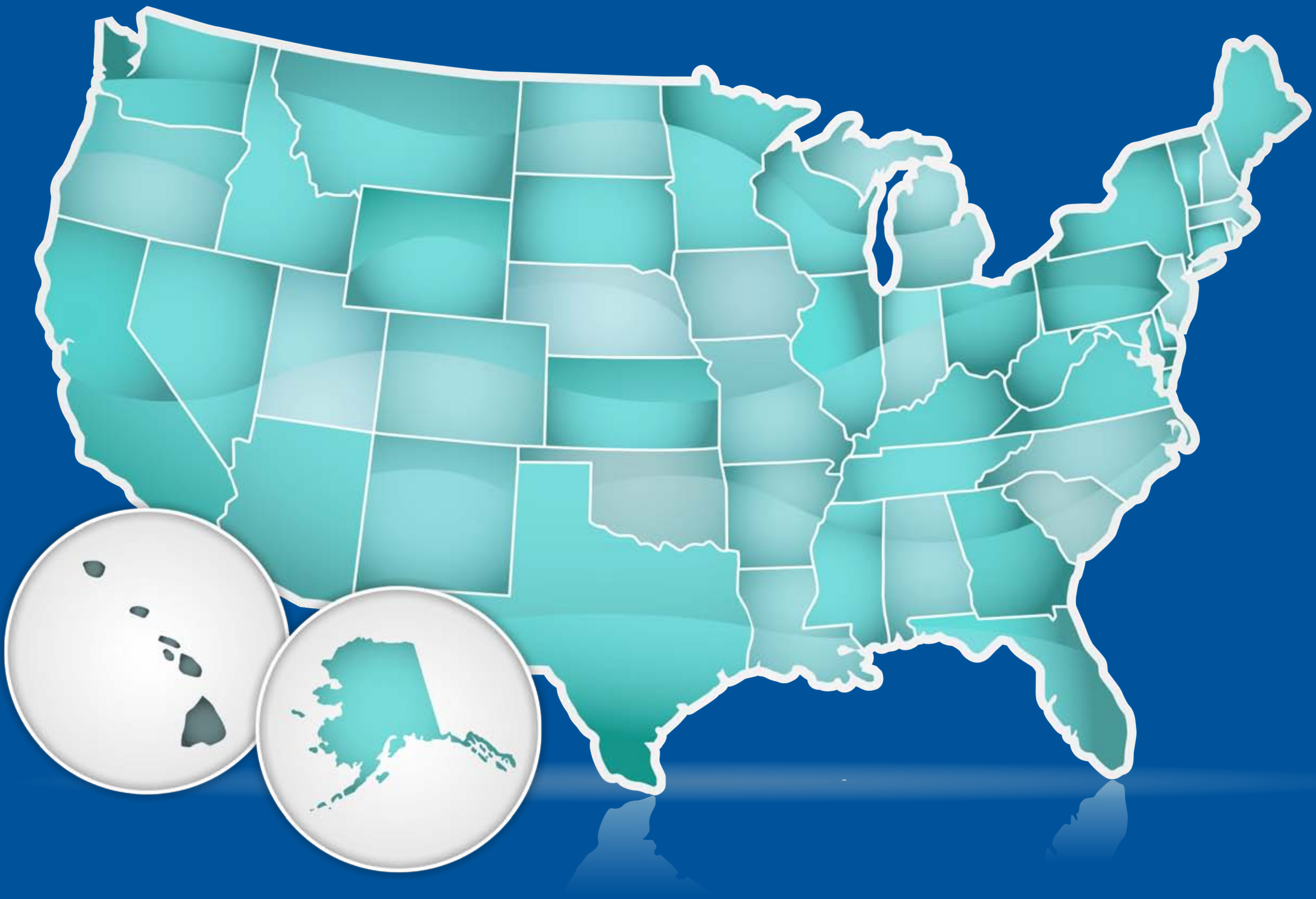
STATE OF THE STATES



2011

SAFE STATES

www.safestates.org

About the Safe States Alliance

The Safe States Alliance is a national non-profit organization and professional association whose mission is to serve as the national voice in support of state and local injury and violence prevention professionals engaged in building a safer, healthier America.

To advance this mission, Safe States Alliance engages in activities including:

- Increasing awareness of injury and violence throughout the lifespan as a public health problem;
- Enhancing the capacity of public health agencies and their partners to ensure effective injury and violence prevention programs by disseminating best practices, setting standards for surveillance, conducting program assessments, and facilitating peer-to-peer technical assistance;
- Providing educational opportunities, training, and professional development for those within the injury and violence prevention field;
- Collaborating with other national organizations and federal agencies to achieve shared goals;
- Advocating for public health policies designed to advance injury and violence prevention;
- Convening leaders and serving as the voice of injury and violence prevention programs within state health departments; and
- Representing the diverse professionals making up the injury and violence prevention field.

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From the Safe States Alliance

Lori Haskett
President

Amber N. Williams
Executive Director

The Safe States Alliance is proud to present the *State of the States: 2011 Report*, the only national assessment of capacity among state public health injury and violence prevention programs in the United States. Now in its fourth iteration, the State of the States Report provides the most up-to-date and comprehensive information about the structure, organization, people, resources, and work of state injury and violence prevention programs.

This report is intended to provide an update of comprehensive national data on the status of state injury and violence prevention programs; build on the 2005, 2007, and 2009 reports by describing changes in state injury and violence prevention programs over time; and highlight achievements of injury and violence prevention programs. New in 2011, we've added:

- Greater detail about the funding sources utilized by state injury and violence prevention programs to accomplish their work;
- More graphs to illustrate key findings in the data; and
- An online, interactive report for clear and quick access to 2011 data (http://safestates.org/sots).

We thank Safe States members for their commitment and effort to complete the extensive survey in a time when there are ever increasing demands and ever fewer resources. State of the States is made possible by the continued financial support from the Centers for Disease Control and Prevention. We would also like to thank the members who contributed to the development of the survey and reviewed the report.

We welcome your comments on this report and the entire survey. Visit us online at http://safestates.org/sots.

Lori K Haskett

Lori Haskett
President
Safe States Alliance

Amber N. Williams

Amber N. Williams
Executive Director
Safe States Alliance

From the Centers for Disease Control & Prevention

Linda C. Degutis, DrPH, MSN
Director

The Centers for Disease Control and Prevention's (CDC) National Center of Injury Prevention and Control (Injury Center) is pleased to support the Safe States Alliance in its work to develop the *State of the States: 2011 Report*. Injuries, including unintentional and violence-related injuries, kill more people in the first four decades of life than any other disease, regardless of sex, race, or socioeconomic status. Robust state violence and injury prevention programs ensure adequate state data are available to guide and direct interventions; coordinate efforts among a variety of organizations working on violence and injury prevention; and support the development, implementation, and evaluation of state and local program and policy strategies to prevent violence and injuries in their communities.

This report makes a significant contribution to our understanding of violence and injury prevention and control at state health departments and supports the importance of working to prevent violence and injuries across the nation. For policy-makers, researchers, and public health practitioners at the federal, state, and local levels, this report advances our understanding about state activities in preventing violence and injuries.

I commend the Safe States Alliance and the state health departments that participated in this important initiative. CDC's Injury Center is proud to support this work and will continue to foster integration and collaboration among public health professionals in improving public health practice.

Sincerely,

Linda C. Degutis, DrPH, MSN
Director
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Background

Injuries are the leading cause of death for people ages 1-44 in the United States. Injuries and violence have a significant impact on the overall health of Americans including premature death, disability, and the burden placed on the health care system. However, despite the existence of prevention strategies proven effective, each year there are:

Over 29 million people treated	**in Emergency Departments for injury[1]**
Over 2.8 million hospitalizations	**related to injury occur each year[1]**
More than 180,000 injury related deaths	**occur each year - nearly 1 person every 3 minutes[1]**
$406 billion ultimately spent in a single year	**on medical costs and lost productivity due to injuries[2]**

Fortunately, violence and injuries are preventable. Effective prevention efforts require a comprehensive and coordinated approach addressesing the complex underlying factors contributing to the occurrence of violence and injuries. This is often referred to as the public health approach. The public health approach involves: data collection and analysis; identification of the populations and locations at greatest risk; identification of risk and protective factors; and development and utilization of evidence-based strategies and programs to address injuries and violence at the individual, family, community, and societal levels.

Injury and violence prevention efforts are most effectively facilitated through state public health injury and violence prevention programs. The Safe States Alliance has defined five (5) core components critical to the development, growth, and sustainability of innovative and effective state injury and violence prevention programs.[3] The five (5) components are:

- Build a solid infrastructure for injury and violence prevention;
- Collect and analyze injury and violence data;
- Design, implement, and evaluate programs;
- Provide technical support and training; and
- Affect public policy.

A comprehensive and effective injury and violence prevention program located within the state health department can provide focus and direction for prevention efforts. A state health department injury and violence prevention program grounded in the public health approach and attuned to the five (5) core components is best positioned to meet the challenges associated with coordinating many diverse prevention partners and making the best use of limited resources.

Given the importance of building and maintaining comprehensive state programs to prevent and address issues of injury and violence, it is critical to conduct regular assessments of their capacity to understand the underlying causes of injuries, take effective actions to prevent these causes, and collectively make progress in reducing injury deaths and disability in each state and throughout the nation.

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1. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online] (2007) [accessed 2012 Aug 4]. Available from URL: http://www.cdc.gov/injury/wisqars.
2. Finkelstein EA, Corso PS, Miller TR, Associates. Incidence and Economic Burden of Injuries in the United States. New York: Oxford University Press; 2006.
3. *S*tate and Territorial Injury Prevention Directors Association. Safe States, 2003 Edition. Atlanta

About the Survey: Methodology & Results

The State of the States: 2011 Report presents results from the fourth administration of the Safe States Alliance State of the States Survey. The Safe States Alliance plans to conduct this data collection activity on a biennial basis to continually develop a comprehensive picture of the status of U.S. state health department injury and violence prevention programs over time.

The 2011 State of the States Survey was reviewed with a pilot group of states and a contracted evaluator. Most questions remained the same between 2007, 2009, and 2011; however, some were updated for clarification purposes. Additionally, new questions were added to the 2011 survey, including some related to specific organizational capacity indicators of injury and violence programming.

The 2011 State of the States Survey was administered in early 2012 to collect data on the status of programs in 2011. A total of 47 states participated in the 2011 State of the States Survey. However, not all states responded to all survey questions, so the number of states responding to each question varies, as noted in figures, tables, and the document text.

In most states, the state health officer appoints a staff person from the injury and violence prevention program to serve as the designated Safe States Alliance representative for the state. In these cases, the survey was sent to this state representative. In states without a current Safe States Alliance member, the state injury and/or violence prevention program was contacted to identify the appropriate person to complete the survey. The Safe States Alliance sent each state representative an email containing a link to the online survey. A copy of the survey was also included as an attachment to the email. Participating states completed the survey online or sent the Safe States Alliance a completed hard copy. If a hard copy was submitted, Safe States Alliance staff entered the data into the survey database.

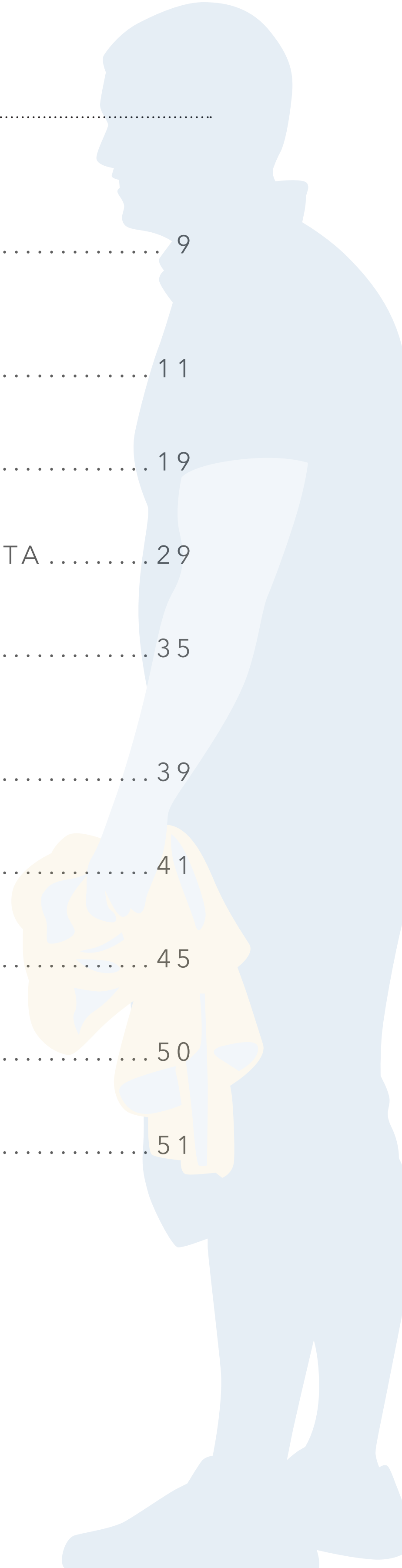
Special considerations regarding the data presented are as follows:

- Results within the report are organized around each of the five (5) core components identified by the Safe States Alliance as essential elements of a comprehensive state public health injury and violence prevention program.
- Some questions, such as those about injury and violence prevention program staff, were asked at the individual level instead of the state level. For these questions, the exact number of staff members referenced in each question is reported in the figures, tables, and document text.
- All totals on graphs and charts may not add up to 100% due to rounding and occurrences in which the respondents could select more than one response (i.e., "check all that apply").
- Unless noted otherwise, all reported results reflect the status of state injury and violence prevention programs in Federal Fiscal Year 2011 (also referred to within the report as FFY 2011).

