to ensure that prevention programs are effectively prioritized, targeted and evaluated. Additional funding also is needed to expand the state infrastructure required to effectively conduct injury and violence prevention programs.



### Arkansas Division of Health Injury Prevention Program

http://www.healthyarkansas.com/ injury\_prevention/injury\_prevention.html P.O. Box 1437, Slot H-17 Little Rock, AR 72203-1437 (P) 501-280-4776 • (F) 501-280-4769

# GALIFORNIA **Department of Health Services**

ISSUE Intimate partner violence is a major health problem in California that affects all age and socio-economic groups. Data from the state's Department of Justice shows that in 2003, local law enforcement received 194,228 domestic violence calls for assistance. The faith community has been identified as playing a key role in preventing and intervening in this violence.

## PROGRAM OVERVIEW

The California Department of Health Services' Epidemiology and Prevention

for Injury Control Branch developed and implemented a Faith Leaders and Domestic Violence Project in partnership with state agencies, statewide organizations and constituencies. The project's goal is to decrease domestic/intimate partner violence and promote "zero tolerance of intimate partner violence" throughout the state by engaging the faith community in all levels of prevention.

The project focuses on delivering training for faith leaders on how to infuse domestic/intimate partner violence prevention into their work (e.g., in sermons, presentations, pre-marital counseling, and religious education curricula). Project objectives include:

- train faith leaders to enhance their role in their communities as promoters of peaceful families;
- encourage faith leaders to participate in domestic/intimate partner violence prevention and intervention activities in their communities: and
- establish new and strengthen existing links between domestic/intimate partner violence prevention advocates and faith leaders through their participation in prevention and intervention activities.

Mini-grants were awarded to local faith groups for community training and education workshops and other activities to engage faith leaders in domestic/intimate partner violence prevention and intervention. All project materials have been translated into Spanish and there is a project website.

The Epidemiology and Prevention for Injury Control Branch also brought together advocates and faith leaders to build new -- or mend fractured or weak -- relationships and work as partners in preventing domestic/intimate partner violence in their communities. Mini-grants were awarded to teams of domestic/intimate partner violence prevention advocates and faith leaders to receive training so they could in turn provide workshops for their local colleagues. The project also sponsored an educational and networking summit in May 2005 for faith leaders and advocates of domestic/intimate partner violence prevention.

In mid-2005, the project began focusing on embedding its work into local communities throughout California in order to reach additional faith leaders, connect them to local domestic/intimate partner violence prevention and intervention resources and encourage them to become involved in community prevention efforts.

**PROGRAM RESULTS** Over 600 faith leaders from more than 30 denominations have been trained in developing a spiritual community that does not tolerate or unintentionally encourage domestic/intimate partner violence among its members or congregants. Faith leaders have learned what healthy partner relationships look like and how to implement prevention strategies, reach out to those at risk, make their congregations safe havens, work with the advocacy agencies in their communities, and become involved in community activities that promote violence free families.

Additionally, advocates of domestic/intimate partner violence prevention have been trained in working more effectively with their faith leaders to address this violence in their local communities. These local partnerships have become very effective. Examples of post-workshop feedback include:

- to each group by the other.
- facilitators who work with men who are potentially abusive.

Most importantly, these projects have reached out across California's religious, ethnic and cultural divides and brought people together to work toward assisting families and communities to become healthier and more peaceful.

### **IMPACT OF ADDITIONAL FUNDING**

Additional funding would allow this project to continue in a more comprehensive way. A local mini-grant program was eliminated due to a reduction in funding. Restoring the ability of local faith leaders and advocates to address domestic/intimate partner violence would increase the impact of the project by broadening its scope and outreach to underserved and diverse populations.



• The American Indian Hoopa community in Humboldt County has begun to address this issue for the first time. There has been more open and honest dialogue between faith leaders and advocates, and more referrals made

Three young pastors from the Southeast Asian Mien community have joined a training for men's program

### **Calfornia Department of Health Services** Epidemiology and Prevention for Injury Control (EPIC) Branch

http://www.dhs.ca.gov/epic MS 7214, P.O. Box 997413 Sarcramento, CA 95899-7413 (P) 916-552-9800 • (F) 916-552-9810

# COLORADO Department of Public Health and Environment

ISSUE In 2002, Colorado's suicide death rates were the seventh highest in the nation and were nearly 40 percent higher than the national rate. Suicide is the state's ninth leading cause of death, as well as the second leading cause of death for ages 10-34. The total of direct and indirect costs to the state due to suicide deaths and attempts is estimated to be more than \$552 million annually.

### PROGRAM OVERVIEW Since its establishment in 2000, the Office of Suicide Prevention, housed in

the Injury, Suicide and Violence Prevention section of the Colorado Department of Public Health and Environment, has played an important role in the state's overall injury and violence prevention efforts. The Injury, Suicide and Violence Prevention section participated in the original commission that studied suicide in Colorado and developed the state plan in November 1998. It has supported the efforts to establish the office and continues to support efforts by providing and analyzing data, providing technical assistance and collaborating in the development and design of program activities. The office is charged with implementing the Colorado Suicide Prevention and Intervention Plan, which provides recommendations in four principal areas, including the development of a statewide, ongoing and comprehensive public information and education campaign.

Since 2001, the Office of Suicide Prevention has implemented a multi-faceted campaign to provide accurate information to citizens about suicide risks and warning signs, and to reduce their fears, prejudices and misconceptions about suicide and mental illness. Outreach efforts to Colorado communities include presentations for events such as town meetings, a speaker's bureau, distribution of prevention materials, and public service announcements. Highlights include:

- Posters with 14 different messages targeting various age and multicultural groups were designed and distributed in 2001, and continue to be distributed around the state.
- Public service announcements were aired regularly on a number of local television stations beginning in January 2003. These spots reached over 734,000 people, and were done at no charge by a member of the Office of Suicide Prevention Advisory Board.
- During suicide prevention week in May 2003, the office released several public service announcements that targeted to all age groups and carried three main messages: suicide prevention is everyone's business, there is hope and help is available, and depression is a treatable illness. The announcements were aired on radio stations across the state and newspaper advertisements using the suicide prevention posters were placed in major newspapers in the state to advertise the state's 1-800-SUICIDE hotline number and suicide prevention messages.

**PROGRAM RESULTS** Following the release of the television public service announcements through Comcast, crisis calls to the 1-800-SUICIDE number increased by an average of 62 percent. Raising awareness about the availability of the 800 number and that help is available is an essential component of suicide prevention.

## **IMPACT OF ADDITIONAL FUNDING**

Additional funding would permit the development and dissemination of additional public service announcements that target specific at-risk groups with messages to raise awareness about the crisis lines and encourage people to seek help or give help.

> **Colorado Department of Public Health and Environment Injury, Suicide and Violence Prevention Section**



http://www.cdphe.state.co.us/pp/suicide/suicidehom.asp 4300 Cherry Creek Drive South PSD-A4 Denver, CO 80246-1530 (P) 303-692-2539 • (F) 303-691-7901

## GUNNECTICUT **Department of Public Health**

ISSUE Falls are responsible for approximately half of the 22,000 hospitalizations due to injuries each year in Connecticut. Over 70 percent of fall-related hospitalizations are among persons 65 years and older. Direct hospital charges are estimated to be \$200 million annually. It is estimated that 25-30 percent of older adults living independently in their communities will fall each year, and falls are the most frequent preventable cause of nursing home placement. The death rate due to falls is six times higher among older adults than the rate for the state population as a whole.

### **PROGRAM OVERVIEW**

The Connecticut Department of Public Health's Injury Prevention Program

works with local health departments to implement community-based fall prevention programs for older adults. This activity is supported by Preventive Health and Health Services Block Grant funding which state and local health departments receive on an annual basis to address their specific health needs, including injuries.

Each year, the Injury Prevention Program provides technical assistance, training and program monitoring to approximately three local health departments that choose to address fall prevention. Since 1997, the number of local health departments conducting programs each year has ranged from two to six. Programs typically address risk factors for falls among older adults, including environmental hazards, medication interactions and physical inactivity.

- Local health departments, usually in collaboration with home health care agencies, conduct home safety visits to identify and correct fall hazards.
- Home visitors provide safety supplies and fall prevention education, and work with older adults and their families and caregivers to correct fall hazards.
- Local program staff provides fall prevention presentations and medication safety reviews in a variety of community settings.
- Multi-session exercise classes are provided to improve strength, balance and flexibility among older adults.

**PROGRAM RESULTS** The Injury Prevention Program, through its collaboration with local health departments and service providers, has demonstrated a decrease in reported falls and fall injury risks among older adults participating in the fall prevention programs. Local programs follow up with all home safety visit recipients to determine if home safety hazards have been corrected and if any falls have occurred since the visit. Data during 2002-2004 program implementation and follow-up visits show that:

- Over 400 home visits were provided to older adults living in local communities.
- At least 80 percent of identified fall injury hazards were corrected during these home visits.
- only 3 percent reported falling at follow up visit or phone call four months later.
- continuing to exercise at end of the 12-week program.
- of these participants reported taking action to reduce fall risks as a result of the programs.

### **IMPACT OF ADDITIONAL FUNDING**

Fall prevention activities are currently reaching only a small percentage of Connecticut's older adult residents. During Federal Fiscal Year 2001-2003, these activities reached only 0.3 percent of the state's population age 65 and over. Additional funding would enable the Injury Prevention Program to improve injury surveillance to identify communities with high fall rates, expand fall prevention activities to additional communities and reach more at-risk older adults.



While 50 percent of persons who received a home safety visit reported falling during the year prior to the visit.

Multi-session exercise classes were provided to over 275 adults, and 92 percent of these participants reported

Over 700 persons participated in fall prevention presentations or medication safety review programs; 80 percent

### **Connecticut Department of Public Health**

**Injury Prevention Program** 

http://www.dph.state.ct.us/ 410 Capitol Ave., MS #11PRE Hartford, CT 06134-0308 (P) 860-509-7791 • (F) 860-509-7720

# DELAWARE **Division of Public Health**

ISSUE Injury is the leading cause of death and disability in Delaware for persons ages 1-44. Injury is one of the leading causes of death among all age groups, and the leading cause of premature mortality (early death) in the state. Professionals who work to prevent injuries come from many disciplines, including public health, emergency medical services, law enforcement, fire departments, hospitals, and schools, but they typically lack formal injury and violence prevention training.

### **PROGRAM OVERVIEW**

The Delaware Division of Public Health's Office of Emergency Medical Services

manages the state's Injury Prevention Program.. Responding to a need for a standardized education program for injury prevention practitioners, the Office of EMS contracted with the University of Delaware to develop an Injury Prevention Practitioners Basic Certification Course on CD-ROM for distribution through its distance learning program.

The course goal is to build a common base of knowledge and skills that are essential for those working in injury and violence prevention, thereby improving the quality and effectiveness of community-based prevention programs. The course consists of eight two-hour modules and a final objective competency examination. Individuals completing the basic certification course have the ability to:

- describe and explain injury and/or violence as a major social and health problem;
- access, interpret, use, and present injury and/or violence data;
- design and implement injury and/or violence prevention activities; and
- · evaluate injury and/or violence prevention activities.

The course also addresses specific injury areas such as motor vehicle crashes, burns, drowning and submersions, and sports injuries.

### **PROGRAM RESULTS**

- raises awareness that the Office of EMS is a focal point for state injury prevention efforts;
- enables course participants to share the knowledge and skills gained from the course with colleagues;
- strengthens the relationship between the University of Delaware and other statewide injury and violence prevention partners; and,
- collaborating with the Office of EMS to reduce death and disability from injury in Delaware.

### **IMPACT OF ADDITIONAL FUNDING**

Additional funding would allow the Office of EMS to expand upon the basic certification course and develop an Advanced Injury Prevention Certification Course that would provide more in-depth information on key injury topics and further enhance participants' skills.



The Injury Prevention Practitioners Basic Certification Course:

• encourages networking partnerships with statewide groups engaged in injury prevention and interested in

**Delaware Division of Public Health** Office of EMS

http://www.dhss.delaware.gov/dhss/dph/ems/ems.html Blue Hen Corporate Center, Suite 4H 655 South Bay Road Dover, DE 19901 (P) 302-744-5400 • (F) 302-744-5429

# FLORIDA Department of Health

ISSUE Of the 27 children ages five and under killed in motor vehicle crashes in 2003 in Florida, 11 were not using a safety restraint. A Florida Traffic Crash Facts report from 2003 shows that the fatal injury rate for children under age four without restraints was 4.7 times higher than for those in the same age group with restraints. Among children ages 4-5, the fatal injury rate was 14.5 times higher among those without restraints in a crash than those with restraints.

There is a need for programs that loan seats/restraints designed to accommodate children with special health care needs. These special needs seats/restraints typically are not available in retail outlets, and parents or caretakers of children with special health care needs often have no choice but to select a seat/restraint for their child from a catalog, which does not allow the seat to be fitted to the child or their vehicle.

### PROGRAM OVERVIEW

Since 2002, the Florida Department of Health's Office of Injury Prevention has

developed and managed the Florida Special Needs Occupant Protection Program to provide appropriate child safety seats/restraints to children with special health care needs. The program is funded through an annual Florida Department of Transportation highway safety grant.

The Office of Injury Prevention works with four children's hospitals around the state to provide these seats/restraints on a "loaner" basis to the families or caregivers of children with special health care needs. Three additional children's hospitals are in varying stages of implementing a program site within their facility. Program highlights include:

- Each participating hospital receives an assortment of special needs seats/restraints to be loaned out to the families or caretakers of children in need. In addition, the hospital receives a laptop computer to store seat installation instructions and prepare reports and a digital camera to record final seat installations.
- The Office of Injury Prevention coordinates training for hospital staff members participating in the program. The participating staff members are required to successfully complete the National Standardized Child Passenger Safety Training Program, a 32-hour standardized training from the National Highway Safety Traffic Administration. A "Transporting Children with Special Health Care Needs" training developed by the Riley Hospital for Children in Indianapolis, Indiana is provided for free to these staff members.
- A four-hour course is provided to nurses at the Florida Department of Health's 27 Children's Medical Services offices to raise their awareness of child passenger safety, discuss the unique transportation issues faced by their clients with special health care needs, and provide information on available resources.
- The Office of Injury Prevention implemented a media campaign directed to parents and children on misuse and safe installation of child safety seats/restraints. The campaign included working with Radio Disney to produce three 60-second public service announcements on child passenger safety.

### **PROGRAM RESULTS**

- increase in evaluations from the previous year.
- Special Health Care Needs" training.
- distributed to radio stations around the state.
- books were available in English. Spanish and Creole.
- the program sites.

## **IMPACT OF ADDITIONAL FUNDING**

Despite the success of this program, additional children's hospitals and hospitals not specifically designated as a children's hospital who serve children with special health care needs would benefit from this program. Additional funding would allow the Office of Injury Prevention to expand the program to additional hospitals and provide more child safety seats/restraints, outreach materials and public service announcements.



 The Children's Hospital of Southwest Florida joined as the program's fourth site. Over 220 special needs child safety seats/restraints were ordered and placed within the four hospital sites. • During the 2003-2004 grant year, 152 children were evaluated to determine their individual special child safety seat/restraint needs and the appropriate seat was loaned to the child's parent or caregiver. This is a 27 percent

· Seventeen new Child Passenger Safety Technicians were certified and received the "Transporting Children with

Over 250 compact discs containing the public service announcements produced with Radio Disney were

 Over 10,000 "I'm Safe! In the Car" child passenger safety educational story books and activity books were distributed among the four participating hospitals. The storybooks were available in English and the activity

Over 3,000 sticky notes marketing the Florida Special Needs Occupant Protection Program were distributed to

### **Florida Department of Health**

**Office of Injury Prevention** 

http://www.doh.state.fl.us/workforce/injuryprevention/index.html Bin C15, 4052 Bald Cypress Way Tallahassee, FL 32399-1735 (P) 850-245-4440 Ext. 2774 • (F) 850-488-2512

# GEORGIA **Division of Public Health**

ISSUE The leading cause of death for children ages 1-14 in Georgia is motor vehicle crashes. Among children ages 1-9, a total of 6,731 children were injured and 40 were killed in car crashes in the state in 2003. The National Highway Traffic Safety Administration estimates that child restraint systems such as child safety seats reduce fatal injuries by 71 percent for infants and by 54 percent for toddlers in passenger vehicles. However, it is often difficult to directly measure the impact of child safety seat programs.

## **PROGRAM OVERVIEW**

The Injury Prevention Section of the Georgia Division of Public Health man-

ages occupant safety programs which promote that Georgia children ride safely in motor vehicles. Its Child Occupant Safety Project, supported by a grant from the Governor's Office of Highway Safety, supports local communities in their efforts to promote the correct and consistent use of child restraint devices (e.g., infant, convertible, booster, and special needs seats) by distributing these seats to families in need, providing appropriate training on their correct installation, and conducting a unique program evaluation project with first responders.