The results presented in this report were analyzed using the statistical software, *Statistical Package for the Social Sciences* (SPSS), Version 16.0, SAS Enterprise Guide 5.1, and ArcGIS 10.1.

Table of Contents

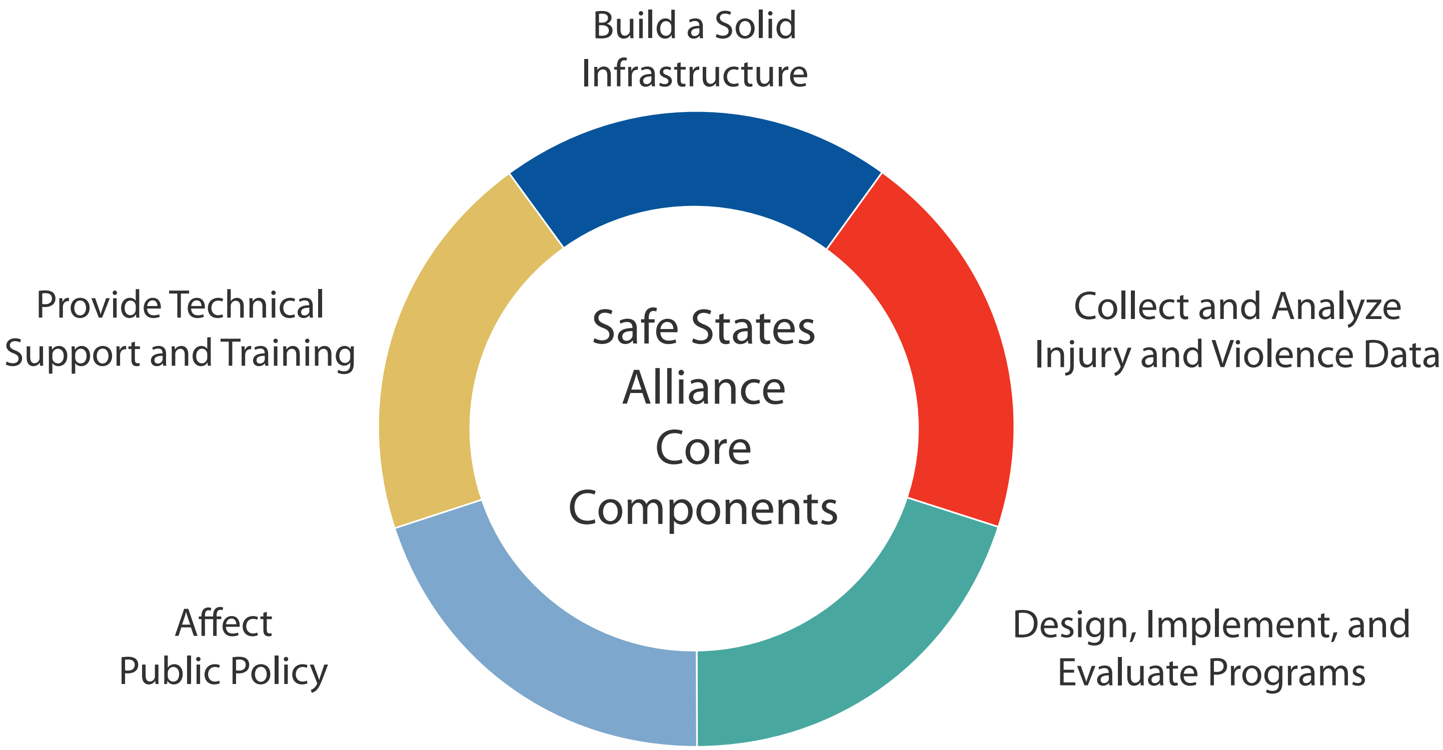
EXECUTIVE SUMMARY 9
BUILD A SOLID INFRASTRUCTURE FOR INJURY AND VIOLENCE PREVENTION 11
PARTNERSHIPS AND COLLABORATION 19
COLLECT AND ANALYZE INJURY AND VIOLENCE DATA 29
DESIGN, IMPLEMENT, AND EVALUATE PROGRAMS 35
HIGHLIGHTS OF SELECTED INJURY AND VIOLENCE TOPIC AREAS 39
PROVIDE TECHNICAL SUPPORT AND TRAINING 41
AFFECT PUBLIC POLICY 45
ACKNOWLEDGEMENTS 50
APPENDIX A: GLOSSARY OF TERMS 51



Executive Summary

The *State of the States: 2011 Report* highlights findings from the Safe States Alliance 2011 State of the States Survey. This survey is the fourth national assessment of capacity among state injury and violence prevention programs.

The contents of this report are organized around the five (5) core components identified by the Safe States Alliance as essential elements of a comprehensive state health department injury and violence prevention program.


Build a Solid Infrastructure
Collect and Analyze Injury and Violence Data
Design, Implement, and Evaluate Programs
Affect Public Policy
Provide Technical Support and Training
Safe States Alliance Core Components

MAJOR FINDINGS FROM THE 2011 STATE OF THE STATES SURVEY (N=47)	
Program Location & Movement	Nearly half of state injury and violence prevention programs changed their location within the health department at least once between 2005 and 2011. Four (4) state injury and violence prevention programs changed their location three (3) times, two (2) programs changed their location twice, and 12 programs changed their location once during that period.
Program Decentralization	Compared to 2009, more states reported having an identified injury and violence prevention program and decentralizing injury and violence prevention program activities throughout the health department. In 2011, 41 (89%) of states reported they had an identified IVP program—a 12% net increase (3 states) since 2009. In 2011 (32%) states reported IVP program activities are decentralized throughout the health department compared to 6% in 2009.
Funding	In Federal Fiscal Year 2011, $101.5 million was invested nationally in state public health injury and violence prevention programs. Out of 332 funded awards, 74% were federal grants, 18% were from state sources, and 8% were other sources.
Full-time Equivalent (FTE) Employees	Twenty-three (23) funding sources supported 424 individual employees working in state health department injury and violence prevention programs, which equated to 343 FTEs.
Access to Data Professionals	In 2011, 59% of state injury and violence prevention programs had access to one or more FTEs serving in a primary role described as 'data collection and analysis'.
Primary Focus Areas	In 2011, the most commonly reported primary focus areas were motor vehicle injuries, fall injuries, sexual assault/rape, injuries to children, and child passenger safety. These focus areas, except for fall injuries have remained in the top five since 2007.
Evaluation	High level program implementation and evaluation involves reporting program and policy evaluation outcomes to stakeholders. At least half of all states focusing on the five most common primary programmatic areas reported program and policy evaluation outcomes to stakeholders.
Technical Assistance	State injury and violence prevention programs with a full-time director were significantly more likely to offer practical experience to students (p=0.037), respond to request for technical assistance (p=0.010), and offer courses for academic credit or CEUs (p=0.004).
Policy Infrastructure – Key Staff	State injury and violence prevention programs with access to an evaluator, epidemiologist, and/or a full-time director were significantly more likely to engage in the following methods to inform public policy: • Work to create/encourage adoption of organizational policies for injury and violence prevention; • Participate in boards and/or commissions; • Request opportunity to review bills; • Invite state or local legislators to meetings events; • Send materials to policymakers; • Testify at state and local hearings; and/or • Work to increase public awareness of laws.

Build a Solid Infrastructure for Injury and Violence Prevention

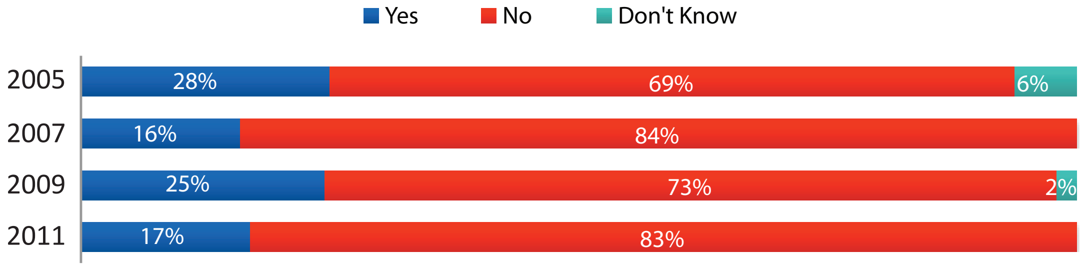
Infrastructure refers to the basic physical and organizational components making it possible for a state injury and violence prevention (IVP) program to function. Key characteristics of a program's infrastructure may include (but are not limited to): state mandates, strategic plans, staff, funding, and partnerships. Each of these characteristics can impact how a state IVP program is structured, how it operates, and what it is capable of achieving.

State Mandate

State mandates may originate from a variety of sources including the state legislature, the state public health official, or another source. State mandates provide explicit legal authority to state IVP programs, and may address features such as the existence of the IVP program, the program's placement within the state system, the duties of the program, and program funding.

As reflected in past years, the majority of states reported they did not have a state mandate for a comprehensive injury and/or violence prevention program (Figure 1). In 2011, only nine (9), 17% states, reported they had a state mandate – a reduction of three (3) states since 2009. Of the nine (9) states with a state mandate in 2011, only two (2) reported the mandate was funded.

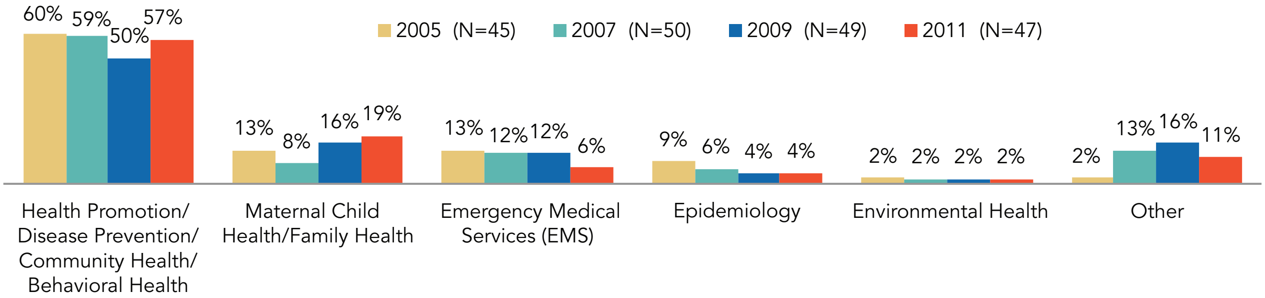
Figure 1.
States with a Mandate for a Comprehensive Injury and/or Violence Prevention Program, 2005, 2007, 2009, 2011



Program Location

The majority (45) of the IVP programs were located within state health departments. More than half (60%) of IVP programs were located in an organizational unit addressing health promotion, disease prevention, community health, and/or behavioral health in 2011 (Figure 2).

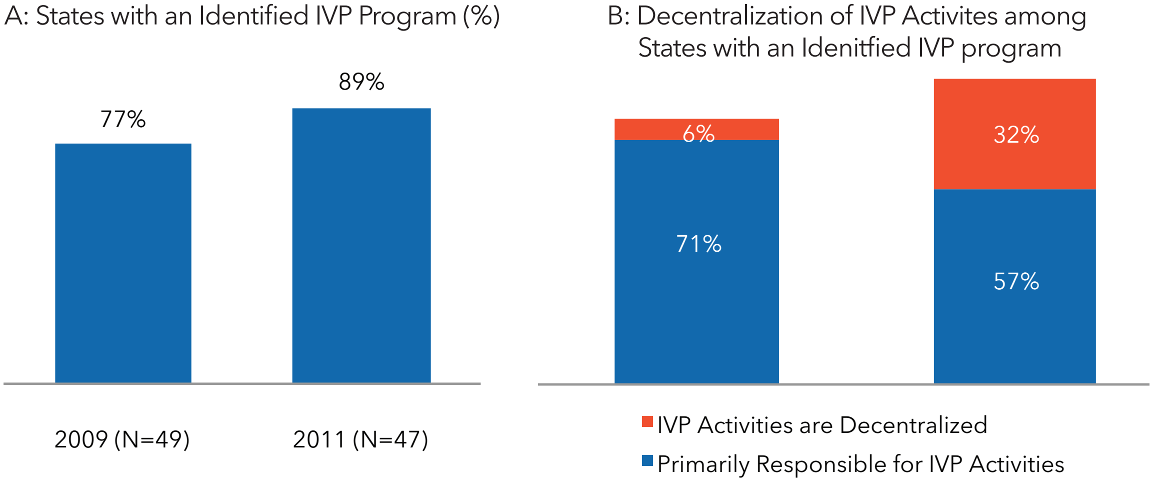
Figure 2.
Location of Injury and Violence Prevention Programs in State Health Departments, 2005, 2007, 2009, and 2011



The difference in the location across years can result from reorganizations or changes in leadership within the state health departments over time. Nearly half of state IVP programs changed their location within the health department at least once from 2005 to 2011. Four (4) state IVP programs changed their location three (3) times, two (2) programs changed their location twice, and 12 programs changed their location once during that period. The most common change in location from 2005 to 2011 was from Health Promotion/Disease Prevention/Community Health/Behavioral Health to Maternal Child Health/Family Health. Another common location change was from Emergency Medical Services, Epidemiology, and Maternal Child Health/Family Health to Health Promotion/Disease Prevention/Community Health/Behavioral Health.

Compared to 2009, more states reported having an identified IVP program. In 2011, 41 (89%) of states reported they had an identified IVP program – a 12% net increase (three (3) states) since 2009 (Figure 3a). State IVP programs were asked who was responsible for the IVP activities conducted at the state health department. Some states decentralize their IVP program activities throughout the health department. Decentralized activities are defined as IVP activities implemented by multiple programs and/or divisions throughout the state health department.[4] In 2011, (32%) states reported IVP program activities are decentralized throughout the health department compared to three (3) programs (6%) in 2009 (Figure 3b).

Figure 3.
States with an Identified Injury and Violence Prevention Program, 2009 and 2011



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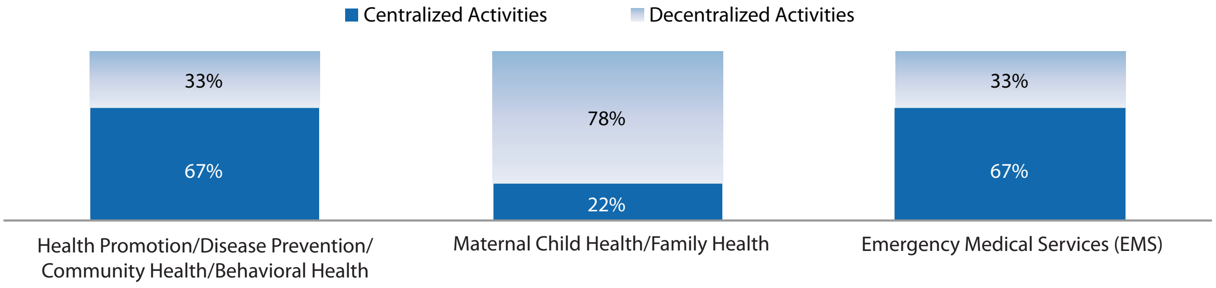
4. Decentralized activities are defined as IVP activities that are implemented by multiple programs and/or divisions throughout the state health department.

In 2011, more state IVP programs reported decentralizing program activities throughout various organizational units within the state health department. One-third (33%) of state IVP programs primarily located in the division of Health Promotion/ Disease Prevention/Community Health/Behavioral Health have some of their program activities located in other divisions (Figure 4). Similarly, state IVP programs located in the division of Maternal and Child Health/Family Health are decentralizing their activities– seven (7) out of nine (9) IVP programs had activities outside Maternal Child Health/Family Health. The specific partnerships states developed and the methods in which they collaborated with other entities within and outside of the state health department are further described in the section titled, *Partnerships and Collaboration*.

Figure 4.
Centralization of Injury and Violence Prevention Activities by Injury and Violence Prevention Program Location in State Health Departments, 2011



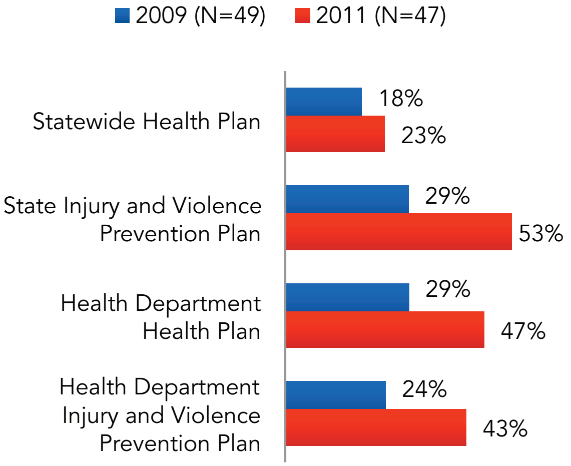
Strategic Planning

The majority of states reported some type of plan existed in the state to address IVP activities. Overall, the number of health plans addressing IVP statewide or at the health department level increased compared to previous years (Figure 5). The number of states reporting the existence of state IVP plans (produced by multiple agencies outside of the health department) increased from 29% in 2009 to 53% in 2011. Similarly, the number of states reporting the existence health department IVP plans also increased from 24% in 2009 to 43% in 2011.

The existence of health plans (addressing multiple health issues) also increased compared to previous years. However, the number of statewide health plans remained low in comparison to other plans.

State IVP programs also used these plans to monitor and evaluate programmatic activities and outcomes within specific communities and throughout the state. Sixty-two percent (62%) of states reporting the existence of a state IVP plan also reported using the plan to monitor and evaluate their activities. Similarly, 58% of states reporting having a health department IVP plan also used it to evaluate and monitor programmatic activities and outcomes.

Figure 5.
States Reporting the Existence of State and/ or Health Department Plans, 2009 and 2011



Funding

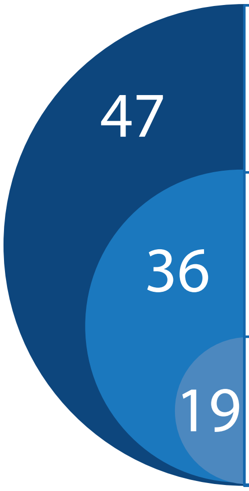
In Federal Fiscal Year 2011 (FFY 2011), $101.5 million was invested nationally in state public health IVP programs. This was an average of $2.2 million per state IVP program (median of $1.3 million, ranging from $5,500 to $19.4 million). Investments in state public health IVP programs came from a variety of funding sources, including federal agencies, state government, non-profit organizations, and foundations.

Out of a total of 332 funded awards states received in FFY 2011, 74% were federal grants, 18% were from state sources, and 8% were from other sources. Federal sources contributed $61.6 million (61%) of all funding through 247 funding awards to state IVP programs nationwide. State funds contributed $37.1 million (36%), and other sources of funding (i.e., universities, private/corporate, non-profits, etc.) contributed $2.9 million (3%). Three times as many awards came from federal sources than state and other sources combined.

While all participating states reported they received federal funding, 11 (23%) states received funding from federal sources only (Figure 6). Only 19 states (40%) reported receiving funding from federal, state, and other sources.

State IVP programs received funding from a median of seven (7) total funding sources (ranging from one (1) to 17 funding sources): a median of five (5) federal sources (ranging from one (1) to 14 sources), two (2) state sources (ranging from one (1) to three (3) sources), and one (1) other source (ranging from one (1) to three (3) sources).

Figure 6.
Funding Source Types Awarded to State Health Department IVP Program, FFY 2011



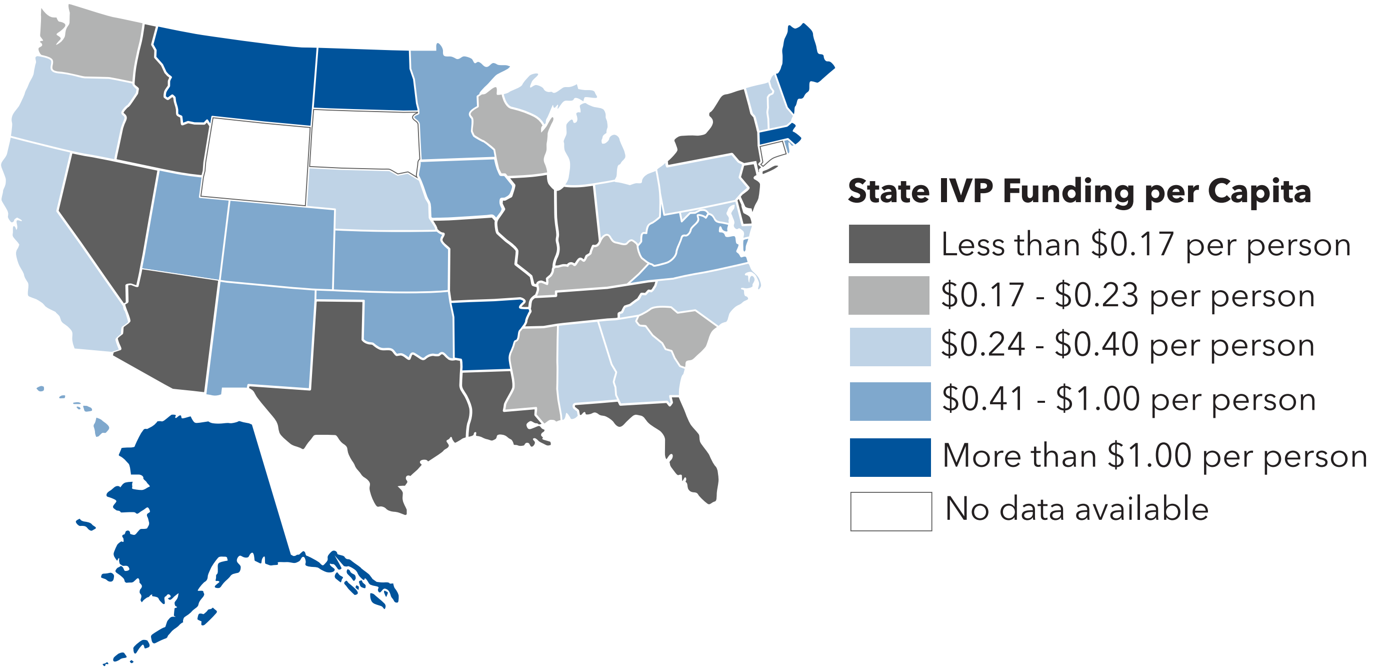
Federal	• All states received federal sources • 11 (23%) states received federal sources only
Federal and State	• 36 (77%) states received federal and state sources • 17 (36%) states received federal and state sources only
Federal, State, and Other	• 19 (40%) states received federal, state, and other sources

State & National Per Capita Comparisons

In a single year, injury and violence will ultimately cost the United States $406 billion, which includes over $80 billion in medical costs and $326 billion in lost productivity.[5] This is an annual cost of nearly $1,303 for every individual living in the U.S.[6] In contrast, only about $101 million was invested nationally in state public health IVP programs in FFY 2011. This amount resulted in a national average investment of only $0.32 per person.[7]

While 13 state IVP programs were funded at amounts close or equal to the national average of $0.32 per person, 18 state programs were funded at less than the national average (Figure 7). Five (5) state programs received between $0.17 and $0.23 per person, while 13 state programs received less than $0.17 per person. At the other end of the spectrum, several states received funding amounts greater than the national average. Ten (10) state programs received between $0.41 and $1.00 per person, while another six (6) state programs received and invested more than $1.00 per person to support IVP efforts.

Figure 7.
State Health Department Injury and Violence Prevention FFY 2011 Funding per Capita:
State Funding per Capita Compared to National Funding per Capita ($0.32 per capita)



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5. Finkelstein EA, Corso PS, Miller TR, Associates. Incidence and Economic Burden of Injuries in the United States. New York: Oxford University Press; 2006.
6. The cost of injury per capita was calculated using 2010 national population data from the U.S. Census Bureau.
7. State and national per capita investments in state public health injury and violence prevention programs were calculated using 2010 state and national population data from the U.S. Census Bureau.