The Child Occupant Safety Project:

- coordinates a bulk purchase and delivery of child safety seats through a statewide contract established by the state's Department of Human Resources;
- maintains and supports local injury prevention coalitions, who perform child safety seat distribution and caregiver education on correct seat use and installation;
- supports local coalitions conducting public information activities to increase awareness of the life-saving benefits of child safety seats and safety belts:
- provides technical assistance on program set-up, implementation, collaboration, and reporting; and
- provides training or referral for staff interested in becoming or recertifying as a certified Child Passenger Safety Technician.

In order to demonstrate the impact of its child safety seat program, the Child Occupant Safety Project established an innovative partnership with first responders (EMS, fire and law enforcement) to document the potential lives saved and injuries reduced. Project-specific stickers are placed on all child safety seats distributed through the project. When a motor vehicle crash occurs, participating first responders use a simple fax-back form to report to the Injury Prevention Section the number of children who were restrained in a child safety seat provided by the project. As an incentive to participate in the evaluation, first responders receive child safety seats to replace the state-funded seats involved in the crash, as well as injury prevention-related incentive items that can be used to promote occupant safety.

### PROGRAM RESULTS

• The program distributes an average of 5,000 child restraint devices per year to parents and caregivers through local coalitions, including those led by local health departments and/or SAFE KIDS coalitions. In 2004, the program distributed 6,660 seats.

- percent increase from 2003.
- evaluation program.

### IMPACT OF ADDITIONAL FUNDING

Despite the preventability of motor vehicle-related death and injuries to children, only 10,000 children of an estimated 249,000 children who meet the poverty criteria in Georgia each year will receive assistance in obtaining a child safety seat. Additional program funding would ensure that more child restraint devices will be made available to children and caregivers in need. The fax back evaluation program also can be expanded to further illustrate the severity of reported crashes by detailing whether the non-child occupants of the crash were injured. According to National SAFE KIDS estimates, every dollar spent on a child safety seat saves the nation \$32.



• In 2004, the Injury Prevention Section maintained and supported 69 local coalitions around the state -- a 21

• From 2002 to September 2005, at least 52 children were saved from death or serious injury as a result of child safety seats and education received through the Child Occupant Safety Program, as documented by the fax back

> **Georgia Division of Public Health Injury Prevention Section**

http://www.health.state.ga.us/programs/injuryprevention 2 Peachtree Street NW. 15.402 Atlanta, GA 30303 (P) 404-657-6335 • (F) 404-463-2726

# State Department of Health

ISSUE Injury is the leading cause of death among children and young adults in Hawai'i, and the fourth leading cause of death among state residents of all ages. Motor vehicle crashes is a leading cause of fatal injury in the state, accounting for about 70 deaths each year.

Preliminary research conducted by the Hawai'i State Department of Health's Injury Prevention and Control Program determined that the risk of motor vehicle crashes varies around the state, with rural counties experiencing a higher per capita fatality rate compared to Honolulu County. In particular, Hawai'i County has the highest rates, and its residents are more than four times more likely to die in a motor vehicle crash (five-year mortality rate of 78 deaths per 100,000 population) compared to residents of Honolulu County (19 deaths per 100,000 population). Results are similar if adjustment is made for vehicle miles traveled instead of resident population.

### PROGRAM OVERVIEW

To address the problem of motor vehicle-related crashes in rural areas of

Hawai'i, the Injury Prevention and Control Program partnered with a local coalition of health care providers and community organizations - called the North Hawai'i Outcomes Project - to more closely examine this disparity, build public awareness of the problem and ultimately secure more resources for local prevention efforts.

The first step in the partnership between the Injury Prevention and Control Program and the North Hawai'i Outcomes Project was to review and summarize data from fatal crashes, including linking datasets from death certificates and the Fatal Analysis Reporting System, which provides a national census of fatal motor vehicle crashes in the U.S. This review included demographic information on the victims, geographic location of the crash, alcohol use estimates, seat belt use, and information on contributing factors in the crash, such as speeding or reckless driving. The Hawai'i Department of Transportation later provided aggregated non-fatal crash data to the project members, which the program helped to analyze.

Findings from these analyses were incorporated into the North Hawai'i Outcomes Project reports and presented to coalition members. A poster-sized map showing the geographic locations of crashes in Hawai'i County was produced and distributed to local schools and public safety agencies. These analytic efforts helped to provide direction on prevention strategies. As North Hawai'i Outcomes Project meetings continued and membership expanded, the Injury Prevention and Control Program provided analytic support on an ad hoc basis, as well as more program-oriented support.

**PROGRAM RESULTS** The analytic support provided by the Injury Prevention and Control Program helped the North Hawai'i Outcomes Project bring partners to the table, inspire them to collaborate and take action on this priority issue, and obtain new resources to address it.

Early successes of this collaboration include:

- County Impaired Driving task force;
- for 52 sobriety roadblocks in 2005;
- You Drive. You Lose":
- a cabinet level task force appointment by the County Mayor to address traffic safety; and
- a collaboration with the local Drug Free Coalition to address impaired driving.

### **IMPACT OF ADDITIONAL FUNDING**

Additional funding for the Injury Prevention and Control Program is necessary for the program to continue to provide timely and accurate injury data to organizations such as the North Hawai'i Outcomes Project, communities, policy makers, and the media. Data is essential for analyzing public health problems, identifying groups at-risk, developing and evaluating interventions, building community awareness, and securing additional resources that can be used to address these public health problems.



• a \$52,000 Safe Communities Grant to the North Hawai'i Outcomes Project to support development of a Hawai'i

\$500,000 to Hawai'i County to increase high visibility enforcement of driving under the influence and funding

linking Hawai'i County with the National Highway Traffic Safety Administration's national campaign "You Drink.



## Department of Health and Welfare

ISSUE Falls are the leading cause of injury death for Idahoans ages 65 years and older. Idaho fall fatalities for persons ages 65 and older are almost twice that seen nationally -- 58.6 per 100.000 population (2000-2002 average) versus 29.8 per 100,000 population for the U.S. (2001). Estimated EMS ambulance run data for 2000-2002 show that 50 percent were for adults ages 65 years and older. Seventy-five percent of falls in Idaho occur in private residences. Health care costs for falls average almost \$20,000 per incidence, but falls also take a toll on older adults through reduced mobility, reduced independence, increased admittance to long-term care facilities, and higher risk of premature death.

Risks for falling include lower body weakness, problems with walking and balance, visual impairments, chronic health conditions, taking four or more medications per day, and taking psychoactive medications. The risk of falls may be reduced by participating in exercise classes to improve strength, balance, flexibility, and endurance at least twice a week for several weeks.

### **PROGRAM OVERVIEW**

The Idaho Department of Health and Welfare's Injury Prevention Program

developed the Fit and Fall Proof program, a cooperative effort that begain in 2004 between the state program and district health departments to promote a fall prevention exercise program that began in 2004.

- The Injury Prevention Program uses Preventive Health and Health Services Block Grant funding to contract with Idaho's seven health districts to implement the fall prevention exercise program in communities throughout the state.
- The Injury Prevention Program worked with the College of Southern Idaho and Boise State University to develop the Fit and Fall Proof curriculum and a class to train lay individuals as community exercise class leaders.
- Under the guidance of the Injury Prevention Program, a network of exercise classes has been developed at senior centers and other sites where seniors gather.
- Local health districts recruit volunteer class leaders to be trained to provide classes that will meet a minimum of twice a week for periods of at least six consecutive weeks. Pairs of leaders are being trained for each site.
- The Injury Prevention Program developed an evaluation tool to determine whether or not individuals decrease their risk for falling as a result of class participation.

### **PROGRAM RESULTS**

health care costs that result from falls.

- In the first year of the program, 19 community Fit and Fall Proof class sites were established and six more were identified throughout the state.
- training for 45 persons from across the state.
- At least 18 new Fit and Fall Proof class sites will be developed in 2006.
- At least 14 existing Fit and Fall Proof classes will be maintained throughout Idaho in 2006.
- Preliminary data show an improvement (reduced risk of falling) for most individuals who attended classes over a six-week period.

### IMPACT OF ADDITIONAL FUNDING

With additional funding, the number of class sites and class leader trainings could be increased in each health district. Program staffing could be expanded to provide technical assistance to and improved management of volunteer class leaders. Qualitative evaluations could be conducted to improve volunteer recruitment and retention methods and to better meet the needs of class participants.



The Fit and Fall Proof program enhances Idaho's capacity to reduce fatalities, injuries and related

Representatives from the American Association of Active Lifestyles and Fitness conducted exercise class leader

### Idaho Department of Health and Welfare **Injury Prevention Program**

### http://www.healthandwelfare.idaho.gov/ site/3545/default.aspx P.O. Box 83720 Boise, ID 83720-0036 (P) 208-334-5627 • (F) 208-334-6573

# ILLNOS Department of Public Health

ISSUE Estimates suggest that one in three females will be a victim of sexual or intimate partner violence during their lifetime. Many victims/survivors of these crimes do not seek services through victim services programs or the criminal justice system, but they do interact in some way with health care providers. These providers could deliver key prevention messages and provide early intervention services, but research shows that less than 10 percent of physicians routinely assess their patients for domestic/intimate partner, sexual or elder violence.

### PROGRAM OVERVIEW

The Illinois Department of Public Health's Division of Iniury and Violence

Prevention collaborates with the Illinois Violence Prevention Authority and other partners to implement Illinois Health Cares, a project to help communities strengthen their local health care systems' capacity to engage in domestic/intimate partner violence, sexual and elder violence prevention and intervention. The Division of Injury and Violence Prevention funds a part-time coordinator for the initiative, and the Illinois Violence Prevention Authority funds statewide collaborative work and community grants.

At the national level, Illinois Health Cares was selected as one of 15 states to participate in the Family Violence Prevention Fund's National Standards Campaign. Project staff also have helped to (1) produce national consensus guidelines for the health care response to domestic/intimate partner violence, (2) develop a training curriculum for domestic/intimate partner violence prevention and response programs in public health departments, and (3) change the Joint Commission on the Accreditation of Health Care Organizations' standard on the identification of abuse and violence in hospital settings.

At the state level, work is driven by the Illinois Health Care Leadership Team, which leads the project's statewide resource development, funding goals and guidelines for the community grants program.

Illinois Health Cares grantees include local public health departments and domestic/ intimate partner violence prevention service providers. Requirements for grantees include the following:

- develop a coalition that includes at least one hospital, clinic or group practice, public health department, domestic/intimate partner violence program, sexual assault program, and an elder abuse program;
- provide public education on domestic/intimate partner, sexual and elder violence as health care issues;
- advocate for improvement in the clinical response to domestic/intimate partner, sexual and elder violence; and
- participate in grantee networking activities.

### **PROGRAM RESULTS**

wide:

- networking and advocacy conference.
- abuse.

At the community level:

- projected to reach an estimated 757,023 viewers.
- and where to refer patients, and in their ability to help patients develop a safety plan.
- 4.500 "Dear Provider" postcards urging physicians to assess patients for abuse were distributed.
- Month.

### IMPACT OF ADDITIONAL FUNDING

Despite the project's success, currently it can fund only seven communities and statewide train-the-trainer sessions must limit attendance. Additional funding would expand program capacity and reach additional healthcare providers and local communities throughout Illinois.



The project has been cited nationally as a model program and is unique in providing local level funding and using collaborative work to bring about change in the health care system's response to violence. State-

85 participants attended a train-the-trainer session and 130 violence prevention advocates attended a

• Health care provider resource materials on victim identification and referral were broadly distributed. Educational bulletins were produced about Illinois Health Cares and the health care system's response to elder

A poster campaign on city buses to identify domestic/intimate partner violence as a health care issue was

 Evaluation of a training for over 2,100 health care providers and other stakeholders showed that participants reported an increase in their confidence to document suspected abuse, in their knowledge of reporting laws

6,000 drink coasters with messages urging women experiencing abuse to contact their doctor or domestic/

intimate partner violence program were distributed to restaurants and bars during Domestic Violence Awareness

### **Illinois Department of Public Health Division of Injury and Violence Prevention**

http://www.idph.state.il.us/ 535 West Jefferson, 2nd Floor Springfield, IL 62761 (P) 217-558-4081 • (F) 217-782-1235

# State Department of Health

ISSUE Although deaths due to fireworks are not as common as other mechanisms of injury, two Indiana residents died as a result of complications sustained from fireworks-related injuries in 2001. According to the U.S. Consumer Products Safety Commission, 9,300 people were treated in U.S. emergency departments for fireworks-related injuries in 2003. Children ages 14 and younger sustained about 45 percent of these injuries, and males sustained about 72 percent. Improved fireworks-related injury surveillance in Indiana would provide a better understanding of groups at risk for these injuries and who to target with prevention messages.

### PROGRAM OVERVIEW

The Indiana State Department of Health's Injury Prevention Program

used funds from a capacity building grant from CDC's National Center for Injury Prevention and Control to conduct surveillance of fireworks-related injuries in the state. Legislation passed by the Indiana General Assembly in 2003 required physicians, hospitals and outpatient surgery centers to report all injuries resulting from fireworks or pyrotechnics to the state's Injury Prevention Program during 2003 and 2004.

- The Injury Prevention Program, in collaboration with the Indiana Hospital and Health Association and emergency physicians, created a fireworks injury reporting form that was available to be downloaded from the state's website. Reports were submitted online, by fax or by mail.
- Almost 500 fireworks-related injury cases were reported to the Injury Prevention Program in 2004.
- Analyses confirmed that children and adolescents are most at risk of fireworks-related injury. Fifty-three percent of all fireworks-related injuries involved children and adolescents, who represent only 26 percent of Indiana's population.
- Information on the prevention of fireworks-related injuries was disseminated through an epidemiology newsletter produced by the state health department and through the state Emergency Medical Services for Children website.
- To increase public awareness of fireworks-related injuries, Injury Prevention Program staff responded to requests for radio and newspaper interviews and provided data updates to media outlets.

### **PROGRAM RESULTS**

analysis effort:

- The program developed the state's first fireworks surveillance system.
- Injury Prevention Program.
- they represent only 26 percent of the population in Indiana.
- The program used the surveillance data to communicate key messages such as who is most at risk of fireworks-related injury, the most frequent types of injury sustained and the most common types of fireworks that caused injury.
- surveillance capacity and experience.

### **IMPACT OF ADDITIONAL FUNDING**

Ongoing public awareness and education efforts are needed to prevent fireworks-related injury in Indiana, especially given the impact of these injuries on children and adolescents. Additional funding for the state's Injury Prevention Program would strengthen the program's capacity to continue fireworks-related surveillance activities and disseminate effective educational information throughout the state.



The Injury Prevention Program achieved the following results from this data collection and

As of mid-December 2004, a total of 494 unduplicated fireworks-related injury cases had been reported to the

• The Injury Prevention Program used the data to identify the population most at risk of fireworks-related injury: children and adolescents. While 53 percent of all fireworks-related injuries involved children and adolescents,

The fireworks-related injury surveillance projected helped build the Injury Prevention Program's overall injury

### **Indiana State Department of Health**

**Injury Prevention Program** 

http://www.in.gov/isdh/programs/injury/ 2 North Meridian Street, Section 6A Indianapolis, IN 46204 (P) 317-233-7164 • (F) 317-233-7805

# Department of Public Health

ISSUE Victims of domestic/intimate partner violence are more likely to speak with health care providers than report the abuse to law enforcement authorities. While lowa hospital emergency departments are required to implement policies for identifying and referring victims of domestic violence, a 1998 survey revealed that only four of 119 emergency departments - about three percent - were routinely screening for domestic/intimate partner violence.

### PROGRAM OVERVIEW

The Iowa Department of Public Health's Violence Prevention Program used Vio-

lence Against Women Act and private grant funds to implement a pilot training and technical assistance project in lowa emergency departments to assist providers in improving their facilities' response to domestic/intimate partner violence. Teams from 15 hospitals in both rural and urban areas of the state participated. Each team included a doctor, nurse, administrator, social worker and local domestic/intimate partner violence prevention advocate. Project activities included:

- Each facility conducted a pre-training survey to identify and describe facility policies and practices regarding the identification of patients who are victims of domestic/intimate partner violence.
- A two-day training session was held for all 15 teams on how to assess, intervene, document, and refer patients identified as victims of domestic/intimate partner violence. The training also addressed how to improve institutional policies and establish a facility-wide task force to implement routine screening policies.
- Each facility identified one person to attend a daylong train-the-trainer session that provided materials and resources for conducting professional training at their home facility.
- · During project implementation, the lowa Department of Public Health worked with participating hospitals to track their progress toward project goals, project teams received ongoing mentoring from a state advisory group, and team members attended a follow-up conference after nine months.

### **PROGRAM RESULTS**

domestic/intimate partner violence, conducted provider training, and established a quality assurance mechanism.

violence – up from the three percent that reported doing this screening in 1998.