Allocation of Funding and Programmatic Topic Areas Supported

In FFY 2011, the majority of state IVP program funding (54%, $54.5 million) was allocated to grants, mini-grants, and contracts supporting IVP programmatic efforts (Figure 8). The next highest allocation of funding went to support personnel - $29 million (29%). Overhead expenses, safety equipment, and other spending categories made up 17% of the expenses incurred by state IVP programs.[8]

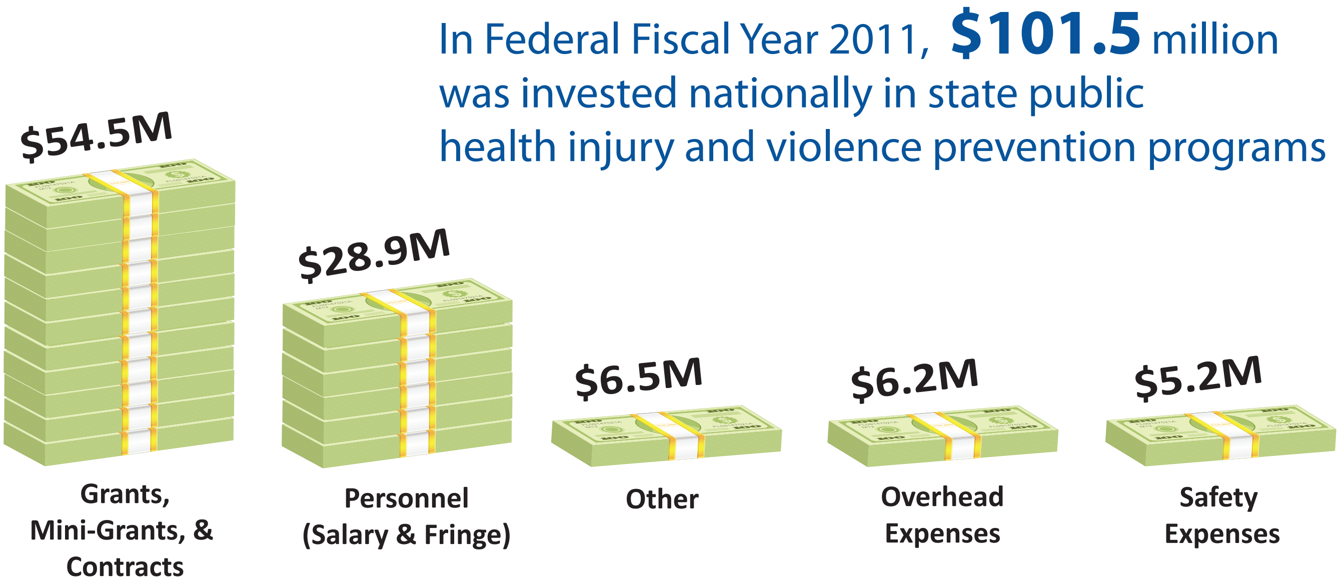
States were asked to list the injury and violence topic areas addressed using each funding source. Almost all funding sources were used to address multiple injury and violent-related issues, and most states used multiple funding sources to address injury and violence-related topic areas.

The top five (5) injury and violence topic areas supported by all funding streams were:

1. Motor vehicle injury prevention;
2. Fall injury prevention;
3. Child passenger safety;
4. Poisoning prevention; and
5. Suicide/self-inflicted injury prevention.

As shown in Table 1, state IVP programs used multiple funding sources to address each topic area. Twenty (20) sources and 116 awards were used nationwide to address motor vehicle injury prevention efforts. States working on motor vehicle injury prevention had a median of two (2) funding sources (ranging from one (1) to seven (7) sources). The most commonly reported funding sources used to support motor vehicle injury prevention were CDC/NCIPC Core, the HRSA/MCHB Title V Block Grant, and the State Highway Safety Office. Similarly, falls injury prevention efforts were supported by multiple funding sources - 15 funding sources and 80 awards nationwide among state IVP programs. The most commonly reported funding sources for fall injury prevention were CDC/NCIPC Core, the CDC Preventive Health and Health Services (PHHS) Block Grant, and the HRSA/MCHB Title V Block Grant. Each state received a median of two (2) funding sources to support fall injury prevention efforts (ranging from one (1) to five (5) sources).

Figure 8.
Funding Allocations for State Injury and Violence Prevention Programs, FFY 2011



In Federal Fiscal Year 2011, **$101.5** million was invested nationally in state public health injury and violence prevention programs

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[8] Overhead expenses include indirect costs. Safety equipment may include items such as child booster seats, smoke alarms, helmets, etc. Other expenses include: travel, meetings, educational material, surveillance systems, etc.

Table 1.
Top Five Injury and Violence Topic Areas and Supporting Funding Sources, FFY 2011

Rank	IVP Topic Area	No. of Funding Sources (No. of Awards)	Funding Sources States Used to Support IVP Topic Area	
			Most Commonly Reported Sources	Median (Range)
1	Motor Vehicle Injury Prevention	20 (116)	CDC/NCIPC Core (VIPP and Part I); HRSA/MCHB Title V Block Grant; State Highway Safety Office	2 (1-7)
2	Fall Injury Prevention	15 (80)	Core (VIPP and Part 1); CDC PHHS Block Grant; HRSA/MCHB Title V Block Grant	2 (1-5)
3	Child Passenger Safety	16 (72)	State Highway Safety Office; HRSA/MCHB Title V Block Grant; Core (VIPP and Part 1)	2 (1-8)
4	Poisoning	14 (69)	Core (VIPP and Part 1); State General Revenue; CDC PHHS Block Grant	2 (1-5)
5	Suicide/Self-Inflicted Injury	9 (68)	CDC/NCIPC NVDRS; State General Revenue; SAMHSA State and Tribal Youth Suicide Prevention Grants	2 (1-7)

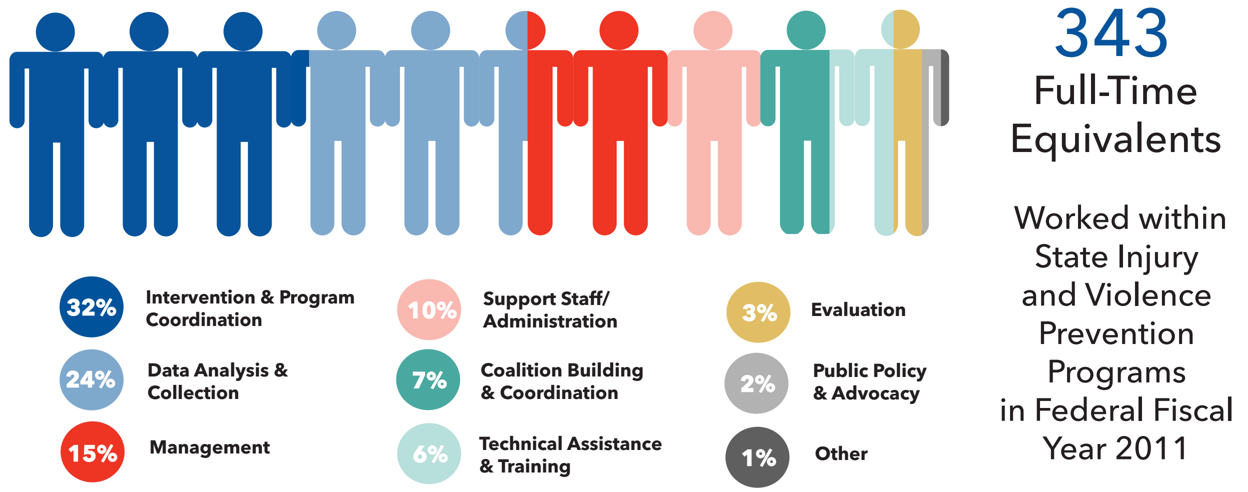
Full-Time Equivalent (FTE) Employees

A total of $101.5 milion from 23 sources supported 424 individual employees working in state health department IVP programs. Of these individuals, 381 (90%) were full-time or part-time paid staff, 25 (6%) were full-time or part-time contractors, and the remaining 18 (4%) worked in other capacities. The staff time dedicated to state IVP programs is measured in terms of full-time equivalents (FTEs).[9] The 424 individual employees working in state IVP programs in FFY 2011 equated to a total of 342.96 FTEs.

States had a median of 5.45 FTEs and an average of 7.30 FTEs, with values ranging from 0.33 to 28.50 FTEs working in IVP programs within state health departments. Twenty-five percent (25%) of states had less than 1.45 FTEs in their IVP program, the middle 50% of states had between 1.47 and 13.17 FTEs, and the remaining 25% had more than 13.18 FTEs.

FTEs contributed to IVP efforts through a variety of primary roles, including intervention/program coordination (32%), data collection and analysis (24%), and management (15%) (Figure 9). The majority of states did not have any FTEs with primary roles in public policy (77%), evaluation (72%), technical assistance and training (72%), and coalition building (53%). No states had a staff with time dedicated to each of the eight primary roles depicted in Figure 9.

Figure 9.
Distribution of FTE Primary Roles in State Injury and Violence Prevention Programs, FFY 2011



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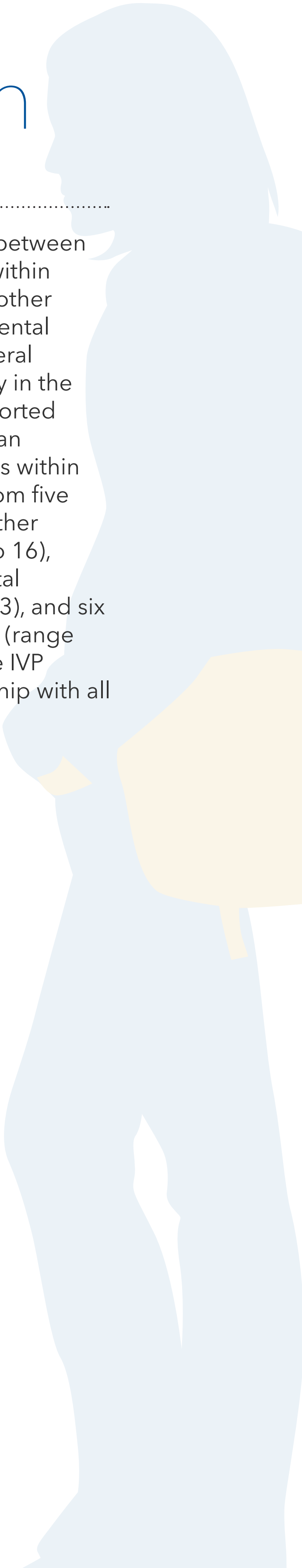
[9] Full-time equivalents (FTEs): the total number of hours worked by an individual employee divided by the total number of work hours in a full-time schedule (defined as 40 hours per week).

Partnerships & Collaboration



There are many causes of injuries and violence, and effectively addressing them requires multifaceted solutions. This makes collaboration and coordination essential to every aspect of a state injury and violence prevention (IVP) program. The many diverse partners at state and local levels may include (but are not limited to): those in the fields of chronic disease prevention, maternal and child health, mental health, aging, transportation, police, fire and emergency services, criminal justice, hospitals, schools, and academic institutions.

Overview of Partnerships

The State of the States Survey asked respondents to indicate how they perceived the strength of their potential partnerships with 75 specific agencies/entities within each organization type. If an agency/entity existed, respondents selected the strength of the relationship as either 'strong', 'new and developing', 'needs improvement', or 'no relationship'. Additionally, if the relationship existed with any agency/entity, respondents were asked to describe the nature of their partnership through six (6) activities:

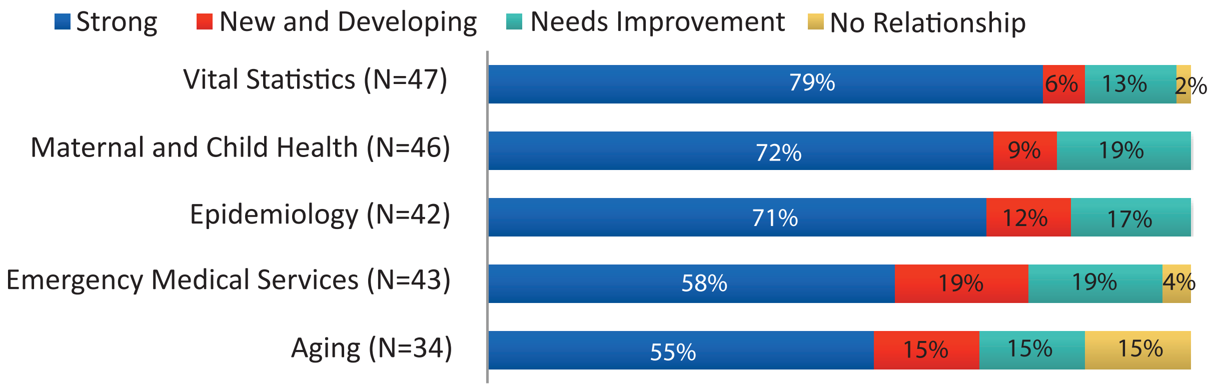
1. The IVP program and partner shared data;
2. The partner was actively involved in IVP program planning;
3. The IVP program provided funding to the partner;
4. The IVP program received funding from the partner;
5. The IVP program and partner collaborated on policy; and
6. The IVP program provided or received training/technical assistance.

The survey explored the relationship between state IVP programs and 23 agencies within the state health department, 16 from other state agencies, 23 from non-governmental organizations, and seven (7) from federal agencies. Overall, states varied greatly in the total number of partnerships they reported having with other entities. States had an average of 13 partnerships with offices within the state health department (range from five (5) to 23), nine (9) partnerships with other state agencies (range from three (3) to 16), 11 partnerships with non-governmental organizations (range from two (2) to 23), and six (6) partnerships with federal agencies (range from one (1) to seven(7)). Two (2) state IVP programs reported having a relationship with all agencies/entities listed in the survey.

Partnerships within the State Health Department

In 2011, state IVP programs were asked to describe the strength of their partnerships with other offices within the state health department.[10] The most common partnerships within the state health department were with Vital Statistics, Maternal and Child Health, Epidemiology, Emergency Medical Services, and the Division of Aging (Figure 10). Although all states reported having a partnership with Maternal and Child Health and Epidemiology, some states perceived their partnerships with those divisions needed improvements (19% and 17% respectively). More states reported having a strong relationship with Vital Statistics (79%) than any other division in the health department.

Figure 10.
Top Injury and Violence Prevention Partnerships within the State Health Department Ranked by Strength, 2011



Of the partnerships existing within the state health department, the majority are "integrated" with Maternal and Child Health, Vital Statistics, Epidemiology, Health Promotion/ Disease Prevention/ Community Health/ Behavioral Health, and Adolescent Health. "Integration" is the process whereby formal units jointly pursue a shared objective in order to improve the health of the populations.[11] They do this through joint decision-making, sharing responsibility for program development/improvement, having mutual accountability of results, and sharing the risk and awards of the program.[12,13]

The Division of Maternal and Child Health was one of the most commonly reported strong partnerships and most active IVP partnerships compared to other divisions within the state health department. Maternal and Child Health ranked third out of 18 in sharing data, first for actively involved in planning, fourth in providing funding to, first in receiving funding from, first in collaborating for policy, and fourth for providing/receiving training and technical assistance (Table 2). Similarly, the Division of Aging ranked in the top 5 for all partnership activities; however, 45% of state IVP programs reported their partnership with the Division of Aging needed improvement, were new and developing, or did not exist. Additionally, 13 states reported there was not a Division of Aging within their state health department.

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[10] Respondents indicating an agency 'did not exist' are excluded from values (N and percents) in Figure 10 and discussion in Table 2.

[11] Mark, Henry, and Julnes (2000). Evaluation: An integrated framework for understanding, guiding, and improving policies and programs. Jossey-Bass: San Francisco, CA. [Social betterment]

[12] Himmelman, AT. Collaboration for a Change: Definitions, Decision-Making Models, Roles, and Collaboration Process Guide. http://depts.washington.edu/ccph/pdf_files/4achange.pdf. [Continuum from networking through collaboration]

[13] Slonim AB, et al. Recommendations for integration of chronic disease programs; are your programs linked? Prev Chronic Dis [serial online] 2007 Apr [August 21, 2012]. Available from http//www.cdc.gov/pcd/issues/2007/apr/06_0163.htm

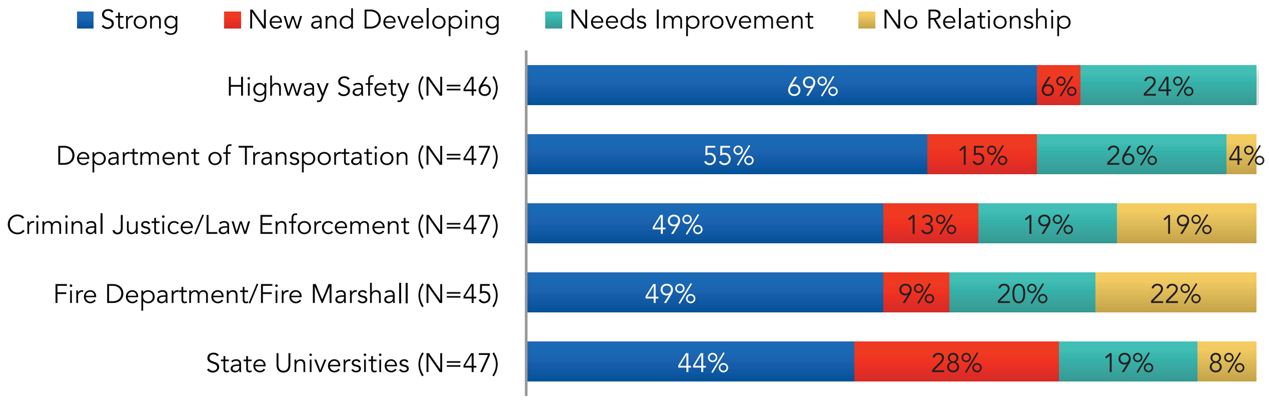
Table 2.
Ranking of Injury and Violence Prevention Partnerships within the State Health Department Engaging in Specified Partnership Activities

Rank	Shared Data	Actively Involved in Planning, Programs, Etc.	Funding Exchanged: IVP Program Provided Funding TO	Funding Exchanged: IVP Program Received Funding FROM	Collaborated for Policy	IVP Program Provided/ Received Training/ Technical Assistance
1	Vital Statistics	Maternal and Child Health	Epidemiology	Maternal and Child Health	Maternal and Child Health	Aging
2	Epidemiology	Aging	Aging	Aging	Aging	Environmental Health
3	Maternal and Child Health	Health Promotion	Chronic Disease	Chronic Disease	Emergency Medical Services	Chronic Disease
4	Emergency Medical Services	Emergency Medical Services	Maternal and Child Health	Emergency Medical Services	Mental Health	Maternal and Child Health
5	Aging	Sexual Health	Sexual Health	Health Promotion	School Health	Occupational Health

Partnerships with Other State Agencies

State IVP programs were asked to describe the strength of their partnerships with other state agencies.[14] The most common partnerships with other state agencies were with Highway Safety, Department of Transportation, Criminal Justice/ Law Enforcement, Fire Department/Fire Marshall, and State Universities (Figure 11). While all state IVP programs reported having a partnership with Highway Safety, where 69% reported having a 'strong' partnership. Within the most commonly reported strong partnerships, several states reported not having a relationship/partnership with the Fire Department/Fire Marshall (22%), Criminal Justice/ Law Enforcement (19%), State Universities (8%), and the Department of Transportation (4%).

Figure 11.
Top Injury and Violence Prevention Partnerships with Other State Agencies Ranked by Strength, 2011



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[14] Respondents that indicated an agency 'did not exist' are excluded from values (N and percents) in Figure 11 and discussion in Table 3.

In addition to being ranked as the top strongest partnerships, IVP partnerships with Highway Safety and Department of Transportation were also among the most active in comparison to other state agencies (Table 3). Although the Division of Elder's Affairs/Aging was not among the top five (5) strongest partnerships (44% reported the partnership as 'strong'), it ranked first out of all 20 agencies for active involvement in planning, programs, etc; IVP program provided funding to; and IVP program received funding from.

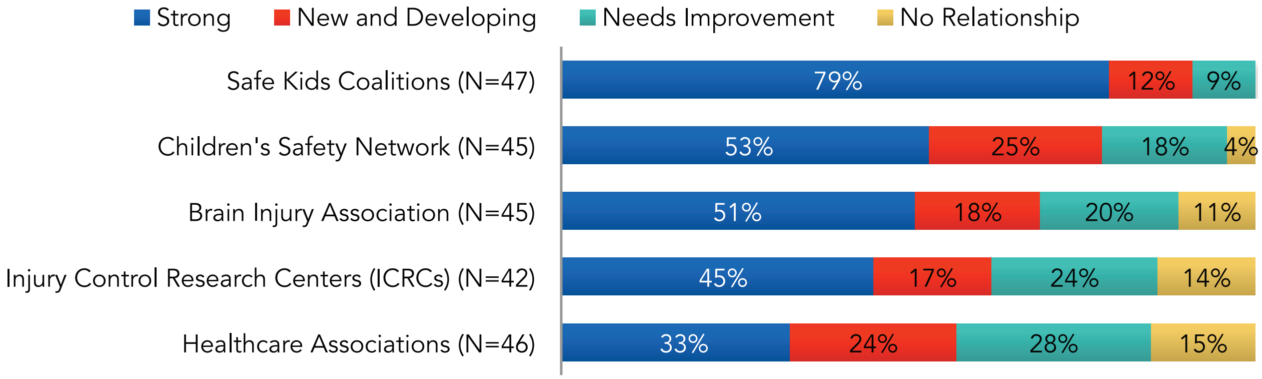
Table 3.
Ranking of Injury and Violence Prevention Partnerships with Other State Agencies Engaging in Specified Partnership Activities

Rank	Legal Agreement or MOU	Shared Data	Actively Involved in Planning, Programs, Etc.	Funding Exchanged		Collaborated for Policy	IVP Program Provided/ Received Training/ TA
				IVP Program Provided Funding TO	IVP Program Received Funding FROM		
1	State Universities	Highway Safety	Elder's Affairs/ Aging	Elder's Affairs/ Aging	Elder's Affairs/ Aging	Highway Safety	Attorney General's Office
2	Criminal Justice/Law Enforcement	Fire Dept/Fire Marshall	Highway Safety	State Universities	Highway Safety	Child Welfare Agencies, Dept of	Fire Dept/Fire Marshall
3	Child Welfare Agencies	Criminal Justice/Law Enforcement	Mental Health	Criminal Justice/Law Enforcement	Dept of Transportation	Attorney General's Office	Elder's Affairs/ Aging
4	Attorney General's Office	Dept of Transportation	Fire Dept/Fire Marshall	Fire Dept/Fire Marshall	Child Welfare Agencies	Mental Health	Education
5	Dept of Transportation	Child Welfare Agencies	State Universities	Attorney General's Office	Criminal Justice/Law Enforcement	Criminal Justice/Law Enforcement	Dept of Transportation

Partnerships with Non-Governmental Organizations

State IVP programs were asked to describe the strength of their partnerships with non-governmental organizations in their state.[15] The most common partnerships with non-governmental organizations were state and/or local Safe Kids Coalitions (100%), Children's Safety Network (96%), Brain Injury Association (89%), Injury Control Research Centers (ICRCs) (86%), and Healthcare Associations (85%). All states reported having a partnership with Safe Kids Coalitions (state and/or local) and the majority (79%) of state IVP programs reported these partnerships were 'strong'.

Figure 12.
Top Injury and Violence Prevention Partnerships with Non-Governmental Organizations Ranked by Strength, 2011



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[15] Respondents that indicated an agency 'did not exist' are excluded from values (N and percents) in Figure 12 and discussion in Table 4.

Safe Kids Coalitions were the most active IVP partnership compared to other non-governmental organizations (Table 4). Partnerships with Safe Kids Coalitions ranked first out of 23 organizations for the following partnership activities: sharing data, actively involved in planning programs, IVP program provided funding to, IVP program received funding from, and collaborated for policy.

Table 4.
Ranking of Injury and Violence Prevention Partnerships with Non-Governmental Organizations Engaging in Specified Partnership Activities

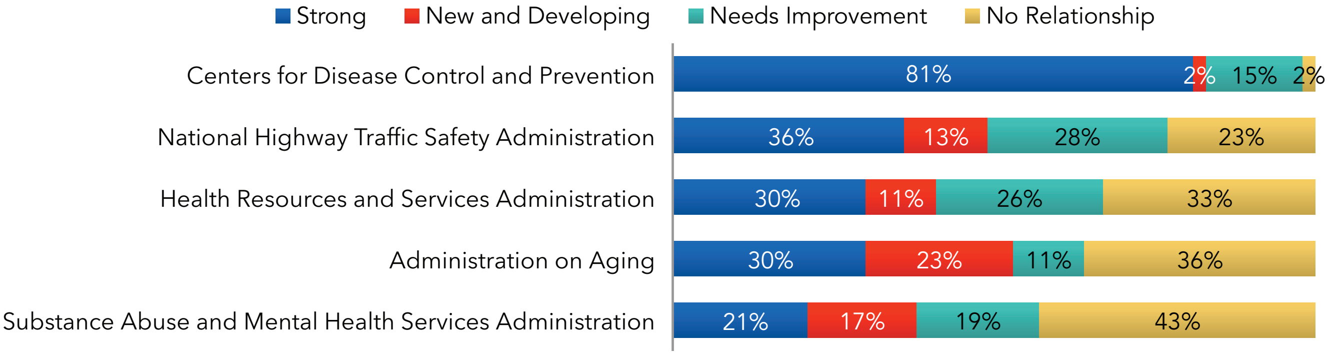
Rank	Legal Agreement or MOU	Shared Data	Actively Involved in Planning, Programs, Etc.	Funding Exchanged		Collaborated for Policy	IVP Program Provided/ Received Training/ Technical Assistance
				IVP Program Provided Funding TO	IVP Program Received Funding FROM		
1	Academic Institutions	Safe Kids Coalitions	Safe Kids Coalitions	Safe Kids Coalitions	Safe Kids Coalitions	Safe Kids Coalitions	Children's Safety Network
2	Safe Kids Coalitions	Brain Injury Association	Brain Injury Association	Brain Injury Association	Businesses	Sports Associations	Academic Institutions
3	ICRCs	ICRCs	Academic Institutions	Academic Institutions, Youth Serving Orgs	Academic Institutions	ICRCs	Safe Kids Coalitions
4	Brain Injury Association	Children's Safety Network	ICRCs	American Red Cross Chapters	Safety Council	Brain Injury Association	ICRCs
5	Youth Serving Orgs	Healthcare Assn	Healthcare Assn	ICRCs	ICRCs	MADD	MPOs

Partnerships with Federal Agencies

State IVP programs were asked to describe the strength of their partnerships with federal agencies. States most commonly reported relationships with the Centers for Disease Control and Prevention (CDC) (98%); 81% reported the relationship as 'strong' while 15% reported it 'needs improvement'.