### IMPACT OF ADDITIONAL FUNDING

The lowa Department of Public Health used private grant funding to offer a train-the-trainer session for remaining hospitals and public health clinics in 2003. With additional funding, the department could help strengthen lowa's hospital rules to encourage or require routine domestic/intimate partner violence screening and provide a broader range of training opportunities. Through increased and improved screening and identification, victims of domestic/intimate partner violence would have greater opportunity to receive intervention and referral for community resources.



• All of the 15 participating pilot hospitals implemented routine screening policies for

By 2001, almost 30 percent of lowa's hospitals were conducting routine screening for domestic/intimate partner

Iowa Department of Public Health **Bureau of Disability and Violence Prevention** 

http://www.idph.state.ia.us/bhpl/domestic violence.asp Lucas State Office Bldg. 321 E. 12th Street Des Moines, IA 50319 (P) 515-281-5032 • (F) 515-281-4535

# KANSAS **Department of Health and Environment**

ISSUE About 70 percent of residential fire fatalities in Kansas occur in properties without working smoke alarms. In Kansas, children ages 0-5, adults who are disabled and older adults ages 65 and over are particularly at risk of injury or death due to residential fire. Adults ages 65 and older are three times more likely to die in a residential fire than the general population. Adults ages 75-84 are nearly four times at risk and those ages 85 and older are more than five times at risk.

## PROGRAM OVERVIEW

The Kansas Department of Health and Environment's Office of Iniury Preven-

tion and Disability Programs received a grant from the CDC's National Center for Injury Prevention and Control to lower the number of residential fire-related injuries and deaths and reduce the loss of property. The Kansas Fire Injury Prevention Program was developed to identify at-risk homes, install long life lithium battery smoke alarms and the deliver public fire and life safety education. Highlights of this statewide program include:

- Since 1998, the Kansas Department of Health and Environment has worked with 31 counties to implement the program on the local level.
- The program has partnered with Safe Kids Kansas (a coalition of over 60 statewide and regional organizations and businesses), the Kansas Department of Health and Environment's Bureau for Children, Youth and Families, the Kansas Department on Aging, the Kansas Hospital Association, local fire departments, local health departments, churches, and church-based organizations.
- Community partners canvassed high-risk neighborhoods to provide fire safety information, inspect existing alarms and install long life lithium battery smoke alarms. They also installed smoke alarms designed to meet the needs of people who are deaf or hearing-impaired.
- School children and older adults received fire safety education in schools and at local daycare and senior centers.
- In the homes of older adults in one county, the home inspection also included an assessment of risk factors for falls. An inventory was made of safety equipment that was needed to reduce the risk of falls, and local contractors were used to install safety items such as grab bars in bathtubs.

### **PROGRAM RESULTS**

- occupants and they were able to escape.
- have been installed in 4,857 homes.
- organizations.

## **IMPACT OF ADDITIONAL FUNDING**

Although lives have been saved through the program, others remain at risk as homes continue to go unprotected by a working smoke alarm. In addition, at-risk populations continue to increase, especially as the Kansas population ages. Additional funding would allow the program to continue beyond the period funded by the CDC grant, and would provide fire safety resources to high-risk populations, including young children and older adults.



The Kansas Fire Injury Prevention Program has achieved important results. During 2001-2004, 14 lives were saved as a result of the program's efforts to ensure adequate smoke alarm coverage in each home visited. In a single incident in Labette County, the lives of seven adults and two children were saved when a fire broke out in a home with smoke alarms installed by the program. The alarm notified the

• A total of 10,210 alarms – 10,149 lithium battery smoke alarms and 61 smoke alarms for the hearing-impaired

Thousands of Kansas citizens have received fire safety information at home, in local schools and through partner

Kansas Department of Health and Environment **Office of Injury Prevention and Disability Programs** 

> http://www.kdhe.state.ks.us/idp/index.html 1000 SW Jackson, Suite 230 Topeka, KS 66612-1274 (P) 785-296-8163 • (F) 785-296-8645

# KENTUCKY Cabinet for Health and Family Services

ISSUE Kentucky's state and local agencies compile detailed information about patterns and trends in violence, but this information is fragmented among agencies and data sources. Creating a system to link data sources would help create a comprehensive picture of violent incidents in Kentucky, which in turn can be used to inform decision makers about the magnitude, trends and characteristics of violent deaths, and to evaluate and improve state-based violence prevention policies and programs.

### PROGRAM OVERVIEW

The Kentucky Cabinet for Health and Family Services, which houses the

state's Department for Public Health, and the Kentucky Injury Prevention and Research Center have collaborated on several projects in recent years to improve the state's surveillance of violent incidents.

During 1999-2004, the Kentucky Cabinet for Health and Family Services' Department for Public Health utilized a grant from CDC's National Center for Injury Prevention and Control to conduct public health surveillance of intimate partner violence. The Intimate Partner Violence Surveillance Project was carried out by the Kentucky Injury Prevention and Research Center.

- The surveillance project aimed to develop a comprehensive picture of intimate partner violence experienced by adult women in Kentucky.
- The project linked matching records among three separate data sets: hospital discharge data, domestic violence protective order data and Adult Protective Services data.
- The project designed and conducted a statewide telephone survey to estimate the nature and prevalence of intimate partner violence in Kentucky.
- The project established baseline data, including quantifying the magnitude of the problem, characterizing the nature of the violence and measuring injuries sustained as a result of partner violence.

In a separate but related project, the Department for Public Health received a grant from CDC's National Center for Injury Prevention and Control in 2004 to establish the Kentucky Violent Death Reporting System. This system:

- links records from the state's Department for Public Health, coroners, medical examiners, state police, and the state police's Criminal Identification and Records Branch and forensic crime laboratories to provide a more complete picture of each violent incident; and
- provides timely information through faster data retrieval.

**PROGRAM RESULTS** Collaboration between the Department for Public Health and the Kentucky Injury Prevention and Research Center has produced numerous analyses and publications that offer an improved understanding of the problem of violence in the state. For example, one analysis linked coroner, medical examiner, vital statistics, and administrative judicial data to provide new information about homicides that are followed by suicide. Specifically:

- himself in two thirds of cases.
- Female victims of the intimate partner violence-related homicides may not have had contact with law such contacts.

## **IMPACT OF ADDITIONAL FUNDING**

Although Kentucky is part of the National Violent Death Reporting System, this system does not capture data on the victim's involvement with the Department of Community Based Services. Additional funding for the Intimate Partner Violence Surveillance Project would enable Kentucky to continue documenting the history of intimate partner violence and better understand how to prevent it.



• Although only a small percentage (6.5 percent) of the state's 492 firearm homicides during 1998-2000 were followed by firearm suicide, when women were shot and killed by their intimate partners, the perpetrator shot

enforcement, a physician or another third party, or these issues may have gone undetected or unreported during

### **Kentucky Cabinet for Health and Family Services**

http://chfs.ky.gov 275 East Main Street Frankfort, KY 40621 (P) 502-564-7042 • (F) 502-564-7091

# LOUISIANA Office of Public Health

ISSUE Unintentional injury is the leading cause of death among children in Louisiana. Playgrounds are a common venue for childhood injuries. Most injuries occur when children fall from playground equipment that is too high onto surfacing that is too hard. Factors contributing to playground safety include proper adult supervision when children are at play, age-appropriate design of playground equipment, safe playground surfaces, and equipment maintenance.

### PROGRAM OVERVIEW

The Louisiana Office of Public Health's **Injury Research and Prevention** 

Program supported a program to assess and promote playground safety.

- The Injury Research and Prevention Program provided educational presentations to local school boards and city councils on playground-related injuries and prevention strategies.
- The program visited and inventoried 14 playgrounds using a standard best-practice tool, a tape measure, and a digital camera.
- Analysis of these data indicated that all but two of the 14 sites visited had significant safety shortcomings, which were illustrated using the digital photographs.

### **PROGRAM RESULTS**

safety standards.

- those which were inventoried and those that were not.

## **IMPACT OF ADDITIONAL FUNDING**

Additional funding would enable the program to enhance playground-related injury prevention in many ways. The program could:

- organize teams of surveyors to evaluate the safety of all public playgrounds;
- conduct cost-benefit analyses on the return on investment for playground improvement.



• Six of the 14 playgrounds were scheduled for renovations to bring them up to accepted

• Grant funds were identified to support renovations and repairs on many of the remaining playgrounds - both

Playground safety standards were introduced to local planning board policies and school operations policies.

establish physician and emergency room surveillance for playground injuries in order to better document the

problem and build community support for playground injury prevention efforts; and,

Louisiana Office of Public Health **Injury Research and Prevention Program** 

http://www.oph.dhh.state.la.us/injuryprevention P.O. Box 60630 New Orleans, LA 70160 (P) 504-568-2509 • (F) 504-568-7312

## MANE Center for Disease Control and Prevention

ISSUE Suicide is the second leading cause of death for Maine youth ages 15-24. Maine's youth suicide rate is more than 25 percent higher than the national rate. Hospitalization for self-inflicted injury is higher for persons ages 15-19 than any other age group in the state.

## PROGRAM OVERVIEW

The Maine Injury Prevention Program, housed within the Maine Center for Dis-

ease Control and Prevention's Division of Community Health, implements both unintentional and violence prevention programs. These include the Maine Youth Suicide Prevention Program, a multi-faceted program for the general public, young people at risk and persons in direct contact with youth. The program aims to reduce the incidence of suicidal behavior among youth ages 10-24, and to improve youth access to appropriate prevention and intervention services.

In 2002, the Maine Injury Prevention Program received funding from CDC's National Center for Injury Prevention and Control to implement the School/Community Youth Suicide Prevention Intervention Project. This project works with 12 high schools to implement and evaluate two suicide prevention programs – the Lifelines Program (implemented in all 12 schools) and the Reconnecting Youth Program (implemented in six of these schools).

The Lifelines Program includes guidance for school personnel on suicide prevention, intervention and advanced planning for the crisis presented by a youth suicide attempt or death. The program takes a whole-school approach to provide:

- "gatekeeper" training for selected school staff and community members willing to learn how to recognize and respond to suicidal behavior;
- train-the-trainer workshops for gatekeepers who will conduct school and community awareness education programs:
- suicide prevention awareness education for all school personnel;
- training for health teachers who will teach students about suicide prevention; and
- suicide prevention lessons for inclusion in the school's comprehensive health education curriculum.

Reconnecting Youth is a school-based prevention program designed to help students who are at-risk for problematic behaviors such as dropping out, substance abuse and suicide. Students participate in a semester-long class to help them learn and practice life skills that can enhance their resiliency to and reduce the risk of suicide or other selfdestructive behaviors. School staff members receive training and technical consultation to conduct these classes. The program also emphasizes partnerships with peers. parents and school personnel.

### **PROGRAM RESULTS**

- All 12 schools developed prevention, intervention and crisis planning protocols.
- exhibits suicidal behavior.
- Six months after gatekeeper training, trainees had maintained significant gains in: - knowledge about suicide
  - knowledge of intervention steps for suicidal behavior
  - personal confidence in their ability to intervene
  - their reported likelihood to ask directly about suicide when necessary - knowledge of available resources
- and 54 percent to other in-school resources.
- Lifelines lessons had significantly greater gains than did students in the control group.

### **IMPACT OF ADDITIONAL FUNDING**

Additional funding would allow extension of the Lifelines and Reconnecting Youth programs to additional Maine high schools and youth at risk for suicide. After CDC funding ends in 2006, the program only will be able to continue the Lifelines Program in a small number of high schools, unless additional resources are identified.



The impact of the Lifelines Program in Maine includes:

 More than 300 school personnel and members of surrounding communities participated in gatekeeper training. and at least two individuals in each school were identified as primary contacts who can intervene if a student

• School-based gatekeepers have seen 198 students as of April 2005. Many of these students were referred to single or multiple sources of help. All students identified by gatekeepers as potentially at risk for suicide were referred for further assessment; 55 percent were referred for crisis services, 38 percent to community resources

• By April 2005, a total of 1177 students had participated in Lifelines Program lessons. Data from pre- and postsurveys show that students had significant gains in help seeking, knowledge about suicide prevention, belief that their school was ready to handle a suicide crisis, and how to talk about suicide. Students who received the

### Maine Center for Disease Control and Prevention

Maine Injury Prevention Program

http://www.maine.gov/dhhs/bohdcfh/inj/ 11 State House Station Key Bank Plaza, 5th Floor

Augusta, ME 04333 (P) 207-287-3265 • (F) 207-287-3993

# MARYLAND Department of Health and Mental Hygiene

ISSUE Injury is the leading cause of death in Maryland for persons age 1-44. In 2003, there were over 512,000 injuries reported in Maryland. Of these, 3,510 were injury-related deaths, 36,903 (7 percent) required hospitalization and 471,680 (92 percent) resulted in emergency department visits.

Injuries cause immense costs to individuals, their families and society. During 2003, injury-related hospitalizations accounted for five percent of all hospitalizations in Maryland, with charges of over \$360.7 million. Additionally, the total number of injury-related emergency department visits accounted for 15 percent of all emergency room visits and totaled almost \$140 million in medical costs.

Most of these injuries are preventable and consequences of injuries that do occur often can be mitigated by the provision of appropriate post-injury rehabilitative information and services. Building injury prevention capacity at the local health department level is essential for an effective state-wide injury prevention program. In some jurisdictions, mini-grants are the only source of available injury prevention program funding.

## PROGRAM OVERVIEW

The Maryland Department of Health and Mental Hygiene's Center for

Preventive Health Services includes the Division of Injury Prevention and Epidemiology. Part of the center and division's strategy for preventing injury and violence in the state is to increase the capacity of others to affect meaningful injury prevention in both new and existing practice settings. Since 1989, the Center has focused on increasing injury prevention capacity by offering mini-grants to local health departments.

- The mini-grants are funded through Public Health and Human Services block grant funds.
- The mini-grants support activities to increase the capacity of Maryland's local health departments to plan, implement and evaluate targeted injury prevention programs based on identified community needs.
- The grants include provisions for training and educating health department and related agency staff in injury prevention science and program implementation skills.
- In addition to building local capacity, the mini-grant program also supports small-scale feasibility-testing of promising local prevention activities.

### **PROGRAM RESULTS**

- supported injury prevention initiates in 20 of Maryland's 24 jurisdictions;
- supported initiatives that addressed child passenger safety, water safety, fall prevention in the elderly, farm safety for children, child care provider training, shaken baby syndrome awareness, sleep safety for infants, playground safety, firearm safety, and adolescent suicide prevention; and

### **IMPACT OF ADDITIONAL FUNDING**

Additional funding would enable the Center for Preventive Health Services to:

- increase awareness of injury and violence as a major public health problem at the community level;
- strengthen the ability of local health departments to address local needs; and
- enhance injury prevention information, skills and self-efficacy at the local level.



During Fiscal Year 2005, the Center for Preventive Health Services' mini-grant program:

• was selected as a test site for the World Health Organization's comprehensive injury prevention curriculum called TEACH-VIP (Teaching, educating and advancing collaboration in health on violence and injury prevention).

### Maryland Department of Health and Mental Hygiene

Center for Preventive Health Services - Division of Injury Prevention and Epidemiology

http://fha.state.md.us/cphs 201 West Preston Street, Room 306 Baltimore, MD 21201 (P) 410-767-5780 • (F) 410-333-5030

## MASSACHUSETTS **Department of Public Health**

ISSUE In 2003, there were 27,715 fire and explosion incidents reported by Massachusetts fire departments to the state Fire Marshal's Office. These incidents caused 79 deaths and 12,738 non-fatal injuries. In 26 percent of residential fires, there were no working smoke detectors. Immigrants, refugees, older adults, and young children are especially at risk for fire injury.

## **PROGRAM OVERVIEW**

The Massachusetts Department of Public Health's Injury Prevention

Program received funding for 2001-2006 from CDC's National Center for Injury Prevention and Control to implement a community-based project to install smoke alarms and provide fire safety education to at-risk residents. This statewide program is implemented in coordination with the State Fire Marshal's Office. Program highlights include:

- Participating communities are required to have collaboration between the local fire department and at least one community-based organization.
- The community-based agencies often can provide access to potential at-risk families and individuals who require smoke alarms and fire safety education. They also provide translations, especially for home visits.
- The fire department personnel typically are responsible for conducting home visits to install long-life lithium battery smoke alarms; they also provide fire safety education.
- Follow-up visits are conducted by either the fire department or the community agency approximately six months after the initial home visit to ensure that the smoke alarm installed by the program is still present and functioning.

**PROGRAM RESULTS** As of September 2005: • At least 30 lives have been saved as a result of the smoke alarms installed through this project. These lives saved include incidents in which the smoke alarm alerted the resident to a problem that the resident was able to resolve, such as covering a smoking/flaming pan, or for which the resident called the fire department for assistance.

- A total of 75 communities and one statewide program participate in the project.
- A total of 2,493 homes have been visited and 6,500 alarms have been installed.

### **IMPACT OF ADDITIONAL FUNDING**

Approximately 25 percent of Massachusetts' communities are covered through this project. With additional funding, many more of the state's high risk populations would be properly protected by working smoke alarms and fire-safety education.



**Massachusetts Department of Public Health** 

**Injury Prevention and Control Program** 

http://www.mass.gov/dph/fch/injury/index.htm 250 Washington Street, 4th Floor Boston, MA 02108-4619 (P) 617-624-5413 • (F) 617-624-5075

# MICHIGAN Department of Community Health

ISSUE Rape, a form of sexual violence, is a significant public health problem in Michigan. The estimated lifetime prevalence of rape among Michigan's adult women is 14.6 percent, which is higher than the U.S. rate of 13.4 percent. This means that one in seven Michigan women has experienced at least one forcible rape sometime during her lifetime. Most rapes and other types of sexual violence are committed against children and adolescents, especially adolescent females. More than 61 percent of all reported rape cases occur among victims under age 18, and it is estimated that only one out of six rapes is never reported.

### PROGRAM OVERVIEW

The Michigan Department of Community Health's Injury and Violence Preven-

tion Section manages the state's Rape and Sexual Assault Prevention Education Program, which uses funds from a five-year CDC Rape Prevention and Education grant to work with local communities to change attitudes, beliefs and behaviors about sexual violence.

The program works at the state level to coordinate activities in 22 counties. Program interventions focus on youth and include appropriate process and outcome evaluation objectives. For example:

- Local project coordinators gave presentations to youth to positively affect awareness, attitudes and behaviors related to preventing sexual violence. Presentations ranging from one to 12 sessions took place in a variety of settings, including schools, youth-serving agencies and juvenile detention facilities. Follow-up is provided by trained staff.
- Project coordinators also worked with adults who have influence with youth, such as parents, teachers and coaches, to provide positive influences that reinforce the prevention messages.
- To reach underserved populations, project staff worked with local law enforcement, schools and local organizations, as well as health care, religious and business leaders.

### **PROGRAM RESULTS**

- Over 19,000 youth participated in sexual violence prevention programming in a variety of settings
- Education and skill building was provided to 2,237 parents and 6,966 community members.
- Data collected before and after presentations to youth demonstrated statistically significant increases in knowledge of and positive attitudes and beliefs about sexual violence and its prevention among youth participants.

### IMPACT OF ADDITIONAL FUNDING

This effective program is currently offered in only 22 of Michigan's 83 counties, and in these 22 counties, only a small number of potential participants can be reached due to limited resources. Additional funding would allow the program to expand the type and breadth of prevention activities offered to these counties, while expanding the program to additional counties throughout the state.



Program evaluation data from 2004 show promising results: A total of 5,566 professionals received training about sexual violence and its impact on Michigan's citizens.

**Michigan Department of Community Health** 

**Injury and Violence Prevention Section** 

http://www.michigan.gov/injuryprevention/

Washington Square Building 109 Michigan Avenue Lansing, MI 48913 (P) 517-335-9513 • (F) 517-335-8269

# MINNESOTA Department of Health

ISSUE outcomes.

Injury and violence prevention professionals need timely data and information on proven prevention strategies in order to effectively control, reduce or eliminate injury and violence and improve health

## PROGRAM OVERVIEW

During Fiscal Year 2004, the Minnesota Department of Health's Injury and Vio-

lence Prevention Unit expanded its efforts to publish and disseminate findings from a variety of data analyses, share useful prevention strategies and keep prevention partners informed. Selected topics and issues addressed were identified through data analysis and input from organizations with which the unit collaborates. The publications were funded by grants from CDC's National Center for Injury Prevention and Control and state appropriations. The reports and publications can be accessed on the unit's website.

- Firearm-Related Injury Violence Data Brief: 1998 to 2001 summarizes trends and demographics of Minnesotans injured and killed by firearms. For example, 76 percent of firearm deaths were by suicide.
- Charting: The Invisible Role of Physicians in Injury Prevention is a pocket card developed in consultation with health care professionals on the unit's Violence Data Advisory Committee. It guides physicians and nurses in writing notes on patient charts to document unintentional injuries and abuse. Unit staff also conducted a related presentation for medical residents.
- Domestic and Sexual Violence in Minnesota: Strategies for Prevention and Intervention summarizes five-year objectives and strategies for professional and community education, coordination and collaboration, quality and consistency of services, policy development, and organizational commitment. The plan was developed following a thorough assessment of Minnesota's services and needs, and with the strong support and involvement of public health, victim services and other professionals and consumers of services in Minnesota.
- Best Practices in Injury Prevention is a series that currently addresses nine topics, including the two most recently published documents on drowning and poisoning.
- Injury and Violence Prevention News is a regular unit publication with a primary audience of health educators and public health nurses at the local level, but content and audiences have been expanded to include other state agencies and advocacy organizations interested in injury and violence prevention. Eight issues were published and disseminated during the year.

### **PROGRAM RESULTS**

- through a statewide radio news network. The release generated considerable media interest
- Individuals and agencies have shown their support for the domestic and sexual violence prevention and reimbursement to providers for domestic and sexual violence screening and related services.

### **IMPACT OF ADDITIONAL FUNDING**

Additional CDC funding would enable the unit to continue developing ways to share its data and information with additional audiences.



Results from the unit's expanded effort to share data and information include: A news release issued along with the firearm data brief was printed in newspapers statewide and distributed The charting card was distributed to medical residents following injury and abuse documentation training, and physician and nurse members of the unit's Violence Surveillance Advisory Committee have distributed the card to colleagues. Articles about the card have been published in several health care professional publications. intervention plan by registering as "plan supporters" and by agreeing to work on implementing plan objectives. An implementation grant helped explore and act on several concerns described in the plan, such as inadequate

> **Minnesota Department of Health** Injury and Violence Prevention Unit

http://www.health.state.mn.us/injury/ 85 East 7th Street. Suite 400 P.O. Box 64882 St. Paul, MN 55164-0882 (P) 651-281-9832 • (F) 651-215-8959

# MISSISSIPPI Department of Health

ISSUE Mississippi leads the nation with the highest death rate due to residential fire. Exposure to smoke, fires and flames was the third leading cause of injury death in the state, with a fatality rate of 3.6 per 100,000 population, three times the national rate of 1.07 per 100,000 population. Children and older adults have a greater risk for fire-related injury and death. Among the 261 persons who died in Mississippi during 1999-2001 from residential fires, 12 percent were children ages 0-4 and 29 percent were ages 65 and older. Together, these age groups account for only 20 percent of the population, but total 41 percent of the deaths caused by fires.

## PROGRAM OVERVIEW

The Mississippi Department of Health's Injury and Violence Prevention Program

utilized grant funds from CDC's National Center for Injury Prevention and Control to implement a prevention program aimed at reducing residential fire-related injuries and fatalities in the state. Highlights of the Fire Prevention Program from 1998-2005 include:

- Program staff coordinated activities in three public health districts. The districts were selected based on population size, fire death rate, and average household income.
- The program purchased smoke alarms in bulk and distributed them to the participating public health districts.
- The program worked with local public health and fire departments to identify neighborhoods and areas within each county that were considered at high-risk for residential fire-related injury.
- To identify homes without adequate smoke alarm coverage, program coordinators and community volunteers canvassed high-risk neighborhoods and areas, conducting home visits that included smoke alarm inspection and installation, and fire prevention education.
- The National Fire Protection Association's Learn Not to Burn program was conducted at local elementary schools in each program community. The program's messages were reinforced during visits in homes with children.
- Fire safety awareness and prevention classes were conducted for parents and children at Mississippi Head Start programs.
- Remembering When, a national fire and fall prevention program for older adults, was conducted at local senior activity centers/homes.

### **PROGRAM RESULTS**

- installed 3,467 smoke alarms in high-risk residences;
- canvassed 5,459 households, of which 2,311 were enrolled;
- reached over 73,700 individuals through public awareness activities; and,
- distributed 4,000 fire safety packets during home visits and fire safety presentations.

To assess the impact of the program, evaluation data were collected by community program coordinators, who revisited a sample of the original homes that had received a home visit. This follow-up was conducted eight months after the original visit. Results include:

- all of the alarms were still in the proper location in the home;
- 99.8 percent had tested their smoke alarms since installation:
- conducted;
- the average number of days since having tested smoke alarms was 47.1;
- one percent of households reported having a fire in their home; and
- practiced it was 98.8 days.

## IMPACT OF ADDITIONAL FUNDING

Despite the success of this program, many Mississippi residents still lack a working smoke alarm. The state is predominantly rural, with approximately 75 percent of the population living in non-metropolitan areas. Additional funding for the Fire Prevention Program would enable it to expand the program into all counties of the state.



During 2003-2004, the Fire Prevention Program:

99.7 percent of households reported that their smoke alarms were working and there were no problems;

94.5 percent of residents have tested their alarm within the last six months before the follow-up visit was

68.1 percent of the residents reported having a fire escape plan and the average number of days since they last

### **Mississippi Department of Health**

Injury and Violence Prevention Branch

http://www.msdh.state.ms.us/msdhsite/static/43.0.98.html P.O. Box 1700, 570 E. Woodrow Wilson Jackson, MS 39215-1700 (P) 601-576-7781 • (F) 601-576-7444

# MISSOURI **Department of Health and Senior Services**

ISSUE According to the 2003 Missouri Youth Risk Behavior Survey, one in 11 high school senior girls reported that she had been forced to have sexual intercourse against her will. In addition, schools report that bullying is a significant concern.

## PROGRAM OVERVIEW

In 2005, the Missouri Department of Health and Senior Services' Injury and

Violence Prevention Program developed formal agreements with 41 schools to use the School Health Index: A Self-Assessment and Planning Guide to evaluate their school environment regarding injury and violence. The Department of Health and Senior Services used Title V Maternal and Child Health Services Block Grant funds for these programs. The Injury and Violence Prevention Program worked closely with the School Health Program and district nurse consultants to provide technical support in using the index.

The School Health Index assessment tool was developed by CDC in partnership with school administrators and staff, school health experts, parents, and national nongovernmental health and education agencies. The tool:

- enables schools to identify strengths and weaknesses of health and safety policies and programs (i.e., physical environment, curricula, professional development for school personnel);
- · enables schools to develop an action plan for improving student health and safety to correct deficiencies identified in the self-assessment; and
- engages teachers, parents, students, and the community in promoting health-enhancing behaviors and better health.

**PROGRAM RESULTS** By using the School Health Index, the Missouri schools participating in the program actively examined injury and violence occurring in the school environment.

- questions in the index assessment tool and to assess strengths and weaknesses.
- injury and violence prevention in the school.
- occurs, and increased supervision of children arriving and departing the school grounds.
- is stepping up supervision of the school campus in an effort to prevent violence and injuries.
- bullying, verbal aggression, fighting, and social exclusion.
- driving that accompanies such use.

## **IMPACT OF ADDITIONAL FUNDING**

With additional funding, the Injury and Violence Prevention Program could provide funding to additional schools to conduct the School Health Index self-assessment and implement improvements based on that assessment. In addition, more funding would allow the program to implement some school-based improvements that would reduce students' risk of injury and violence.

### **Missouri Department of Health and Senior Services Injury and Violence Prevention Program**



. The schools developed school health committees that included community members to answer the discussion

 After conducting the self-assessment, schools then developed improvement plans for implementing changes. As a result of this process, schools report making improvements in policies and procedures, professional development, and physical environment. In addition, the self-assessment process has heightened the awareness of

One school used signage to indicate where parents should drop off and pick up children and where bus delivery

 The same school has recognized that bullying is a problem. It will hang banners and posters in the school about bullying and implement an anti-bullying curriculum in grades kindergarten through sixth grade. The school also

 Another school is implementing an evidence-based, multi-faceted prevention program recommended by the Substance Abuse and Mental Health Services Administration called Get Real About Violence. This program, implemented in grades kindergarten through eighth grade, addresses a wide range of violence behaviors, including

• This school also is implementing two other programs. It will provide professional development for its staff on the recognition and reporting of child abuse and neglect. It also is participating in the Team Spirit Program, which is designed to empower students to take an active role in preventing alcohol and other drug use and the impaired

> http://www.dhss.mo.gov P.O. Box 570, 930 Wildwood Jefferson City, MO 65102 (P) 573-751-6215 • (F) 573-526-5347

# MONTANA **Department of Public Health and Human Services**

ISSUE When compared with national data, Montana has one of the highest rates for fall injury deaths, as well as a high rate for residential fire deaths. During 2001 and 2002, there were 111 fall-related injury deaths each year. Most of these deaths were among older adults who fell inside their homes. The average annual number of fire deaths ranges from eight to 12; most of the victims are older adults. Over 75 percent of Montana's fire death victims did not have a working smoke alarm.

### **PROGRAM OVERVIEW**

The Montana Department of Public Health and Human Services' Injury Pre-

vention and Control Program began implementing a five-year fire and fall prevention program in 2002. The program, funded by a grant from CDC's National Center for Injury Prevention and Control:

- targets program areas with fire deaths and older adult residents;
- focuses on conducting home visits, during which program staff provide fire and fall injury prevention education to residents, inspect existing smoke alarms and install new alarms with long life lithium batteries, inspect the home for fall hazards, and mitigate these hazards when possible;
- contracts with 10 local fire and health departments statewide to conduct home visits in areas with about 35 percent of the state's population; and
- engages community partners, including area aging advocates, senior services, and senior care homes.

### **PROGRAM RESULTS**

- At least 49 lives have been saved due to smoke alarms installed by the project.
- Nineteen of these lives saved were among victims of very serious structure fires.
- While fall-related injury deaths increased during the late 1990s in Montana, the frequency of these deaths has
- The program has completed over 3,500 home visits and installed over 15,000 alarms.

### **IMPACT OF ADDITIONAL FUNDING**

There have been several fire deaths in areas not participating in the residential fire and fall-injury related prevention program. With additional funding, the program could expand into these areas of the state and prevent further fire and fall deaths.

http://www.dphhs.mt.gov/hpsd/pubheal/healsafe/ems/emsiniurv/iniurvindex.htm P.O. Box 202951 Helena, MT 59620-2951 (P) 406-444-4126 • (F) 406-444-1814



Since its inception in 2002, the program has achieved important results.

decreased since the program began. Fall-related injury deaths dropped from 111 in 2002 to 70 in 2003.

Montana Department of Public Health and Human Services **Injury Prevention and Control Program** 

# NEBRASKA Health and Human Services System

ISSUE Although falls are the leading cause of hospitalization for children in Nebraska, the specific causes of the fall-related injuries typically are not known. More complete data are necessary to develop programs that specifically address the major causes of fall-related injuries among children.

### **PROGRAM OVERVIEW**

SAFE KIDS Nebraska, which is a part of the Nebraska Health and Human Ser-

vices System's Injury Prevention and Control Program, collaborated with the state's Office of Epidemiology to prepare the 2004 Report on Unintentional Fall-Related Injuries. The report provides detailed information on the causes of fall-related injuries among Nebraska children ages 0-14.

The report used Nebraska hospital discharge records to study the frequency of fall-related injuries by patients' age and gender, type of fall, type of injuries caused by the fall, length of hospital stay for inpatients, and place of occurrence of the fall. Analyses were performed on the 11,902 hospital discharge records from 2001 for children under age 15 that were recorded as a fall injury. Death certificate data were used to quantify the fall-related deaths and trauma registry data were used to calculate average hospital charges.

SAFE KIDS Nebraska had ready partners for translating the report findings into prevention through its established coalitions and chapters. The organization is dedicated to preventing unintentional injuries among children age 14 and under.

The fall-related injury report was distributed to the state's SAFE KIDS coalitions and chapters, local and district health departments, and other interested agencies. It also was placed on the Nebraska Health and Human Services website.

### PROGRAM RESULTS

report show that for children under age 15:

- Males had higher fall injury rates than females for all age groups except under age one.
- Fractures were the leading injury caused by falls.
- (30 percent), which includes a fall from a bed, chair, toilet, furniture, or playground equipment.
- cent) of falls among children occurred at home.
- Nebraska Trauma Registry data for 1996-2002.

With this improved and more detailed picture of fall-related injuries among children, the Injury Prevention and Control Program used Preventive Health and Health Services Block Grant funds to award mini-grants to local SAFE KIDS coalitions to conduct fall-related injury prevention projects in cooperation with their local health departments. The report data were used to help the mini-grant projects focus on specific at-risk age groups and causes of falls. Projects were implemented during 2005.

The generation of the fall-related injury report also helped identify areas of improvement that are needed in the coding of hospital discharge records. Many of the records for fall injuries were coded as "other and unspecified" and thus lacked information as to the type of fall. Further research is needed to determine why "unspecified" is chosen as a code for a fall. Specific coding is needed to provide data that are useful in developing targeted prevention activities.

## **IMPACT OF ADDITIONAL FUNDING**

Additional funding would enable the Injury Prevention and Control Program to develop additional injury data reports that can help focus future prevention efforts. Additional funding also would allow the program to fund the local fall prevention programs for multiple years, which would increase the likelihood of sustained impact and allow for better project evaluation.



The fall-related injury report provided important information for guiding prevention efforts of the Injury Prevention and Control Program, SAFE KIDS Nebraska and other interested organizations. Highlights of the

Children ages 1-4 had the highest number of hospital discharges due to falls compared to other age groups.