Several states reported there was not a relationship with the National Highway Traffic Safety Administration (NHTSA) (23%), Health Resources and Services Administration (HRSA) (33%), Administration on Aging (36%), and the Substance Abuse and Mental Health Services Administration (SAMHSA) (43%).

Figure 13.
Top Injury and Violence Prevention Partnerships with Federal Agencies Ranked by Strength, 2011 (N=47)



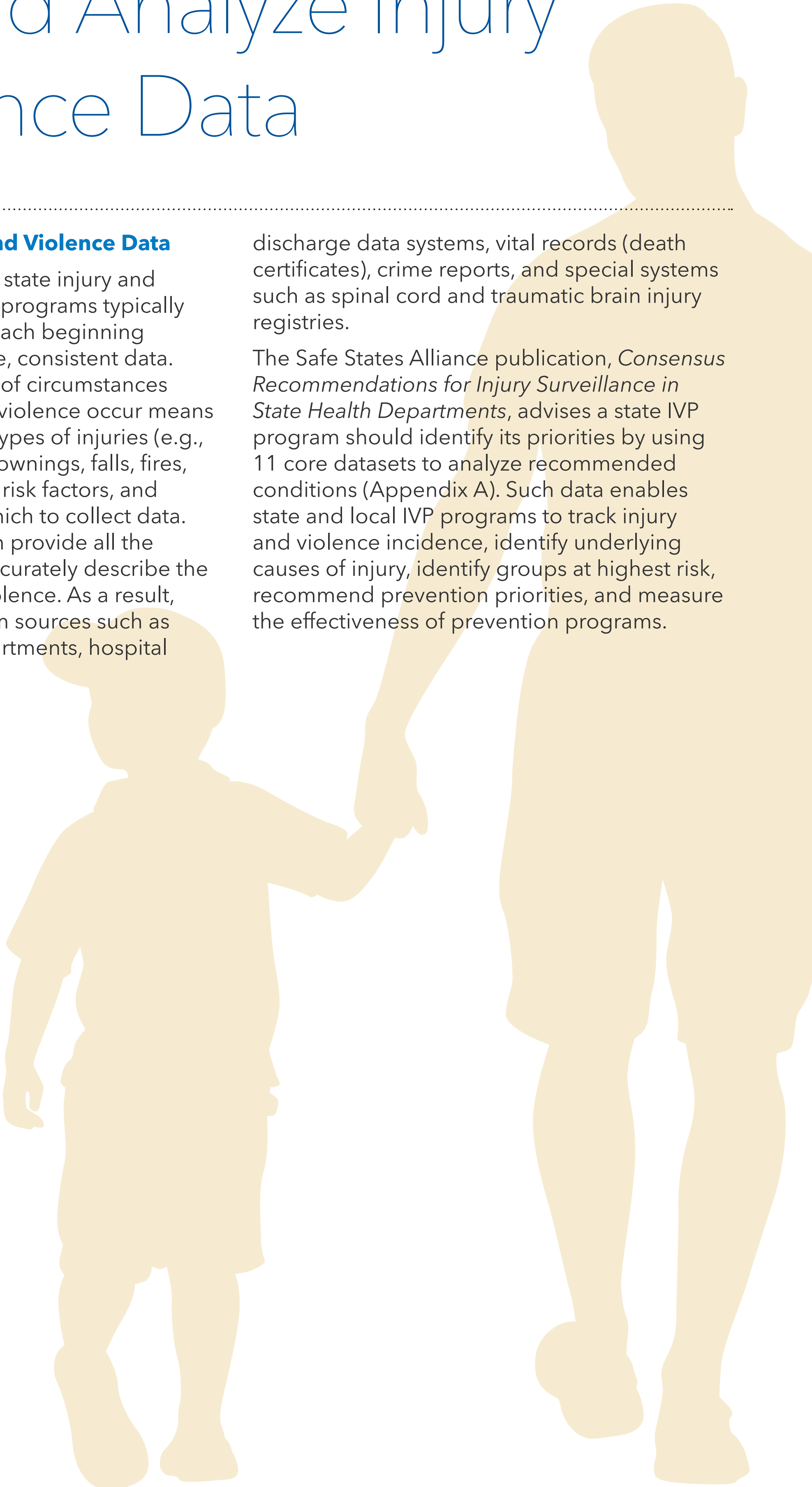
CDC was also the most active IVP partnership in comparison to other federal agencies - ranking first in the following partnership activities: legal agreement/MOU, sharing data, planning programs, received funding from, collaborated for policy, and receiving training/technical assistance.

Table 5.
Ranking of Injury and Violence Prevention Partnerships with Federal Agencies Engaging in Specified Partnership Activities

Rank	Legal Agreement or MOU	Shared Data	Actively Involved in Planning, Programs, Etc.	Funding Exchanged		Collaborated for Policy	IVP Program Provided/Received Training/Technical Assistance
				IVP Program Provided Funding TO	IVP Program Received Funding FROM		
1	CDC	CDC	CDC	Administration on Aging	CDC	CDC	CDC
2	SAMHSA	SAMHSA	SAMHSA	IHS	SAMHSA	NHTSA Safety	IHS
3	HRSA	NHTSA Safety	FHA	-	HRSA		NHTSA Safety
4	IHS	HRSA	IHS	-	NHTSA	IHS	SAMHSA
5	Administration on Aging	FHA	NHTSA	-	FHA	FHA	HRSA

CDC = Centers for Disease Control and Prevention; FHA = Federal Highway Administration; HRSA = Health Resources and Services Administration; IHS = Indian Health Service; NHTSA = National Highway Traffic Safety Administration; and SAMHSA = Substance Abuse and Mental Health Services Administration

Collect and Analyze Injury and Violence Data



Understanding Injury and Violence Data

To track health problems, state injury and violence prevention (IVP) programs typically use a public health approach beginning with the need for accurate, consistent data. However, the wide range of circumstances under which injuries and violence occur means there are many different types of injuries (e.g., motor vehicle crashes, drownings, falls, fires, homicides, and suicides), risk factors, and degrees of severity for which to collect data. No single data source can provide all the information needed to accurately describe the burden of injuries and violence. As a result, programs utilize data from sources such as hospital emergency departments, hospital discharge data systems, vital records (death certificates), crime reports, and special systems such as spinal cord and traumatic brain injury registries.

The Safe States Alliance publication, *Consensus Recommendations for Injury Surveillance in State Health Departments*, advises a state IVP program should identify its priorities by using 11 core datasets to analyze recommended conditions (Appendix A). Such data enables state and local IVP programs to track injury and violence incidence, identify underlying causes of injury, identify groups at highest risk, recommend prevention priorities, and measure the effectiveness of prevention programs.

Access to and Use of Core Datasets

In 2011, state IVP programs' access to and use of core datasets varied (Table 6). As in previous years, all or most state IVP programs reported having access to data from vital records (100%), the Behavioral Risk Factor Surveillance System (BRFSS) (97%), Hospital Discharge Data (HDD) (91%), and the Youth Risk Behavioral Surveillance System (YRBSS) (89%). In contrast, a smaller proportion of states reported access to and use of Child Death Review (CDR) and Fatality Analysis Reporting System (FARS) data in 2011 compared to 2009. Fewer states accessed Emergency Medical Services (EMS) and National Occupant Protection Use Survey (NOPUS) in 2011, but a higher proportion of states reporting access also used the data. Although the number of states reporting having access to BRFSS data remained the same in 2009 and 2011, six (6) fewer states (33 out of 46) reported using this data set for programmatic decisions.

Since the publication of the *Consensus Recommendations for Injury Surveillance in State Health Departments,* the National Violent Death Reporting System (NVDRS) has emerged as a state-based monitoring system designed to eventually create a comprehensive picture of violent death within the U.S. NVDRS reports data from 18 states, and 25 states reported having access to this dataset. This reflects additional states accessing and using NVDRS data for their IVP programs.

Table 6.
Access to Core Datasets and Use of Core Datasets for Programmatic Decisions, 2011 (N=47) and 2009 (N=49)

	2011		2009	
	Accessed Dataset (N)	**Used the Data N(%)**	**Accessed Dataset (N)**	**Used the Data N(%)**
Vital Records	47	43 (91%)	45	43 (96%)
Behavioral Risk Factor Surveillance System (BRFSS)	46	33 (72%)	46	39 (85%)
Hospital Discharge Data (HDD)	43	38 (88%)	43	39 (91%)
Web-based Injury Statistics Query and Reporting System (WISQARS)†	43	31 (72%)	<no data available>	
Youth Risk Behavior Surveillance System (YRBSS)	42	32 (76%)	44	34 (77%)
Child Death Review (CDR)	33	22 (67%)	42	30 (71%)
Emergency Department (ED)	33	26 (79%)	28	28 (100%)
Fatality Analysis Reporting System (FARS)	33	20 (61%)	42	29 (69%)
Medical Examiner	32	24 (75%)	27	21 (78%)
Emergency Medical Services (EMS)	31	18 (58%)	38	19 (50%)
Uniform Crime Reporting System (UCR)	30	19 (63%)	35	27 (77%)
National Violent Death Reporting System (NVDRS) †	25	20 (80%)	20	19 (95%)
State Surveys †	23	19 (83%)	23	19 (83%)
National Occupant Protection Use Survey (NOPUS)	19	14 (74%)	23	11 (48%)
National Trauma Data Bank †	11	3 (27%)	<no data available>	

†Not part of the 11 Core Datasets

Access to and Use of Injury and Violence Data

The reported access to and use of injury and violence data by state IVP programs in 2011 varied by dataset (Table 7). Many state IVP programs used data and information from specific injury and violence topics to report key findings, write reports, evaluate progress, and communicate progress to stakeholders.

At least 90% of states (43 or more states) reported having access to motor vehicle injury data, poisoning data, homicide data, and suicide data. The most common use of data was to report key findings. More than half of the states have reporting access to the most common injury and violence data types also reported using the datasets to report key findings.

Table 7.
Access to Injury and Violence Datasets and Use of Datasets, 2011 (N=47)

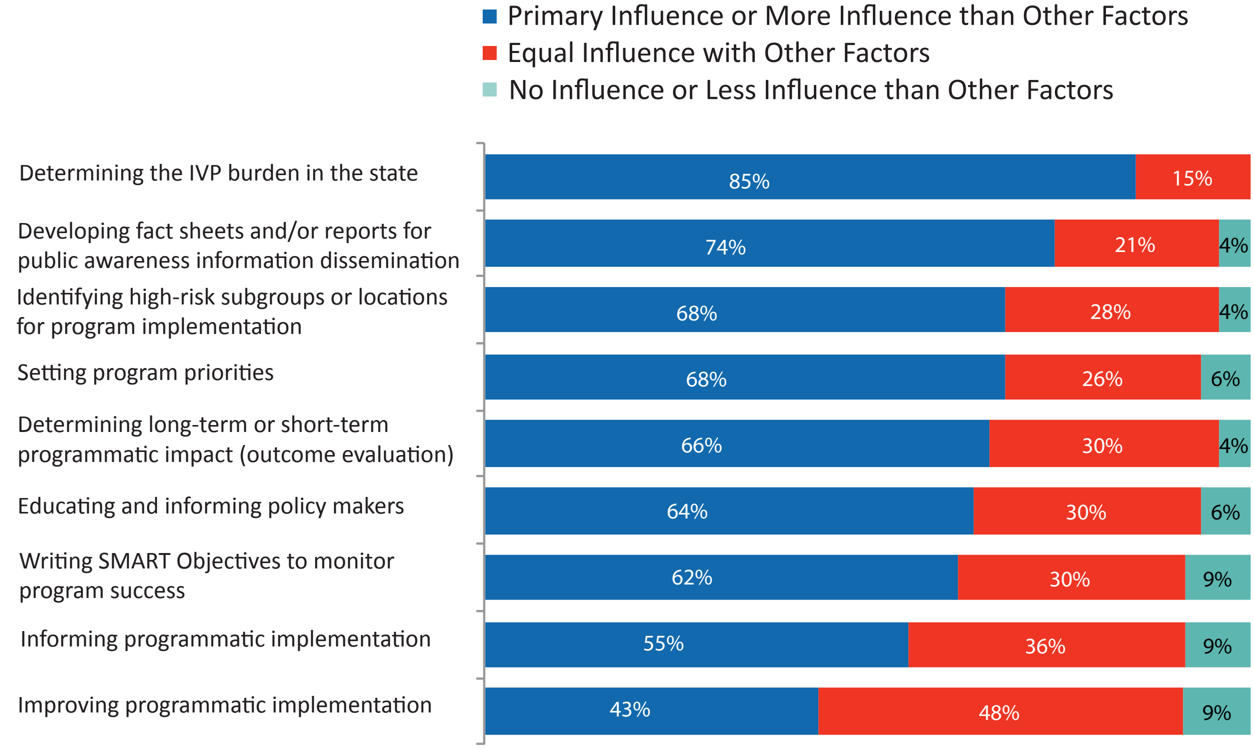
Most Common Injury and Violence Data Types	Access to Dataset (N)	Report Key Findings N (%)	Write Reports N (%)	Evaluate Progress N (%)	Communicate Progress N (%)
Motor vehicle injury data	45	38 (84%)	23 (51%)	23 (51%)	20 (44%)
Poisoning data	45	35 (78%)	23 (51%)	19 (42%)	15 (33%)
Homicide data	45	28 (62%)	18 (40%)	12 (27%)	8 (18%)
Suicide data	43	33 (77%)	25 (58%)	18 (42%)	17 (40%)
Fall injuries data	42	35 (83%)	22 (52%)	21 (50%)	14 (33%)
Traumatic brain injury (TBI) data	42	33 (79%)	20 (48%)	15 (36%)	17 (40%)
Submersion injuries drowning data	42	28 (67%)	19 (45%)	10 (24%)	10 (24%)
Firearm injury data	42	26 (62%)	19 (45%)	11 (26%)	10 (24%)
Fire and burns injury data	42	25 (60%)	19 (45%)	11 (26%)	10 (24%)
Motorcycle injury data	42	24 (57%)	20 (48%)	12 (29%)	9 (21%)

More states reported having access to motor vehicle injury and fall injury data compared to the other top primary focus areas.
The most commonly reported injury and violence primary focus areas for 2011 were motor vehicle injury prevention, fall injury prevention, sexual assault/rape prevention, prevention of injuries to children, and child passenger safety.