• The leading types of falls were "other and unspecified fall" (33 percent) and "other fall from one level to another" The 3,738 hospital discharge records that were coded for place of occurrence showed that almost half (49 per-

• Children ages 10-14 accounted for the vast majority (88 percent) of sports-related fall injuries. • The average hospital charge for patients admitted to a trauma center because of a fall was \$6,550, according to

### Nebraska Health and Human Services System **Injury Prevention and Control Program**

http://www.hhs.state.ne.us/hpe/injury.htm P.O. Box 95044 Lincoln, NE 68509-5044 (P) 402-471-2101 • (F) 402-471-6446

# NEVADA State Health Division

ISSUE Injury is the leading cause of death and disability among children and young adults in Nevada. The state has one of the highest rates of suicide in the country; more Nevadans die of suicide than any other fatal injury-related cause. In 2003, a total of 423 Nevadans died of suicide, compared to 351 Nevadans who died in motor vehicle crashes.

### PROGRAM OVERVIEW

The Nevada State Health Division's Injury Prevention Program received fund-

ing from CDC's National Center for Injury Prevention and Control to build the state's injury and violence prevention capacity. In 2003-2004, it received additional CDC funds to develop youth suicide prevention activities. The Injury Prevention Program's efforts to address youth suicide include:

- The Crisis Call Center in Reno was contracted to provide suicide prevention education to youth in northern Nevada. This area of the state was selected because the Crisis Call Center was able to provide youth suicide prevention within the schools and other community organizations.
- Youth suicide prevention education was conducted throughout the state by distributing informational materials and holding public awareness forums.
- Rural county representatives, including middle and high school counselors, participated in a training on how to prevent youth suicide and develop prevention strategies. A train-the-trainer approach was utilized, enabling these individuals to train teachers at their schools.

**PROGRAM RESULTS** The Injury Prevention Program has strengthened the state's suicide prevention efforts by raising awareness of the problem and promoting the availability of resources for people at risk. These activities include: • 99 suicide prevention presentations were given to 2,640 students;

- 21 suicide prevention presentations were given to 446 parents and community members;
- 20 community and school events reached over 7,000 Nevadans;
- 8,113 pieces of informational materials on suicide prevention were distributed; and
- movie theater ads on suicide awareness were displayed on 27 individual theater screens in Washoe County (Reno is the county seat) for 13 weeks.

### IMPACT OF ADDITIONAL FUNDING

Although the supplemental CDC funding allowed the Injury Prevention Program to reach many students, raise awareness of suicide and promote available prevention and crisis services, Nevada still has high suicide rates. Additional funding for suicide prevention would enable the state health division to expand the program and save lives.





## NEW HAMPSHRE **Department of Health and Human Services**

In 2000, the New Hampshire death rate due to falls among adults ages 65 and over was 27 deaths ISSUE per 100.000 population. The state aims to reduce the rate of elderly falls to 23.3 deaths per 100.000 population by 2010.

### PROGRAM OVERVIEW The New Hampshire Department of Health and Human Services' Injury Prevention Program has facilitated and led a statewide Falls Risk Reduction Task Force since 1999. The task force is

comprised of representatives from numerous organizations working with older adults in New Hampshire.

In 2004, the task force developed a statewide health communications campaign to increase older adults' awareness of falls, their risk factors and how to prevent them. The campaign was supported through a combination of funds from the Preventive Health and Health Services Block Grant, a capacity building grant from CDC's National Center for Injury Prevention and Control, and several partner organizations, including the National Safety Council. Development of the communications campaign included:

- The task force analyzed statewide falls surveillance data, including deaths, emergency department visits and hospitalizations.
- The task force facilitated 14 focus groups with persons ages 65 and older to assess their knowledge of falls and falls risk and to understand what media sources they typically use. In addition, individual question and answer sessions were conducted with 13 homebound older adults.
- A total of 149 people participated in the focus groups and interviews. Participants ranged in age from 60-94, and 70 percent were female.
- Several themes emerged from the qualitative data collection, including:
- Older adults are very concerned about falls, but know little about what they can do beyond environmental modifications to decrease their risk.
- Among females, peers are used as a sounding board for concerns about health, especially falls, but males often will talk to no one about their concerns other than their health care provider, and only if they feel comfortable.
- To reach older adults with prevention information, it is important to take an event to where they live or spend their day.

Based on these data, the task force developed a campaign called "You CAN Reduce Your Risk of Falling." Highlights included:

- Five messages about falls and their risk factors were developed in print and audiovisual formats to help move older adults from a point of fearing falls to taking preventive actions.
- Older adults were shown as support systems and sources of information in the messages.
- Messages were produced as posters and were distributed to 20 falls risk reduction teams in the state, as well as other groups working with older adults.
- and taped and sent to all senior citizen centers in the state and libraries.

### **PROGRAM RESULTS**

state, including 60 local weeklies.

- WMUR.
- Local cable access stations continue to run the messages.
- of New Hampshire older adults in their communities.

## IMPACT OF ADDITIONAL FUNDING

Despite the success of this program and others generated by the New Hampshire Falls Risk Reduction Task Force, one out of thee older adults falls each year, many with catastrophic consequences. Additional funding would enable the program to expand its work to reach additional older adults at risk of falls.

### New Hampshire Department of Health and Human Services **Injury Prevention Program**



 The task force collaborated with a senior acting troupe to produce and perform a play called "Help Me I'm Falling and I Can't Get Up" which incorporated focus group findings. The play was presented at venues across the state,

• The communication campaign messages were submitted to all newspapers in the

• The task force obtained a small grant to run the campaign messages in the statewide newspaper, The Union *Leader.* The messages also were picked up and produced as a public service by the statewide television station,

• The presentation of "Help Me I'm Falling ..." played to over 50 audiences around the state, reaching thousands

http://www.dhhs.state.nh.us/DHHS/MCH

6 Hazen Drive Concord, NH 03301-6527 (P) 603-271-4700 • (F) 603-271-4160

## NEW JERSEY Department of Health

ISSUE In 2002, homicide was the second leading cause of death and suicide was the fourth leading cause for New Jersey youth ages 15-24. The New Jersey homicide rate increased sharply in 2003 to 5.3 per 100,000 population, from 4.0 per 100,000 population in 2002, with the increase concentrated among black males ages 15-34 years. Suicide rates in New Jersey are highest among white males; male suicide victims outnumber female victims four to one.

### **PROGRAM OVERVIEW**

The New Jersey Department of Health and Senior Services' Office of Injury

Surveillance and Prevention received a five-year grant from CDC's National Center for Injury Prevention and Control to implement the New Jersey Violent Death Reporting System, a homicide and suicide surveillance system for the state.

- The new surveillance system collects data on all violent deaths homicides, suicides, unintentional firearm deaths, injury deaths of undetermined intent, and deaths by legal intervention – from a variety of sources. These sources include vital records, medical examiner reports, law enforcement reports, ballistic and crime lab reports, and Uniform Crime Reporting data.
- All violent deaths in New Jersey, and violent deaths of New Jersey residents occurring out-of-state, are included in the New Jersey Violent Death Reporting System beginning with January 2003 events.
- The New Jersey Violent Death Reporting System is an incident-based system that groups data on related deaths occurring within 24 hours together into one incident.

### **PROGRAM RESULTS**

example:

- is killed by an intimate partner.
- with the ultimate goal of reducing violent deaths.
- ment training curriculum to include guidelines on when and how to report suicides.

### **IMPACT OF ADDITIONAL FUNDING**

Funding for the New Jersey Violent Death Reporting System is in its fourth year of a five-year grant. Additional funding is needed to ensure that this essential surveillance system continues to provide a more comprehensive picture of violent incidents in New Jersey.



The New Jersey Violent Death Reporting System is a comprehensive dataset which enables thorough analysis and improved understanding of the circumstances surrounding violent deaths in the state. For

 Analysis of homicides has revealed that the major reasons for homicides in New Jersey are the commission of another crime (such as robbery), arguments and intimate partner violence. Additionally, female homicide victims are far more likely to know their assailant than are male victims. One out of every three female homicide victims

 For suicides, the New Jersey Violent Death Reporting System has shown that nearly one-third of New Jersey suicide victims in 2003 had a diagnosed mental illness at the time of their suicide, and about one-fifth of New Jersey suicide victims in 2003 were reported to have symptoms of depression at the time of their suicide. Information about the circumstances surrounding homicides and suicides in New Jersey generated from the New Jersey Violent Death Reporting System are used to educate public health professionals and policy makers.

• The new reporting system can be helpful to a variety of prevention partners. For example, analysis of suicide cases revealed that a large number of cases from 2003 were not being reported to the prosecutor's office by local departments. Consequently, one county prosecutor's office in New Jersey re-vamped its local law enforce-

### **New Jersey Department of Health Center for Health Statistics**

http://www.state.nj.us/health/chs P.O. Box 360 Trenton, NJ 08625-0360 (P) 609-984-6702 • (F) 609-984-7633

## NEW/MEXICO Department of Health

ISSUE While automobile crashes remain the leading cause of death and injury in New Mexico, the home is one of the leading locations for preventable injuries. A wide range of injuries that most often occur in and around the home are those from fires, burns, airway obstructions, drownings, firearms, falls, animal bites, and inhaled or ingested poisonings. New Mexico led the nation in unintentional injury death rates in 2002, with almost twice the rate of unintentional fall and unintentional firearm deaths, and almost three times the rate of unintentional poisoning deaths.

### PROGRAM OVERVIEW

The Office of Injury Prevention of the New Mexico Department of Health initi-

ated a comprehensive educational program for home day care providers in response to data analysis that identified the home as one of the most high risk environments for children. Home day care providers often have little safety training, and their homes typically are used by a number of family members for multiple purposes while child care is being provided.

To address this problem, the Office of Injury Prevention collaborated with the state's Children, Youth and Families Department from 2001-2003 to publish and distribute a health and safety curriculum for both home day cares and general residential environments. "Improving the Safety of Child Care Environments" is the first curriculum in the nation to address both traditional safety and indoor air quality hazards for residential environments. It also is the first such curriculum to list nontoxic and less toxic substitutes for common products used in the home and non-toxic protocols for eliminating pests. Development of the curriculum was funded by a Healthy Child Care America Grant initiative.

The Office of Injury Prevention was able to reach home day care providers through an existing training network established by the Children, Youth and Families Department that serves as a national model for home day care provider education. The department produces 17 annual educational conferences in the same communities each year, giving providers ready access to the mandatory six hours of annual education required by the state.

**PROGRAM RESULTS** During Fiscal Year 2003, about 50 instructors were trained to teach the health and safety curriculum. By the end of Fiscal Year 2004, 50 percent of the state's 8,000 home day care monitors and providers had taken an introductory workshop utilizing the new curriculum. The remaining 50 percent are expected to complete the course by the year 2007.

## **IMPACT OF ADDITIONAL FUNDING**

Because the home day care curriculum is applicable to all residential environments, the Office of Injury Prevention could use additional funding to partner with other state programs to provide the curriculum course to foster, adoptive, teenage, and at-risk parents, including recipients of Women, Infant and Children support. Social and health workers that provide home visits of any kind also could receive the training. Additional funds also are needed to:

- carbon monoxide detectors, baby-proof door locks, and electrical plug covers;
- settings and target populations.



• expand the program to include the distribution of safety equipment during the training, including smoke alarms,

conduct an epidemiological evaluation of this home safety program to determine its effectiveness in a number of

**New Mexico Department of Health Office of Injury Prevention** http://www.health.state.nm.us/injury.html 2500 Cerrillos Rd. Santa Fe, NM 87505 (P) 505-476-7858 • (F) 505-476-7810

# NEW/YORK State Department of Health

ISSUE From 1997-1999, New York State experienced a residential fire-related death rate of 1.2 deaths per 100,000 population. An average of 237 persons in the state were killed each year and an additional 1,012 were injured seriously enough to be hospitalized. Children ages 0-9 and adults ages 65 and older are most significantly affected by fire. Data from the state's Office of Fire Prevention and Control indicates that for fatal residential fires in 1998, a smoke alarm was present 34 percent of the time but was operational only 26 percent of the time.

## PROGRAM OVERVIEW

The New York State Department of Health's Bureau of Injury Prevention

combines funding from CDC's National Center for Injury Prevention and Control with funding from state fire agencies to conduct a statewide smoke alarm installation and fire safety education program.

- Each year, more than 2,300 requests for applications to participate in the program are sent to every paid and volunteer fire department in the state, every local health department, and a variety of injury prevention professionals. The Bureau of Injury Prevention uses these applications to select program sites with high rates of residential fire-related injury and death or a documented need for alarms.
- The Bureau of Injury Prevention coordinates distribution of long-life lithium battery smoke alarms to the participating communities and provides technical assistance on program implementation.
- Local fire departments and county health departments oversee local program activities, including enrolling households in the program, installing smoke alarms and conducting fire safety education. The program sites use local funds to conduct household and community education programs.
- Local program sites reach high-risk populations through community activities, local service agency networking. local media, schools, and other partnerships.
- The Bureau of Injury Prevention provides local program information to the New York State Risk Watch project, which offers supplemental resources or funds to communities to implement a school-based injury prevention curriculum that includes fire safety education.
- Bureau of Injury Prevention staff serve on state fire safety task forces. This participation allows the Bureau to increase awareness of the program's availability and enables the Bureau to be involved in statewide fire safety initiatives sponsored by other agencies.

### **PROGRAM RESULTS**

homes

- safety education provided by the program.
- The New York State Risk Watch Project currently operates in 50 school districts and 800 classrooms and has reached over 100,000 children with fire safety education.
- Through the statewide collaborations in which the Bureau of Injury Prevention participates, New York State has strengthened laws requiring fire and injury prevention education in schools and created a state-mandated fire and life safety curriculum for teachers completing bachelor and master level education programs.

## **IMPACT OF ADDITIONAL FUNDING**

Additional funding would enable the Bureau of Injury Prevention and its partners to save additional lives from residential fires by purchasing and installing more smoke alarms in high-risk homes and by providing support for the creation and implementation of the first statewide, multi-media, comprehensive fire safety education campaign.



• During 1998-2004, a total of 11 communities installed almost 14,400 alarms in 5,600

• At least 16 lives have been saved in large-scale house fires as a direct result of the alarms installed and fire

New York State Department of Health

**Bureau of Injury Prevention** 

http://www.health.state.ny.us/nysdoh/injury/main.htm

150 Broadway Riverview Center, 3rd Floor West Albany, NY 12204-0677 (P) 518-473-1143 • (F) 518-474-3067

## NORTH CAROLINA Division of Public Health

ISSUE Natural and man-made disasters are not new phenomenons, nor is the profound effect that such disasters have on the health of a population. Public health injury prevention programs can play an important role in preparing for, responding to and documenting the fatal and non-fatal injuries and diseases resulting from disasters.

### PROGRAM OVERVIEW The Injury and Violence Prevention Branch within the North Carolina Divi-

Branch within the North Carolina Divi-

sion of Public Health has collaborated with, and received funding from, the state Office of Public Health Preparedness and Response in order to develop disaster-related injury surveillance measures. This collaboration exemplifies how the involvement of a state health department's injury prevention program in disaster preparedness can enhance the state's level of preparedness and response. For example, the Injury and Violence Prevention Branch:

- contributes the injury surveillance mechanism to the 2004-2005 North Carolina Division of Public Health's state terrorism preparedness exercises (Operation Plotthound);
- provides technical expertise to the state's Public Health Preparedness and Response Team in the development of surveillance instruments and in the analysis and interpretation of injury-related data from natural disasters in planning exercises and real events:
- provides subject matter expertise on injury surveillance to the Public Health Regional Surveillance Teams during preparedness exercises and real event situations:
- serves as liaison to the University of North Carolina Injury Prevention Research Center to coordinate the center's participation in integrating injury surveillance systems into the Public Health Preparedness and Response surveillance systems: and.
- · contracts with the Injury Prevention Research Center for technical assistance in the development of standardized instruments assessing the functionality of state healthcare and rescue/recovery systems to provide disaster response services.

### **PROGRAM RESULTS**

been enhanced through this collaboration.

- slides, snow and ice storms, and chemical releases.
- who serve as first responders from public health in disaster situations.

All of these efforts help bring the issue of injury and injury prevention to the forefront of public health preparedness and response.

### IMPACT OF ADDITIONAL FUNDING

Additional funding would enable the Injury and Violence Prevention Branch to fully develop an injury surveillance system that is linkable to the North Carolina Bioterrorism and Emerging Infection Prevention System.



The capacity of North Carolina to respond to natural disasters and mass casualty events has

 The Injury and Violence Prevention Branch now has the means to assess injuries from any mass casualty event by utilizing the Public Health Regional Surveillance Teams to conduct surveillance at the scene, at the hospital, and in the community. This active surveillance measure reinforces electronic hospital surveillance data, and procurement of this data can help shape injury prevention and mitigation efforts by all agencies in future events. The Rapid Needs Assessment efforts in North Carolina are expanding to include hurricanes and flooding, land

Mechanisms are now in place to provide technical support to the Public Health Regional Surveillance Teams,

### North Carolina Division of Public Health

**Injury and Violence Prevention Branch** 

### http://www.communityhealth.dhhs.state.nc.us/injury.htm 1915 Mail Service Center Raleigh, NC 27699-1915

# NORTH DAKOTA Department of Health

ISSUE Although child safety restraints are known to save lives and reduce the severity of injury to child occupants in motor vehicle crashes, parents and caregivers often are not aware of the importance of children riding properly restrained in safety seats, nor do they know how to properly install these seats. Many parents cannot afford to purchase a seat.

### **PROGRAM OVERVIEW** The North Dakota Department of Health's Injury Prevention Program

manages several programs to improve child passenger safety. Funded by the North Dakota Department of Transportation, these programs focus on training individuals to assist parents in properly installing child safety seats, working with local communities to conduct child safety seat check events, providing child safety seats to families in financial need, and conducting public information and education campaigns. Recent program highlights include:

- During 2004, Injury Prevention Program staff conducted four trainings to certify 48 individuals as Child Passenger Safety Technicians who can assist parents in properly installing child safety seats. Two technicians also were certified as instructors through the training, which is based on a standardized National Highway Traffic Safety Administration curriculum.
- During 2004, program staff partnered with local communities to conduct 59 child safety seat checkup events statewide, inspecting 1,016 seats. About 85 percent of the inspected seats had at least one installation or usage error.
- The program purchased 1580 child safety seats and distributed them through 50 local public health agencies.
- The program developed an educational program promoting child safety restraint use for grades K-2. Materials were shipped to 74 agencies and the prevention messages reached 33,976 children.
- From 2002 to 2004, the program coordinated "Boost, Then Buckle," a public information and education campaign targeting parents and caregivers to increase booster seat use among children 40-80 pounds or under 4'9" tall.
- To measure the campaign's impact, the program worked with 160 kindergarten teachers to send a survey to 4,500 parents six months after the campaign's completion.

**PROGRAM RESULTS**  A statewide observational survey conducted in 10 communities with child safety seat checkup events and safety seat distribution indicated that among children ages 6-10, the child safety seat use rate increased from 70 percent in 2002 to 79 percent in 2004.

- "Boost, then Buckle" campaign.
- for children under age 7.

### **IMPACT OF ADDITIONAL FUNDING**

Additional funds would enable the Injury Prevention Program to train more technicians, provide child safety seats and booster seats to more families who cannot afford them, and educate North Dakota parents and caregivers about the new child safety seat law.



Fifty-five percent of parents or caregivers who completed the follow-up survey reported hearing about the

• In 2005, the state legislature improved North Dakota's child passenger safety law by requiring child restraint use

North Dakota Department of Health

**Injury Prevention Program** 

http://www.ndmch.com/injury-prevention/default.asp 600 East Boulevard Avenue Bismarck, ND 58505-0200 (P) 701-328-2493 • (F) 701-328-1412

# $\mathbf{OHO}$ Department of Health

ISSUE Injury is the leading cause of death in Ohio among persons ages 1-34, however there are few dedicated resources to address the problem of injury and violence at both state and local levels. Most local health departments in Ohio have little capacity beyond child passenger safety activities to develop programs to address injuries in their communities.

### PROGRAM OVERVIEW

The Ohio Department of Health's Injury Prevention Program is building local

injury and violence prevention capacity by offering competitive grants to local health departments to develop comprehensive, multi-faceted, population-based programs that address the risks associated with injuries and violence. To fund this effort, Injury Prevention Program staff helped establish injury as one of two priorities for local project funding through Ohio's Preventive Health and Health Services Block Grant. Highlights of the grant program include:

- The Injury Prevention Program implemented a request for proposal process to solicit requested grant applications from local agencies and organizations to develop injury or violence prevention programs.
- Grant applicants were asked to focus or one or two injury areas, work to develop a comprehensive, multi-faceted approach to preventing those injuries, and develop partnerships within the community.
- The Injury Prevention Program selected 15 local agencies to receive grants. Based on available funding and the quality of the applications, the agencies were funded for a four year funding cycle, depending on the availability of funds and adequate progress toward meeting their program goals. Grant amounts ranged from \$30,000 to \$35,000.
- Funded projects address a variety of injury and violence prevention topics, including traumatic brain injury (i.e., shaken baby syndrome, bicycle safety), residential fires, falls among older adults, agricultural injuries among youth, suicide, all terrain vehicle safety, and playground safety.

### **PROGRAM RESULTS**

injury or violence prevention began developing programs.

- Local projects are collecting injury data to evaluate the impact of their projects.
- resources beyond their local agencies.

## IMPACT OF ADDITIONAL FUNDING

While the grant program provides important seed money for building local injury and violence prevention capacity, the breadth and impact of the projects are limited by the relatively small amount of available grant funding. Additional funds would enable the local agencies to build further capacity, such as funding full time staff dedicated to injury and violence prevention activities.

Likewise, the number of agencies that the Injury Prevention Program can fund is limited by the resources available. The Preventive Health and Health Services Block Grant supports programs in only 15 of Ohio's 88 counties. Additional funds would enable the Injury Prevention Program to fund additional programs and expand statewide.



 Local health departments which previously did not have any programming in place for

Funded agencies are collaborating with other prevention partners in their communities to develop coalitions and

### **Ohio Department of Health**

**Injury Prevention Section** 

http://www.odh.state.oh.us/ 246 N. High Street Columbus, OH 43216 (P) 614-644-8048 • (F) 614-644-7740

# OKLAHOMA State Department of Health

ISSUE A total of 184 children ages 0-9 died as a result of motor vehicle crashes in Oklahoma during 1992-2001; 105 of these deaths were among children ages 0-4. Over 80 percent of children under age 6 who die in a motor vehicle crash are not in a child safety seat, yet these seats are at least 67 percent effective in preventing serious injury or death. Lack of access to affordable child safety seats results in far lower use of these life-saving seats by Medicaid recipients than other children. Only 25 percent of children ages 0-4 who are covered by Medicaid are transported in child safety seats when riding in a motor vehicle.

### **PROGRAM OVERVIEW**

The Oklahoma State Department of Health's Injury Prevention Service, with

funding from the Oklahoma Highway Safety Office, has administered the Oklahoma Child Passenger Safety Advantage Program since March 2001. The Injury Prevention Service works with county health departments to distribute child safety seats to families and caregivers in need and provide training and education on proper seat installation. The Injury Prevention Service:

- purchases child safety seats and supplies for the distribution program;
- distributes 3,000 child safety seats each year through 68 county health departments to families eligible for or enrolled in any Women. Infants and Children Program: and.
- conducts training classes for county health department and Indian Health Service personnel in proper child passenger safety seat installation techniques and usage.

In December 2002, the Injury Prevention Service began a collaborative project with state law enforcement and a county health department to enforce Oklahoma's child passenger safety law, while also addressing the financial barrier families may face in purchasing a child safety seat for their children. The Injury Prevention Service worked with the Oklahoma Highway Safety Office, the Pittsburg County Health Department and the Oklahoma Highway Patrol Troop D to give a certificate to persons in violation of the child passenger safety law. The certificate could be redeemed for an appropriate child safety seat at the Pittsburg County Health Department or a local highway patrol office. The Injury Prevention Service also provided child safety seat installation training to highway patrol officers and county health department staff who participated in the project.

### **PROGRAM RESULTS** • More than 20,000 child safety seats have been distributed to county health department

clients in Oklahoma since 1999.

- Child safety seat use in Oklahoma has increased from 66 percent in 2001 to 83 percent in 2005.
- installation.

### **IMPACT OF ADDITIONAL FUNDING**

Many children continue to be transported unprotected because their families cannot afford child safety seats. Additional funding for the Injury Prevention Service would ensure that more seats are distributed statewide, and ultimately, more lives and health care dollars would be saved.



Approximately 150 county health department and tribal staff have been trained in child passenger safety seat

**Oklahoma State Department of Health Injury Prevention Service** 

http://www.health.state.ok.us/program/injury/ 1000 NE Tenth Street Oklahoma City, OK 73117-1299 (P) 405-271-3430 • (F) 405-271-2799

# OREGON **Department of Human Services**

ISSUE Although injuries are a significant cause of death in the U.S. as a whole and in each state, the number of people who are injured and survive is far greater than those who die from injury. One source of information on these nonfatal events is hospital discharge uniform billing data found in patients' medical records. Hospital discharge data can be a rich source of information about the physical and financial costs of nonfatal injuries to individuals and society.

Hospital discharge data include codes for the injury or injuries treated and codes for the cause of injury (known as e-codes, or external cause of injury codes). For example, if a person was injured by a fall, e-codes would specify the type of fall involved, such as fall from steps or stairs, a ladder, a building, a cliff, or furniture. These codes are needed to analyze injuries by the mechanism (or cause) of injury and then further analyze the data by key characteristics such as age, gender, place, and time.

However, Oregon – like many other states – faces challenges in gathering guality hospital discharge data on nonfatal injuries. In Oregon, the coding of hospital discharge data for injury cases omits external cause of injury codes in 40 percent of cases. Legislative efforts to mandate e-coding have failed due to lack of consensus that a mandate would in and of itself increase coding. The low rates of e-coding limit the usefulness of hospitalization data in determining nonfatal injury problems, identifying high risk populations, and determining risk and protective factors that could be used to develop appropriate community based prevention programs.

### **PROGRAM OVERVIEW** The Injury Prevention and Epidemiology Section of the Oregon Department

of Human Services maintains an injury data information system from primary and secondary sources of injury data. including hospital discharge data. These data are used to determine the magnitude of fatal and non-fatal injuries in Oregon, monitor trends, identify priority areas, complete data requests, and guide program development and policy initiatives.

To improve the reliability and quality of the state's hospital discharge data on non-fatal injuries, the Injury Prevention and Epidemiology Section partnered with the state's hospital association and record coders. The section's injury epidemiologist provided training to records coders at the hospital association's annual meetings and worked with the hospital association and coders to improve the net case coding on injury hospitalizations.

**PROGRAM RESULTS** The percentage of injury hospitalization cases that included an external cause of injury code increased to 81 percent in 2003 – a solid improvement over the previous rate of about 60 percent. This improvement will make hospital discharge data a reliable injury data source that can be analyzed for program development, program evaluation and policy development.

### **IMPACT OF ADDITIONAL FUNDING**

Additional funding to the Injury Prevention and Epidemiology Section could provide support to develop and evaluate curricula on hospital discharge data coding and provide ongoing support for the implementation of coding training.



**Oregon Department of Human Services Injury Prevention and Epidemiology Section** 

> http://oregon.gov/DHS/ph/ipe/ 800 NE Oregon Street, Suite 772 Portland, OR 97232 (P) 971-673-1059 • (F) 503-731-4157

# PENNSYLVANIA Department of Health

ISSUE The Pennsylvania Youth Survey of public school students in the sixth, eighth, tenth, and twelfth grades is conducted every two years by the Pennsylvania Commission on Crime and Delinguency. In the 2003 survey, more than 10 percent of students in the eighth, tenth and twelfth grades reported having attacked someone with the intent of seriously hurting them. Among eighth and tenth graders, 31 percent and 27 percent, respectively, reported having been threatened to be hit or beaten up on school property.

## PROGRAM OVERVIEW

The Pennsylvania Department of Health's Injury Prevention Program uti-

lizes the Preventive Health and Health Services Block Grant to develop youth violence prevention programs. The Injury Prevention Program developed and implemented a mini-grant program through SAFE KIDS Pennsylvania that was made available to school and community partnerships to improve school safety and prevent youth violence. Highlights of the program include:

- The program was based on a toolkit from the *Be Safe and Sound* program, an initiative of the National Crime Prevention Council that seeks to mobilize parents, policymakers, school officials, and students to take action to prevent violence in schools by enhancing school safety and security. It provides concrete measures that parents, community members, and educators can take to make schools safer and more secure.
- In 2003-2004, eight mini-grants of \$5,000 each were awarded to school and community partnerships.
- A one-day training was held for grantees on how to best implement the Be Safe & Sound toolkit.
- Topics commonly addressed by grantees include bullying, improving school security, and developing crisis response procedures.

### **PROGRAM RESULTS**

from grantee activities include:

- creation of a resource library for parents dealing with bullying issues;
- assemblies for students and seminars for parents to raise awareness about youth violence and school safety and to provide resources for students and parents to address this violence;
- staff training on youth violence prevention and school safety improvement; and
- coordination of a local Peace Week with participation from 14 organizations and agencies.

### IMPACT OF ADDITIONAL FUNDING

Limited funding for this program allowed for only eight school and community partnerships to receive mini-grants. There are over 5,700 public, private and non-public schools in Pennsylvania. Additional funding for the Injury Prevention Program would enable continuation of the mini-grant program to more school and community partnerships each year.



Feedback from grantees has been very positive. particularly because the flexibility of grant requirements allows grantees to meet the specific needs identified by the school and community partnerships. Results

### **Pennsylvania Department of Health**

**Injury Prevention Program** 

http://www.dsf.health.state.pa.us/ Health & Welfare Building, Room 1008 Harrisburg, PA 17120 (P) 717-787-5900 • (F) 717-783-5498

## RHODE ISLAND Department of Health

ISSUE In 2002, motor vehicle crashes were the leading cause of death for Rhode Islanders under age 25. Eight percent of deaths due to motor vehicle-related injury in this age group involve collisions between pedestrians or bicyclists and moving vehicles. Many more bicyclists and pedestrians are hospitalized each year in Rhode Island due to collisions with motor vehicles.

### PROGRAM OVERVIEW The Rhode Island Department of Health's Safe Rhode Island Injury and Violence Prevention Program (Safe Rhode Island) has taken a collaborative approach to address the problem of

motor vehicle-related injury to pedestrians and bicyclists. Safe Rhode Island used a capacity-building grant from CDC's National Center for Injury Prevention and Control to leverage resources from the Rhode Island Department of Transportation and establish the Rhode Island Department of Health's Bicycle and Pedestrian Safety Collaborative. The 45-member collaborative is a diverse group of public and private organizations. The colaborative's activities include:

- sustaining a Safe Routes to School program;
- organizing an initiative in Woonsocket that promotes and rewards employees who walk during the work day;
- expanding a successful Bike to Work Day program from Providence to other communities; and
- coordinating bicycle helmet promotion activities with local police forces who give away t-shirts to reward youth who wear helmets.

The collaborative reflects the Rhode Island Department of Health's interest in integrating program activities within its agency and with external programs and agencies relevant to public health. For example:

- By partnering with the state's Initiative for a Healthy Weight, the collaborative took a leadership role in promoting existing bicycle and pedestrian programs.
- A partnership with the Department of Transportation leveraged funds from the state's federal highway allotment. This effort enhanced collaborative relationships among existing bicycle and pedestrian partners and brought in non-traditional partners.

### PROGRAM RESULTS

- of local walking routes:
- active transportation (such as walking); and
- bicycle and pedestrian safety materials.

### **IMPACT OF ADDITIONAL FUNDING**

With additional funding, the Rhode Island Department of Health's Bicycle and Pedestrian Safety Collaborative and the Initiative for a Healthy Weight programs could:

- recreation as a viable option for commuting;
- more communities;
- changes; and
- increase Walk at Work policies at selected worksites.



Highlights of the Bicycle and Pedestrian Safety Collaborative's accomplishments include: • working with the Rhode Island Department of Transportation's Intermodal Planning Division to develop the national Safe Routes to School program, which lead to more children walking to school and increased the safety

increasing safe active transportation for adults through Bike to Work and other community programs to promote

protecting children riding bicycles from head injury through the distribution of 500 helmets and 5000 copies of

• partner with the Worksite Wellness Council of Rhode Island, local businesses and the Rhode Island Public Transit Authority to increase the focus on adult bicycle and pedestrian activity by promoting active transportation and

bring additional attention to children's pedestrian needs by implementing Safe Routes to School programs in

conduct walkability studies around schools and worksites (including digital photographs) to document needed

### **Rhode Island Department of Health**

Safe Rhode Island

http://www.health.ri.gov/disease/saferi/index.php Cannon Building, Room 408 3 Capitol Hill Providence, RI 02906 (P) 401-222-7627 • (F) 401-222-4415

## SOUTH CAROLINA Department of Health and Environmental Control

ISSUE South Carolina ranks tenth in the nation in fire fatalities, and its fire fatality rate is almost double that of U.S. rate. In South Carolina during 1998-2003, there were 693 fire-related injuries among persons ages 65 and older and 735 such injuries among persons ages 17 and under.