The most common partnership and collaboration activity between state injury and violence programs and the health department units/divisions, state government, federal government, and other non-government entities) was sharing data. On average, each state reported sharing data with six (6) partners within each agency type.

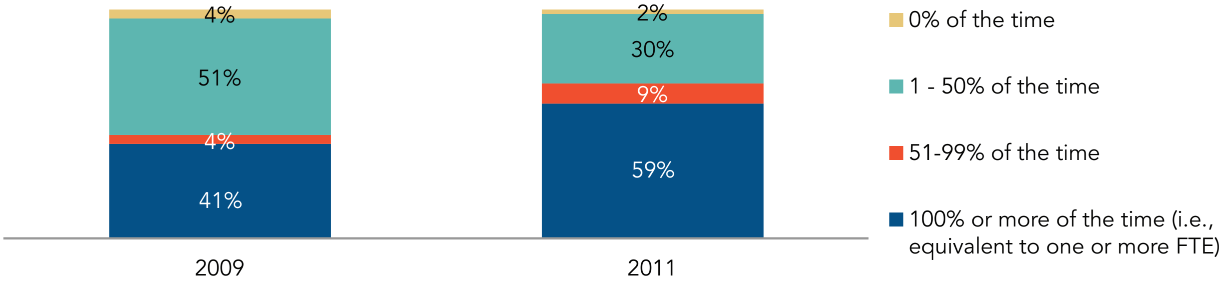
State IVP programs were asked how findings from the analysis of surveillance data influenced their program's engagement in various programmatic activities. The majority of states (85%) reported findings from surveillance data were a primary influence or had more influence than other factors when determining the injury and violence burden in their state (Figure 14). Similarly, when state IVP programs developed fact sheets and/or reports of public awareness/information dissemination, surveillance data was the primary influence on these activities (74%). However, only 43% of state programs reported surveillance data was a primary influence informing their program implementation efforts.

Figure 14.
Influence of Findings from Analysis of Surveillance Data in Specific Activities, 2011



Compared to 2009, state IVP programs reported having greater access to data professionals. In 2011, all but one (1) state (2%) reported access to an epidemiologist, statistician, or other data professional to analyze data for the state IVP program. Many states had access to more than one (1) type of data professional. Sixty-six percent (66%) of states reported having access to a data professional within the state IVP program, 47% reported having access within the State Health Department, 6% reported access by consultant, and 4% reported access by Injury Control Research Center. In 2011, 59% of state IVP programs had access to one (1) or more full-time equivalents (FTEs) whose primary role was data analysis and collection (Figure 15). This was an 18% net increase compared to 2009. At the same time, the percent of state IVP programs accessing a part time data professional (1-99% FTE equivalents) decreased from 55% in 2009 to 39% in 2011.

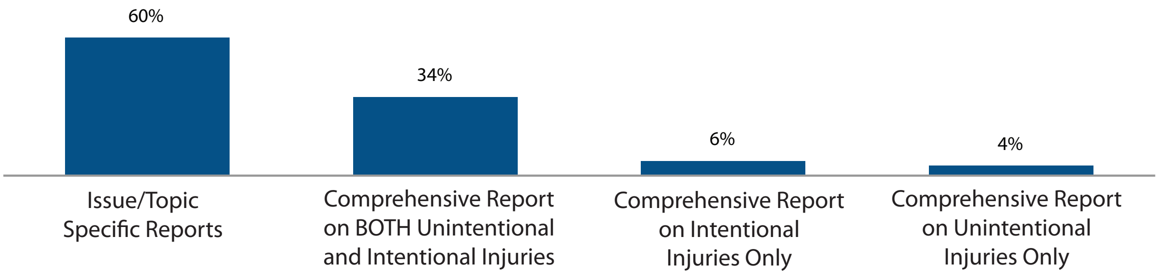
Figure 15.
Percent of Time State Injury and Violence Prevention Programs Have Access to an Epidemiologist, Statistician, or other Data Professional, 2009 (N=49) and 2011(N=47)



In 2011, state IVP programs released a variety of reports. Sixty-percent (60%) of states indicated they released an issue or topic specific report, paper, or other document in 2011 (Figure 16). This is not a significant change from previous years, where 63% of states indicated they released an issue or topic specific report, paper, or other document in 2009. While 34% of state IVP programs released a comprehensive report on both intentional and unintentional injuries, very few released separate, comprehensive reports on intentional injuries only (6%) or unintentional injuries only (4%).

Only ten (10) states (21%) released publications in peer-reviewed journals in 2011, compared to eleven (23%) states in 2009 and 2005. The number of states releasing fall injury-related reports and releasing reports using Hospital Discharge Data increased since 2009. In 2011, 23 states (49%) released a report, paper, or other document specific to falls or fall-related injuries and 27 states (57%) released a report, paper, or other document specifically focused on examining injuries documented in Hospital Discharge Data. Finally, fewer states (57%) made an oral presentation related to IVP at a national or state meeting in 2011 compared to 2009 (69%).

Figure 16.
Types of Reports Released by State Injury and Violence Prevention Programs, 2011 (N=47)



Design, Implement, and Evaluate Programs

Understanding Injury and Violence Prevention Programs & Interventions

Programs and interventions implemented by state injury and violence prevention (IVP) programs should address multiple forms of injury and violence affecting populations across the lifespan – from infancy to advanced age. Given limited resources, state IVP programs should prioritize interventions based on the strongest available evidence, which can reach those at the highest risk of injury. In addition, programmatic approaches should be evaluated regularly to ensure they are appropriately serving their populations and achieving their intended outcomes.

Areas of Program Focus

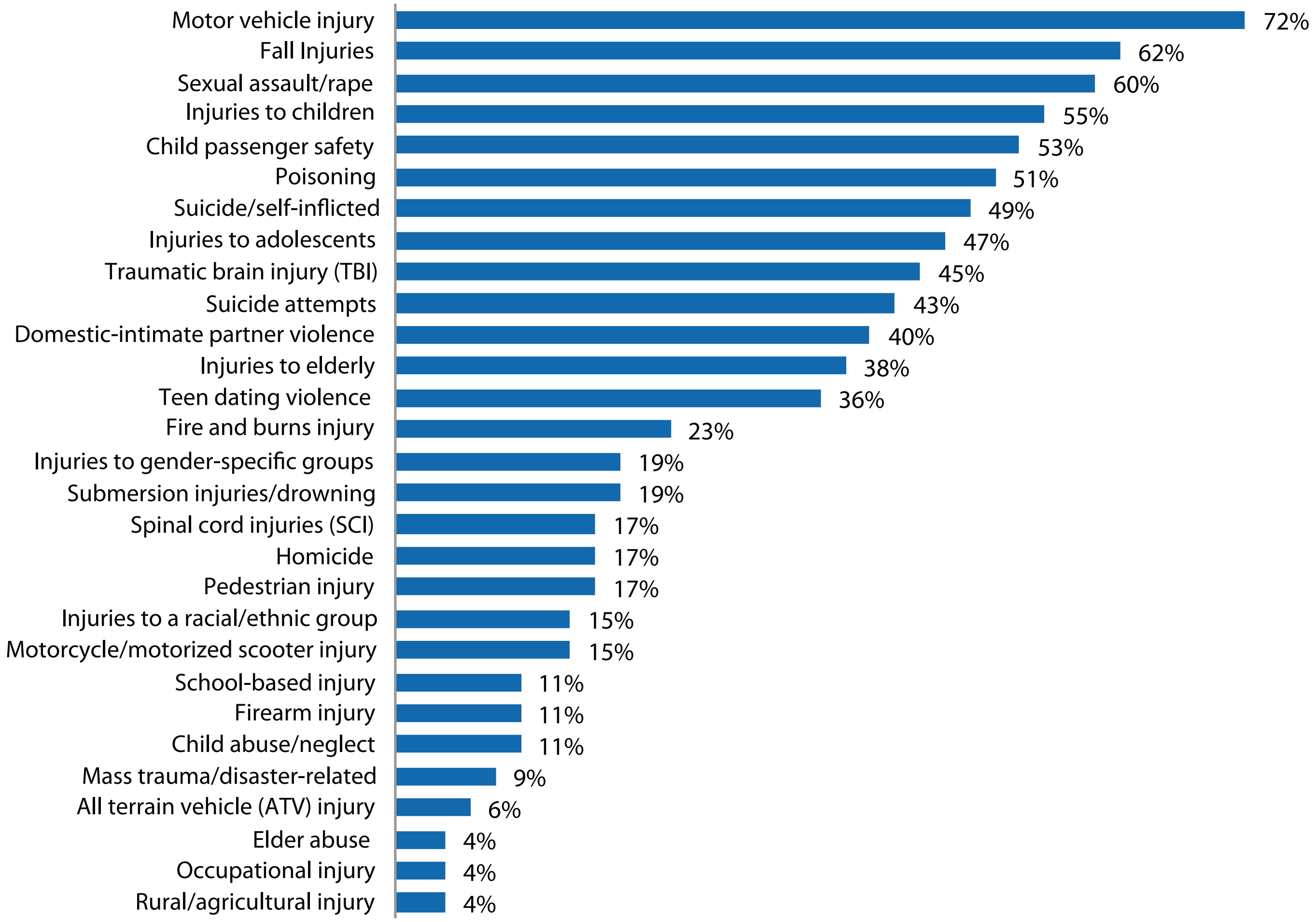
State IVP programs addressed multiple injury and violence areas in 2011. States were provided a list of prevention program topic areas and were asked to identify whether the area was a primary area of focus, secondary area of focus, minimal focus, or not a focus in 2011. Each state could select more than one area of primary focus, and some topics were not mutually exclusive (i.e., motor vehicle injury and child passenger safety). Table 8 provides the most common primary focus areas for the last four (4) survey years.

In 2011, the most commonly reported primary focus areas were motor vehicle injuries (72% of states), fall injuries (62%), sexual assault/rape (60%), injuries to children (55%), and child passenger safety (53%). The topic areas generally not addressed by states in 2011 were mass trauma (70% states reported not addressing this focus area), elder abuse (55% of states did not address this focus area), and occupational injuries (53% of states did not address this focus area). Figure 17 shows the percent of state IVP programs identifying selected injury and violence topics as areas of primary programmatic focus in 2011.

Table 8.
Primary Programmatic Focus Areas among State Injury and Violence Prevention Programs: 2011, 2009, 2007, 2005

Top Primary Focus Areas	2011	2009	2007	2005
1	Motor vehicle injury	Motor vehicle injury	Suicide attempts	Suicide attempts
2	Fall injury	Child passenger safety	Child passenger safety	Sexual assault/rape
3	Sexual assault/rape	Fall injury	Motor vehicle safety	Child passenger safety
4	Injuries to children	Injuries to children	Sexual assault/rape	Traumatic brain injury
5	Child passenger safety	Sexual assault/rape	Injuries to children	Injuries to children
6	Poisoning	Suicide/self inflected injury	Traumatic brain injury	Fall injury
7	Suicide/ self-inflicted injury	Suicide attempts	Fall injury	Fire and burn injury
8	Injuries to adolescents	Traumatic brain injury	Domestic violence/ intimate partner violence	Homicide
9	Traumatic brain injury	Injuries to the elderly	Poisoning	Motor vehicle injury
10	Suicide attempts	Injuries to adolescents	Fire and burn injury	Injuries to the elderly

Figure 17.
Primary Programmatic Focus Areas among State Injury and Violence Prevention Programs, 2011 (N=47)

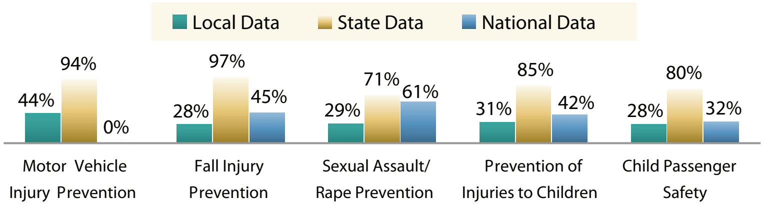


In the 2011 survey, states were asked to convey how areas of primary programmatic focus for IVP efforts were identified. Methods of determination included data, funding directives, needs assessments, state mandates, political influence, and other factors. As seen in Figure 18, data was used by all states selecting the top five (5) programmatic areas for IVP efforts. Specifically, state data was used most often used to determine IVP priorities. Following data, the second and third most common methods of determining primary program focus were funding directives and needs assessments, respectively. State mandates and political influences were the least commonly reported methods of determining primary areas of focus. For example, 86% of states used funding directives whereas 18% used state mandates as a method to choose sexual assault/rape prevention as a primary programmatic focus.