## PROGRAM OVERVIEW In 1998, the South Carolina Department of Health and Environmental Control's

of Health and Environmental Control's

Division of Injury and Violence Prevention created the South Carolina Residential Fire Injury Prevention Program. This effort aims to reduce residential fire-related injury and death in rural, low income areas of the state with high-risk populations such as young children and older adults. The program is supported by CDC's National Center for Injury Prevention and Control and focuses on providing smoke alarm installation and fire safety education to these highrisk groups. Highlights of the program during 1998-2004 include:

- Division of Injury and Violence Prevention staff provides overall project management, offers technical assistance to local project sites and coordinates the purchase and distribution of long-life lithium battery smoke alarms to local project sites around the state.
- The program is coordinated locally by staff from county health departments in the state health districts that are participating in the program. The local coordinators provide fire safety education and coordinate referrals from organizations such as Newborn Home Health Program and the local Councils on Aging to identify homes in need of smoke alarm inspection and installation.
- Local health departments work with local fire departments to canvass neighborhoods and areas with high-risk homes, and to inspect existing alarms and install lithium battery smoke alarms.
- Smoke alarms designed for the hearing impaired are provided when needed.
- Most fire safety education materials are provided in Spanish as well as English in order to reach the growing Hispanic population in the state.
- Promotion of the program is provided locally through newspapers and flyers and statewide through radio and television public service announcements that are distributed by the South Carolina SAFE KIDS Coalition.
- The South Carolina State Fire Marshal's Office has printed fire safety materials and provided the Freddie the Fireless Feline fire safety curriculum for children and an accompanying costume to promote the program and fire safety awareness.

### **PROGRAM RESULTS**

- incidence data, smoke alarm installation data and hospital discharge data;
- installed 6.969 smoke alarms in 5.366 homes that participated in the program;
- reached 904,800 residents weekly through statewide public fire safety announcements;
- canvassed 20,545 homes; and
- reached high-risk populations in 20 counties and four state health districts.

### **IMPACT OF ADDITIONAL FUNDING**

Additional funding would enable the Division of Injury and Violence Prevention to provide smoke alarms in some of the more rural and remote areas of the state that continue to have high fire injury and death rates.

> South Carolina Department of Health and Environmental Control **Division of Injury and Violence Prevention** http://www.scdhec.net/health/chcdp/iniurv/



During project years 1998-2004, the South Carolina Residential Fire Injury Prevention Program has: saved 42 lives, identified through telephone follow-up surveys with residents and yearly data linkage among fire

2600 Bull Street Columbia, SC 29201 (P) 803-898-0314 • (F) 803-253-4001

# SOUTH DAKOTA Department of Health

ISSUE In South Dakota, unintentional injuries are the leading cause of death among children ages 0-14. Deaths from motor vehicle crashes increased 38 percent among South Dakota children ages 14 and younger during 1999-2003. Drugs and alcohol among vehicle drivers were found to be a major contributing factor, along with non-use and misuse of restraint systems such as child safety seats.

Eighty percent of people who die in motor vehicle crashes in South Dakota are not secured in a seat belt or child safety seat. South Dakota Traffic Accident Summary data indicate that of the 54 children ages 0-14 who were killed in traffic crashes during 1999-2003, only 13 were restrained. The state's 2004 seat belt observation survey documented that 72 percent of children under age 5 were in a safety restraint.

South Dakota Department of Transportation crash statistics reveal 105 bicycle-related injuries and one fatality in the state in 2001. Head injury is the leading cause of death in bicycle crashes and a major cause of permanent disability. Wearing a properly fitted bicycle helmet can reduce the risk of serious head and brain injury by as much as 88 percent.

PROGRAM OVERVIEW

The South Dakota Department of Health's Office of Family Health in-

cludes injury prevention in its child and adolescent health programs and services. In 2005, the Department of Health collaborated with the Department of Public Safety's Office of Highway Safety and other local, state, federal, and tribal agencies to develop a statewide strategic plan. The plan intends to guide the development and implementation of traffic safety policies to reduce motor vehicle crashes, fatalities and injuries. Occupant protection has been identified as a priority for the plan.

**PROGRAM RESULTS** The South Dakota Department of Health is one of several state, local and tribal agencies collaborating with the state Office of Highway Safety to address motor vehicle-related deaths and injuries. Projects include:

- Department of Human Services to conduct an annual statewide youth safety conference.
- Department of Health, the Office of Highway Safety and Emergency Medical Services for Children.
- their vehicles.

### **IMPACT OF ADDITIONAL FUNDING**

Additional funding would enable the Department of Health to expand its involvement in injury prevention programs and partnerships with other state, local and tribal agencies.



• The Department of Health partners with the Office of Highway Safety, Department of Social Services and

• Since 1994, *Don't Thump Your Melon* has actively promoted bicycle helmet use by providing educational materials to promote helmet and bicycle safety in South Dakota communities. Program partners include the

 The Office of Highway Safety works with numerous state and local agencies, including local health departments. to implement the Governor's Child Safety Seat Distribution Program. During 2003, the program distributed over 5,600 child safety seats and provided instruction to parents on the proper installation of child safety seats in

### South Dakota Department of Health

**Office of Family Health** 

http://www.state.sd.us/doh/Famhlth/programs.htm 615 East 4th St. Pierre, SD 57501-1700 (P) 605-773-4129 • (F) 605-773-5942

# TENNESSEE Department of Health

ISSUE Motor vehicle crashes are the leading cause of death for children under age 14 in Tennessee and nationally. In Tennessee, 62 children ages 14 and under died in motor vehicle crashes in 2002. Motor vehicle crashes resulted in an economic cost of \$4.6 billion to the state in 2004. According to the National Highway Traffic Safety Administration, child safety seats -- when correctly installed and used -- reduce the risk of death by 70 percent for infants and 47-54 percent for toddlers. Increased use of child safety seats resulting from state laws requiring their use have led to a median decrease in fatal injuries of 35 percent.

violators of this law is distributed to the Tennessee Department of Health for the purchase of child safety seats for

### PROGRAM OVERVIEW

low income families.

Tennessee state law requires children to be restrained in a proper safety restraint system based upon age, weight and height, when riding in a passenger vehicle. Money collected by fining

**PROGRAM RESULTS** The Tennessee Department of Health's Injury Prevention Program leads a statewide network which supports and coordinates statewide child passenger safety activities. Through distribution and education programs, approved child restraint systems are provided to parents at no cost. All programs include educational and instructional components. The programs target parents and caregivers needing assistance in acquiring a child safety seat due to financial hardship or limited understanding on the importance of using child restraint systems.

### **IMPACT OF ADDITIONAL FUNDING**

Promoting child safety seat use and motor vehicle safety at the community level remains an ongoing need. Community-based injury prevention programs can play an important role in motivating and mobilizing prevention efforts at the local level. Such efforts can:

- facilitate collaboration among community groups;
- target the unique educational needs of a community;
- promote the development, strengthening and enforcement of child safety seat laws;
- teach and reinforce the proper use of child safety seats; and
- provide child safety seats for no or low cost to families in need.

Additional funding would enable the Injury Prevention Program to expand the state infrastructure required to effectively conduct this and other injury prevention programs.



### **Tennessee Department of Health**

**Injury Prevention Program** 

http://www2.state.tn.us/health/healthpromotion/index.html Cordell Hull Building, 6th Floor 425 5th Avenue North Nashville, TN 37247-5210 (P) 615-741-0380 • (F) 615-532-8478

## EXAS **Department of State Health Services**

ISSUE Motor vehicle injuries are the leading cause of injury to Texas children ages one and older. Child restraint checkup events to inspect child safety seat installation routinely discover that four out of five children are not properly restrained in appropriate child safety seats or belt systems. Low-income families often cannot afford to purchase needed child restraints.

## **PROGRAM OVERVIEW**

The Texas Department of State Health Services' Safe Riders Program, spon-

sored by a grant from the Texas Department of Transportation, conducts an ongoing statewide child passenger safety program to reduce the number of injuries and deaths among children due to motor vehicle crashes by: increasing the knowledge and importance of child passenger safety among parents and caregivers;

- increasing the number of child restraints that are used correctly; and
- providing child restraints and education to low-income families.

The Safe Riders program, which began in 1985, addresses the above goals through the following activities:

- provides new child restraints and education to low-income families:
- designates and trains a variety of local community groups, who in turn offer community classes in which parents or caregivers can receive new child restraints;
- conducts the four-day National Highway Traffic Safety Administration's standardized Child Passenger Safety Technician workshops, which certify persons to demonstrate safe and proper child restraint installation and best practices to parents and caregivers;
- conducts child passenger restraint checkup events and local "fitting stations," both of which provide parents or caregivers the opportunity to have their children's restraints and installations checked by certified technicians;
- produces and distributes child passenger safety educational materials; and
- provides a toll-free information line and website with child passenger safety information.

### **PROGRAM RESULTS** In 2004, Safe Riders: • established 94 local community programs as

distribution program partners in Texas;

- instruction on how to implement Safe Riders distribution programs in their communities:
- via education classes that focused on the importance of occupant protection;
- certified 75 new technicians to work with families to improve correct usage of child safety seats;

- checked by certified technicians;
- conducted 68 community awareness presentations to parents and children's groups;
- passenger safety information; and,

Safe Riders has played a role in the state's improved restraint use rates. Texas Transportation Institute studies show that restraint use for children under age 5 increased from 61 percent in 1994 to 76 percent in 2004. It also is well documented that child passenger safety efforts have a corresponding positive effect on adult restraint use. The institute's study of 18 Texas cities shows that restraint use for front seat occupants increased from 69 percent in 1993 to 87 percent in 2003.

### **IMPACT OF ADDITIONAL FUNDING**

Consistent federal highway funds passed through the State of Texas have enabled Safe Riders to contribute to positive occupant protection results as indicated above, but much progress still needs to be made. More funding would enable the program to purchase additional child restraints for low-income families. In Texas during 2003, nearly 185,000 babies were born to families covered by Medicaid, but Safe Riders is only able to purchase between 15,000 and 20,000 child safety seats each year. There is a gap between the need for child safety seats and the program's ability to meet this need.



conducted 20 training sessions to provide these programs with basic child passenger safety information and

• collaborated with these community programs to distribute over 18,000 child restraints to low-income families

determined the need for and subsequently conducted six Child Passenger Safety Technician workshops that

assisted with and monitored four technician workshops that were conducted by other groups;

taught four one-day SAFE KIDS Child Passenger Safety update classes for existing technicians and instructors;

conducted 19 fitting stations and participated in 32 checkup events in which child safety seat installations were

• provided over a half a million pieces of child passenger safety educational literature and videos to the public; assisted over 10.000 callers who accessed the program's toll-free information line and website with child

 provided leadership in child passenger safety through coordination of a Child Passenger Safety Advisory Committee, the Texas SAFE KIDS Coalition and assisting with statewide child passenger safety news conferences.

### **Texas Department of State Health Services** Safe Riders

http://www.dshs.state.tx.us/saferiders 1100 W. 49th Street Austin, TX 78756 (P) 800-252-8255 • (F) 512-458-7555

## U AL Department of Health

ISSUE In Utah, injury is the leading cause of years of potential life lost, the leading cause of death for ages 1-44, and the third leading cause of death for all ages. In an average year in Utah, 1,200 residents die, 9,800 will be hospitalized, and 192,700 will be treated in the emergency department; \$249 million will be spent on hospital and emergency department charges for treatment of injuries.

## PROGRAM OVERVIEW

The Utah Department of Health's Violence and Injury Prevention Program

uses funding from a program capacity-building grant from CDC's National Center for Injury Prevention and Control to collaborate with other injury prevention organizations throughout the state. Activities include disseminating data publications that help guide state and local injury and violence prevention planning, and developing a data-driven State Injury Strategic Plan. These efforts included:

- analyzing existing data to better define the magnitude of the injury problem in Utah and to further identify populations at risk and the causes of injury;
- developing a comprehensive injury report for each local health department that can be used to make data-driven decisions for local injury and violence prevention efforts;
- covering essential topics in these reports, including leading causes of death, leading causes of injury, injury hospitalizations, injury emergency department visits, fatal injuries, injury costs, and specific injury mechanisms such as motor vehicle crashes, motor vehicle-related pedestrian injuries, motor vehicle-related bicycle injuries, homicide, and suicide;
- setting priorities for the state's Violence and Injury Prevention Program:
- coordinating an Injury Advisory Council to help in this priority-setting; and
- developing a Year 2010 Injury Strategic Plan based on collaboration and input from a wide variety of agencies throughout Utah.

**PROGRAM RESULTS** Local health departments have used the localized injury reports produced and disseminated by the Violence and Injury Prevention Program to identify program priorities, evaluate activities, prepare educational materials, and work with the media. The data, programmatic and policy efforts of the Violence and Injury Prevention Program have contributed to – in combination with the work of other injury and violence prevention partners in Utah -a decrease in the state's death and hospitalization rates.

- 100,000 population in 2004.
- in 2001 to 7,382 per 100,000 population in 2003.

## **IMPACT OF ADDITIONAL FUNDING**

- Additional funding for the state's Injury and Violence Prevention Program would result in the following: • The Injury Strategic Plan could be more fully implemented.
- Planning, implementation and evaluation of injury prevention programs could be expanded to meet state and local needs and to cover a wider variety of topic areas.
- Better data could be collected and a more in-depth analysis of the data could be conducted.
- More reports on the burden and impact of injury and violence in Utah could be printed and disseminated to diverse audiences.



• The unintentional injury death rate in Utah decreased from 29.5 per 100,000 population in 2002 to 27.8 per

• The unintentional injury emergency department visit rate in Utah decreased from 8,276 per 100,000 population

### **Utah Department of Health**

Violence and Injury Prevention Program

http://www.health.utah.gov/vipp/ P.O. Box 142106 Salt Lake City, UT 84114-2106 (P) 801-538-6864 • (F) 801-538-9134

# VERMONT Department of Health

ISSUE In the U.S. every year, one of every three adults ages 65 and older suffers a fall. Vermont data from 1996-2001 show falls as the leading cause of injury hospitalization. Among older Vermonters, many of these falls end as fatalities, as the hip fractures or head traumas suffered during a fall can reduce mobility and independence and increase the risk of premature death. From 1998-2001, the cost for falls totaled \$45 million in hospital charges in Vermont.

Falls among older adults can be reduced through a combination of strategies, including increasing lower body strength and improving balance through regular physical activity, talking with a physician or pharmacist to review all medicines to reduce side effects and interactions, and reducing home hazards to make the living areas safe.

### PROGRAM OVERVIEW

The Vermont Department of Health's Injury Prevention Program used funds

from a program capacity building grant from CDC's National Center for Injury Prevention and Control to develop an elderly falls prevention program. The prevention program began implementation in September 2003.

- The Injury Prevention Program developed a community implementation guide on preventing falls among older adults. The guide included educational materials that addressed vision, hearing, medications, alcohol, nutrition, gait and balance, physical activity, and home hazards. The guide also included training material for health care providers, home care providers and caregivers about fall prevention among older adults.
- The program conducted statewide training on fall prevention among older adults and offered train-the-trainer sessions for providers on program materials.
- The program made community implementation grants available to local sites participating in the statewide training. Grant recipients used the funding to conduct local falls prevention training and conduct home visits to reach older adults with key prevention messages and materials from the program's community guide.

**PROGRAM RESULTS** • The Injury Prevention Program awarded two community implementation grants. Both communities have sustained their projects beyond the grant funding period.

• Both communities also reported that the physical fitness programs they implemented have shown measurable improvements in strength, flexibility and balance among the older adults who participated in the program.

## **IMPACT OF ADDITIONAL FUNDING**

Despite the success of these community programs, falls remain the leading cause of injury hospitalizations in Vermont. Additional funding for the Injury Prevention Program would enable it to continue existing efforts and expand additional prevention programs into all counties in the state to prevent injuries, save lives and reduce health care costs.



**Vermont Department of Health Injury Prevention Program** http://www.healthvvermonters.info PO Box 70 **108 Cherry Street** Burlington, VT 05402 (P) 802-651-1978 • (F) 802-651-1634

# VIRGINIA Department of Health

ISSUE Injury hospitalization and death data are analyzed annually in Virginia by the state injury prevention program. However, until recently, no system existed enabling Virginians to directly assess these data for their locality.

## PROGRAM OVERVIEW

The Virginia Department of Health's Center for Injury and Violence Preven-

tion developed the Virginia Online Injury Reporting System to provide quick and easy access to basic injury and violence data. The system was developed with support from the Preventive Health and Health Services Block Grant and the Maternal and Child Health Block Grant. It can be accessed at http://www.vahealth.org/CIVP/VOIRS/.

County and city level data are essential to enable state and local health departments to understand and respond to the impact of injury and violence in their communities. Programs require accurate, consistent data to understand local trends, assess injury and violence prevention needs at the community level, select proven or promising prevention programs, and measure program impact.

The online system enables the user to create customized data reports about various causes and intents of injury or violence, and to examine those causes by key variables, such as place of residence and age. Both death data and hospitalization data are available. The online system allows the user to customize a report by choosing among the following variables:

- 17 causes of death or hospitalization;
- place of residence, including county, city, public health district, or health planning district; and
- gender, race, and age groups.

The online system also calculates injury death rates and hospitalization rates in Virginia. These rates are useful for measuring the occurrence of an injury or violence-related event or condition within a specific population for a specific period of time, as well as for comparing the prevalence of these events or conditions across populations and time periods. The first year of data available through the online system is for 2002.

**PROGRAM RESULTS** Local health departments, agencies, organizations, and interested individuals in Virginia can access and query statewide injury and violence data via the web that is specific to their city, county or region and to the demographics or other variables of interest. These data are essential for injury and violence prevention planning, priority setting and program monitoring.

### **IMPACT OF ADDITIONAL FUNDING**

Additional funding would enable the Center for Injury and Violence Prevention to enhance the online system, widely promote it to potential users, train agencies and individuals on its use, and add mapping and charting functions to make the system more user friendly. To improve the quality of injury death and hospitalization data that are available to the Virginia Department of Health and the Center for Injury and Violence Prevention, center staff would use additional funding to provide training on how to accurately code injury and violence-related medical records and accurately submit these data.



**Virginia Department of Health Center for Injury and Violence Prevention** 

> http://www.vahealth.org/civp/ 8th Floor, 109 Governor Street Richmond, VA 23219-2448 (P) 804-864-7733 • (F) 804-864-7748

## WASHINGTON D.C. Department of Health

ISSUE Violence in the District of Columbia takes a toll on youth in the city. In 2004, there were 23 homicide victims ages 15-24, and 12 of these victims were ages 15-17. As in previous years, the majority of these homicide victims are African American males.

## **PROGRAM OVERVIEW**

The District of Columbia Department of Health's Division of Injury and Disability

Epidemiology partnered with 11 government and community-based agencies and District youth ages 12-21 to plan and develop a multi-stage youth summit and training during 2004. Titled "My World, My Views, My Solutions," the three separate summits were based on a public health perspective of youth injury and violence prevention in the District. Funding for the summit was provided by the Howard University DC Baltimore Research Center on Child Health Disparities. Specifically:

- Youth participated in the summit's recruitment of participants, session planning and facilitation of discussions.
- During the first two summits, youth identified specific causes of youth violence, including jealousy, media influence, drug and substance abuse, rumors, invasion of personal space, racism, and aggressive behaviors.
- The youth participants also drafted strategies to prevent violence in their communities, including walking away from a situation and encouraging individuals to serve as community advocates.
- The third summit culminated with a question and answer session between the youth and District Mayor Anthony Williams.

To build upon the momentum of the three-part summit, the Division of Injury and Disability Epidemiology hosted three two-day youth retreats designed to further youth input into violence prevention in the District. The prevention strategies recommended by the more than 100 youth who participated in the summits were used to plan the three retreats.

- . The two-day experience provided youth participants an opportunity to discuss the ramifications of violence and how to navigate through and around situations in which violence is a possibility.
- Community and faith-based organizations that work with these youth on a regular basis participated in these discussions and other activities for the youth.
- The youth received mentoring in communication, leadership and advocacy.
- Following the retreat, participants developed public service announcements in audio, poster and T-shirt formats, created a mural located in the court yard of a dance studio, and developed a web page (www.rightmindsthink. org).

### **PROGRAM RESULTS**

 The Division of Injury and Disability Epidemiology continues to work with the agencies that collaborated on the summits and retreats in order to develop and implement the recommendations that emerged from these events.

- An executive summary was developed and disseminated to the Mayor and collaborating partners.
- campaign on youth violence prevention.
- now working more closely with the Division of Injury and Disability Epidemiology.

## **IMPACT OF ADDITIONAL FUNDING**

Additional funding would allow the Division of Injury and Disability Epidemiology to continue to work with collaborating agencies to more effectively implement the recommendations from the summits and retreats.



Recommendations and communication products from the retreats are being used to develop a year-long media

 Prior to the 2004 summits, Mayor Williams had established a District of Columbia Youth Council, which he consulted regarding youth issues and concerns in the District. As a result of the summits, the youth council is

> **District of Columbia Department of Health** Division of Injury and Disability Epidemiology

> > http://doh.dc.gov/doh/site/default.asp 825 North Capitol St., NE, 3rd floor Washington, DC 20002 (P) 202-442-9147 • (F) 202-442-4796

## WASHINGTON State Department of Health

ISSUE In the state of Washington and throughout the nation, injuries are the leading cause of death for children ages 1-17. During 1999-2001, a total of 654 children ages 0-17 died from injuries in Washington and 10,317 more were hospitalized.

## PROGRAM OVERVIEW

The Washington State Department of Health's Injury and Violence Prevention

Program used a program capacity-building grant from CDC's National Center for Injury Prevention and Control to develop a comprehensive report on childhood injury. The report details the leading causes of injuries among Washington's children and the best or promising practices for preventing these injuries. Highlights of the report's development include:

- A workgroup consisting of injury and violence prevention partners, both internal and external to Department of Health, convened to discuss the purpose, objectives, target audiences, and content of the report.
- Drafts of the initial chapters were sent to internal and external partners to ensure that the contents would be useful to injury prevention partners statewide. Each "cause of injury" chapter contained Washington-specific data including death and hospitalization rates by age and gender, time trend analysis on the death data with a comparison to national data, and cause of death information from Child Death Reviews.
- Each chapter of the report was reviewed by Injury and Violence Prevention Program staff, content experts throughout the state, the state's Children's Safety Network representative, and partners at the Harborview Injury and Prevention Research Center. Input was sought on promising and effective prevention strategies and programs for each cause and mechanism of injury highlighted in the report. The recommended prevention strategies were based on research, literature review and applied best practices.
- Chapters of the report also were sent to members of the target audience to provide feedback on how to make the report a useful addition to their current resources that they would use.

### **PROGRAM RESULTS** • 1,500 copies of the Washington Childhood *Injury Report* were distributed to injury

prevention professionals throughout the state.

• The report was made available on the Injury and Violence Prevention Program website. • A press release announced the release of the report to all major media outlets.

### IMPACT OF ADDITIONAL FUNDING

With additional funding, the Injury and Violence Prevention Program could conduct trainings for injury and violence prevention professionals in the state based on the prevention strategies listed in the report. By implementing the report's recommendations in homes, schools, and communities across the state, Washington can be a safer place for children.



Washington State Department of Health **Injury and Violence Prevention Program** 

http://www.doh.wa.gov/cfh/iniurv/default.htm P.O. Box 47832 Olympia, WA 98504-7832 (P) 360-236-3602 • (F) 360-753-9100

## WEST VIRGINIA **Department of Health and Human Resources**

ISSUE Injury is the leading cause of death among persons under age 45 in West Virginia. Historically, West Virginia has had limited capacity to guickly and accurately determine injury problems due to the lack of a comprehensive statewide injury surveillance system. Reliable, accurate and timely surveillance data are paramount in identifying populations at increased risk of injury and violence, developing appropriate prevention and control strategies and evaluating their effectiveness.

## PROGRAM OVERVIEW

Through a program capacity building grant from CDC's National Center for

Injury Prevention and Control, the West Virginia Injury Prevention Program was created within the state's Department of Health and Human Resources in 1998. Developing an injury and violence prevention infrastructure and improving access to and the quality of injury data in West Virginia became the program's first priority.

- The Injury Prevention Program established a statewide coalition of state agencies and other organizations with a vested interest in injury and violence prevention to provide guidance and share resources. Coalition members include the West Virginia Health Statistics Center, the State Trauma and Emergency Care System, the Office of Emergency Medical Services, and the West Virginia Center for Rural Emergency Medicine.
- The West Virginia Health Statistics Center, located within the state's Department of Health and Human Resources, provides much needed epidemiological support to the program by assessing key injury data sources and analyzing these data to develop an accurate picture of the impact of injury and violence in the state.
- The West Virginia Injury Prevention Coalition, in conjunction with the West Virginia Center for Rural Emergency Medicine, developed the Fatal Injury in West Virginia report, and used it as the state's strategic injury prevention plan.
- State trauma centers provide outreach programs promoting all terrain vehicle safety, seat belt use and child passenger safety, and the State Trauma and Emergency Care System is working with the West Virginia Chapter of the American Trauma Society to develop a fall prevention program.

### **PROGRAM RESULTS**

ments in both areas.

- By bringing together partners with access to injury data sources, the program made significant strides in meeting the need for coordinated data collection and analysis.
- The Injury Prevention Program, the State Trauma and Emergency Care System and the Office of Emergency Medical Services created the Trauma and Emergency Medical Information System, which provides real-time EMS, communication, treatment, cost of care, and disposition information about all patients receiving care in all of West Virginia's emergency departments and trauma centers.
- The system identifies injury and violence problem areas, high risk populations and temporal trends. In conjunction with other data sources, the system provides analysis of the economic burden of injuries in West Virginia.
- care for injured patients.
- The Injury Prevention Program assisted the State Trauma and Emergency Care System and the Office of essential to understanding the impact of injury and violence in the state.

## **IMPACT OF ADDITIONAL FUNDING**

Additional funding would enable the Injury Prevention Program to analyze and publish additional and updated injury data; conduct ongoing review and analyses of data that help program planners prioritize, target and evaluate injury and violence prevention programs; and facilitate the expansion of injury and violence prevention infrastructure, particularly within the state health department.

### West Virginia Department of Health and Human Resources **Injury Prevention Program**



The West Virginia Injury Prevention Program has helped build the state's capacity in two key areas - data and infrastructure. Collaboration among the state's coalition members contributed to important achieve-

 Coalition members developed a system to improve access to trauma center data. A rural-inclusive statewide trauma system includes the state's 28 Level I, II, III, and IV trauma centers and other emergency agencies that

Emergency Medical Services to use existing software to automatically provide correct and appropriate e-coding. E-codes are data from hospital discharge records that indicate a patient's cause of injury. These data are

> http://www.wvdhhr.org/bph/oehp/iniury/ Room 206. Capitol Street Charleston, WV 25301 (P) 304-558-0644 • (F) 304-558-1553

# WISCONSIN **Division of Public Health**

ISSUE Almost 900 people in Wisconsin die from violence-related injuries each year. In 2004, there were 876 such deaths, including 643 suicides, 160 homicides, one legal intervention, 68 undetermined, and four unintentional firearm deaths. Local, state and federal prevention programs and policymakers often lack comprehensive information about violent deaths because the data are fragmented among many data sources and agencies. State-based violent death reporting systems are crucial to providing accurate and timely information that can inform decision makers about the magnitude, trends and characteristics of violent deaths.

### **PROGRAM OVERVIEW**

The Wisconsin Division of Public Health's Injury Prevention Program uti-

lizes funds from a five-year National Violent Death Reporting System grant from CDC's National Center for Injury Prevention and Control to develop and implement the Wisconsin Violent Death Reporting System. This project intends to create a single system that links valuable information from key violent injury-related data sources. This new statebased data system:

- links records from violent deaths occurring in the same incident, in order to identify risk factors and patterns for events such as multiple homicides or homicide-suicides;
- provides timely information through faster data retrieval;
- describes, in greater detail, circumstances that may have contributed to a violent death; and
- characterizes perpetrator traits, including their relationship to victims.

This approach will provide Wisconsin's Injury Prevention Program with a more comprehensive picture of violent incidents throughout the state. The Injury Prevention Program works with the state's vital records office, coroners and medical examiners, law enforcement officials, and crime labs to develop and obtain high quality data for the new system. The linked data provides law enforcement and death investigators with a clearer picture of violent activity in their jurisdictions and can aid statewide prevention programs in implementing more effective prevention plans to reduce the burden of violent injuries and deaths in Wisconsin.

**PROGRAM RESULTS** • The Injury Prevention Program began collecting and entering data from multiple data sources in March 2004. The first complete year of data in the new system is for 2004.

- state and promote practices and policies to reduce these events.
- violent fatality reports that are disseminated to agencies and injury partners throughout the state.

### **IMPACT OF ADDITIONAL FUNDING**

Additional funding would allow the program to expand electronic linkages directly into the violent death reporting system software. For example, these linkages would enable law enforcement data to be electronically transferred directly into the Wisconsin Violent Death Reporting System software and thereby improve the timeliness in which the program receives the data.



• Annual reports using these linked data will be produced to describe the violent injury and death burden in the

The Injury Prevention Program also uses the Wisconsin Violent Death Reporting System to generate aggregate

Fact sheets are developed to highlight the significance, burden and prevalence of violent deaths in Wisconsin.

Wisconsin Division of Public Health **Injury Prevention Program** http://dhfs.wisconsin.gov/health/injuryprevention/ 1 West Wilson Street, P.O. Box 2659

Madison, WI 53701-2659 (P) 608-267-7174 • (F) 608-266-8925

# WYOMING Department of Health

ISSUE Unintentional injury is the leading cause of death for youth ages 1-18 in Wyoming. During 1996-2001, a total of 102 children ages 0-14 died from unintentional injuries in Wyoming. Motor vehicle crashes are the leading cause of these injuries.

In Fiscal Year 2001, the top three causes of injury hospitalizations for children and youth under age 19 were falls (92 hospitalizations), motor vehicle-related (81 hospitalizations) and poisonings (36 hospitalizations). Motor vehicle crashes caused the greatest length of hospital stays and highest total charges. From July 2000 to June 2001, the charges for the 81 motor vehicle-related hospitalizations among patients under age 19 totaled more than \$1.38 million; the 92 falls among this age group totaled over \$658,000.

## **PROGRAM OVERVIEW**

For more than a decade, the Wyoming Department of Health's Division of Pub-

lic Health has been a leader in developing a focused childhood injury control program for the state and establishing SAFE KIDS of Wyoming, a coalition of diverse public and private injury prevention stakeholders. The coalition aims to reduce the number of unintentional injuries among children and adolescents in Wyoming. SAFE KIDS implements a statewide campaign to raise awareness among adults – especially parents, parents-to-be and caregivers – that unintentional injury is the leading cause of death among children ages 1-18 and that injuries are preventable.

Highlights of the coalition's work includes:

- SAFE KIDS of Wyoming implements a 1-800 information line to link parents, parents-to-be and caregivers to health promotion and injury prevention organizations, including the Department of Health's Immunization Program and Women, Infant and Children Program, the state children's health insurance program, Prevent Child Abuse Wyoming, and the state Department of Transportation.
- The coalition focuses on child passenger safety, but also addresses other injury areas, including bicycle, water, pedestrian, and equestrian safety.
- The coalition developed a 2005 action plan that includes goals to reduce motor vehicle crash injuries and improve child injury prevention messages .

### **PROGRAM RESULTS** • SAFE KIDS of Wyoming expanded the number of local chapters from six in 2001 to 11 in

2004, covering over half of the state's counties.

- local and state leaders with information on coalition activities and injury data.
- safely transporting children.
- weigh 80 pounds or less, to be properly secured in a child passenger restraint system.

## **IMPACT OF ADDITIONAL FUNDING**

Additional funding would help SAFE KIDS of Wyoming increase the number of coalition chapters it serves and enhance the quality of its work by using injury data to guide its program planning and incorporating proven prevention strategies.



Since 2003, the state coalition has published a newsletter reaching over 450 SAFE KIDS Wyoming members and

 SAFE KIDS of Wyoming increased the number of persons in the state who completed the National Standardized Child Passenger Safety Training Program (a 32-hour standardized training from the National Highway Safety Traffic Administration) and became certified Child Passenger Safety Technicians. These technicians can assist parents and caregivers in properly installing child safety seats and provide information on best practices for

 SAFE KIDS of Wyoming served as a central point of contact for guestions about a child restraint law that went into effect in 2003. The Wyoming state law requires all child passengers eight years old or younger, and who

### Wyoming Department of Health

http://wdh.state.wy.us 2300 Capitol Avenue, Room 117 Cheyenne, WY 82002 (P) 307-777-7656 • (F) 307-777-7439



## ACKNOWLEDGEMENTS

The Making a Difference: State Health Department Injury and Violence Prevention Programs document benefited from the contributions of a number of people. The State and Territorial Injury Prevention Directors Association extends a special thank you to the individuals listed below.

STIPDA thanks its State Representative members and the staff of state health department injury and violence prevention programs for providing the examples featured in this document and for the committed work they do each day to reduce injuries and violence, save lives and make a difference in the health and well-being of people in their home states, and collectively, across the U.S.

Stuart Berlow of the Association of State and Territorial Health Officials provided excellent guidance in preparing this document and reviewing its content.

Several staff members of CDC's National Center for Injury Prevention and Control contributed to this document. Sarah Foster provided feedback on the data included in the introductory section and overall document concept, Corrine Graffunder provided assistance, and Richard Dunville gave extensive input on the terms and definitions in the glossary.

Xan Young and Erin Lyons of the Educational Development Center and Children's Safety Network in Washington, D.C. provided assistance in gathering information for some state examples.

STIPDA's Executive Director, David Scharf, provided oversight and guidance on the document since its inception.

Kristen Lindemer of STIPDA compiled and edited the information and state examples in this document, and managed the document's production.

Melanie Kyser of STIPDA assisted in gathering information and data for the introductory section.

Graphic design and layout by Jeremy Whigham Design (Atlanta) in partnership with Peterson Design Group, LLC (Atlanta).