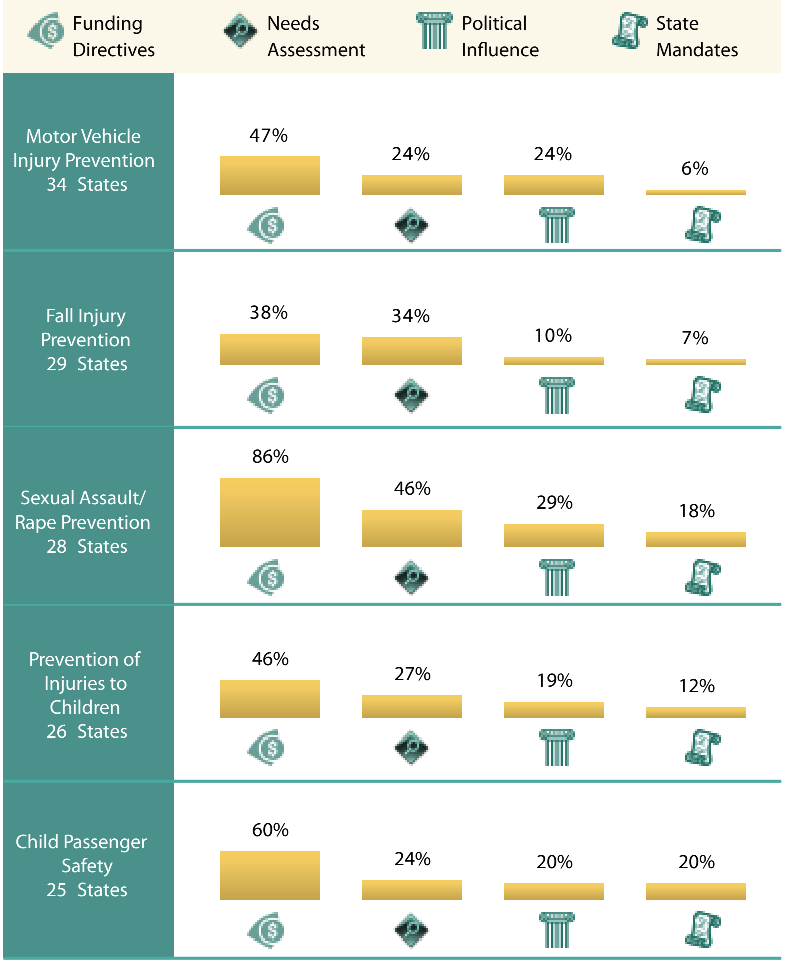
Figure 18.
Methods Used for Selecting Top Five (5) Injury and Violence Topic Areas, 2011

All states used data to select their primary injury and violence topic areas.

The most common data types are:



Other methods used include:



Implementation and Evaluation of Programs

Implementation Plans

More than half of the state health department IVP programs reported having an existing implementation or strategic plan to address their primary programmatic areas. Table 9 shows the IVP program levels of planning for the top five (5) injury and violence topic areas for 2011. While 53% of the states selecting motor vehicle injury as a primary topic area had an existing implementation plan, 26% states reported not having a formal, written plan.

Evaluation Activities & Reporting

Less than half of state health department IVP programs reported having an evaluation plan for their primary programmatic areas (Table 9). In 2011, only four (4) states (15%) primarily focusing on injuries to children had an evaluation plan in place. Although many states reported they did not have evaluation plans, some states conducted evaluation activities (e.g., collecting process and/or outcome evaluation data) to update or change program or policy activities. Child passenger safety programmatic areas had more process (72%) and outcome (64%) evaluation activities than any other primary focus areas.

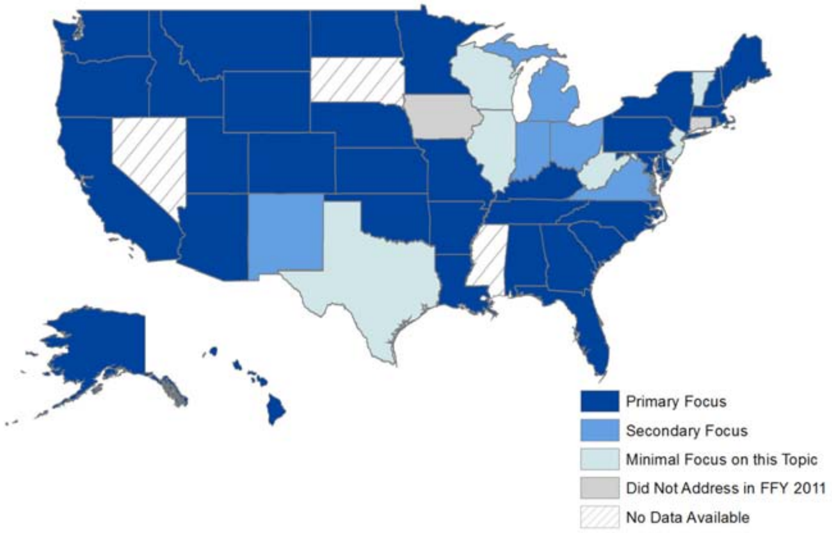
High-level program implementation and evaluation involves reporting program and policy evaluation outcomes to stakeholders. At least half of all states focusing on the five (5) most common primary programmatic areas reported program and policy evaluation outcomes to stakeholders (Table 9). Of the 28 states focusing on sexual assault/rape as a primary area of focus, 61% reported the outcomes to stakeholders, compared to motor vehicle injury prevention, where only 50% of states reported outcomes to stakeholders.

Table 9.
Reported Levels of Programmatic Planning, Evaluation, and Reporting for Five (5) Most Commonly Reported Areas of Primary Program Focus in State Injury and Violence Prevention Programs, 2011

		Motor vehicle injury (N=34)	**Fall injuries (N=29)**	**Sexual assault/rape (N=28)**	**Injuries to children (N=26)**	**Child passenger safety (N=25)**
Implementation Plans	Implementation plan exists	18 (53%)	20 (69%)	22 (79%)	13 (50%)	18 (72%)
	No written formal implementation plan	9 (26%)	7 (24%)	3 (11%)	7 (27%)	3 (12%)
Evaluation	Evaluation plan exists	10 (29%)	12 (41%)	14 (50%)	4 (15%)	12 (48%)
	Process evaluation data is collected to update or change program and/or policy activities	16 (47%)	16 (55%)	18 (64%)	9 (35%)	18 (72%)
	Outcome evaluation data is collected to update or change program and/or policy activities	16 (47%)	14 (48%)	11 (39%)	10 (38%)	16 (64%)
Dissemination of Findings	IVP program reports program and/or policy outcomes to stakeholders	17 (50%)	16 (55%)	17 (61%)	14 (54%)	15 (60%)

Highlights of Selected Injury and Violence Topic Areas

Figure 19.
State Program Focus: Motor Vehicle Injury Prevention, 2011


Primary Focus
Secondary Focus
Minimal Focus on this Topic
Did Not Address in FFY 2011
No Data Available

Nationally, state injury and violence prevention programs invested

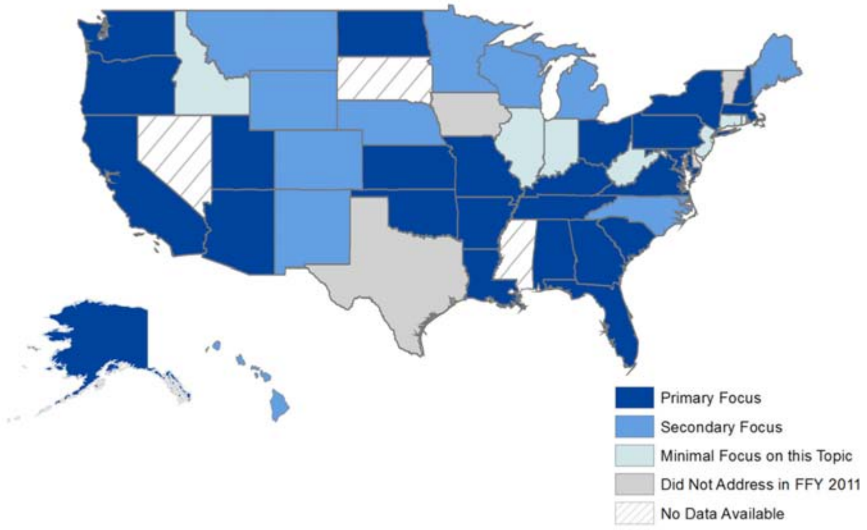
$33.3 million

in motor vehicle injury prevention efforts, which contributed to

117 FTEs

34 states identified motor vehicle injury prevention as a primary focus area

Figure 20.
State Program Focus: Child Passenger Safety, 2011


Primary Focus
Secondary Focus
Minimal Focus on this Topic
Did Not Address in FFY 2011
No Data Available

Nationally, state injury and violence prevention programs invested

$27.5 million

in child passenger safety efforts, which contributed to

90 FTEs

25 states identified child passenger injury prevention as a primary focus area

Table 10 shows the most common motor vehicle injury prevention programs implemented by state IVP programs in 2011. The most common motor vehicle injury prevention programs were related to child passenger safety (90%), seat belt use (58%), bicyclist and/or pedestrian safety (55%), and teen driving/Graduated Drivers Licensing (48%). For each program, more than half of states planned a process and/or outcome. Of the states conducting evaluations of motor vehicle injury prevention programs, a majority yielded results showing their programs to be effective. However, among the four (4) most common programs, only 29% of state IVP programs generated evaluation results showing their child passenger safety programs to be effective.

Table 10.
Most Common Motor Vehicle Injury Prevention Programs, 2011 (N=31)

Program	N (%)	Evaluation planned	Evaluation results showed the program to be effective
Child Passenger Safety	28 (90%)	86%	29%
Seat belt use	18 (58%)	78%	57%
Bicyclist and/or pedestrian safety	17 (55%)	59%	30%
Teen driving/Graduated Drivers Licensing (GDL)	15 (48%)	87%	38%

Provide Technical Support and Training

Understanding Injury and Violence Prevention Technical Assistance and Training

Knowledgeable staff members are necessary for a state public health injury and violence prevention (IVP) program to succeed. State IVP programs should also be equipped to provide practical training and technical support to state and local professionals, students, and the general public. Trainings – whether conducted on the job, virtually, or in classroom settings – should address both foundational and advanced skill-building in the principles, practices, and competencies necessary to successfully conduct injury and violence prevention activities. Developed by the National Training Initiative (NTI), the *Core Competencies for Injury and Violence Prevention*[16] are an essential resource to providing guidance for training initiatives.

Technical Support and Training Methods

Ninety-six percent (96%) of state IVP programs provided some form of training or technical support to partners, grantees, and others engaged in IVP efforts in 2011. State IVP programs used a variety of methods to deliver technical support and training to program partners; the two (2) most commonly reported methods were conducting in-person trainings (84%) and responding to requests for technical assistance (82%). These were also the most commonly reported methods in 2009. In 2011, over one-third of states offered practical experiences for students, conducted distance learning via computer, and/or offered courses for academic credit or CEUs. The percent of states using each method remained fairly consistent from 2009 to 2011, except for conducting distance learning via computer, in which a net increase of 18% was reported.

Table 11.
Methods Used by Injury and Violence Prevention Programs to Provide Technical Support and Training, 2011 and 2009

	2011 (N=47)	2009 (N=49)
Conducted in-person training (workshops, conference sessions, presentations, etc)	38 (84%)	41 (84%)
Responded to requests for technical assistance	37 (82%)	41 (84%)
Offered practical experience for students	18 (40%)	20 (41%)
Conducted distance learning via computer (internet based, webcast, or CD-ROM)	17 (38%)	10 (20%)
Offered courses for academic credit or CEUs	15 (33%)	18 (37%)
Conducted distance learning via satellite, video conference, or video tape	7 (16%)	10 (20%)

State IVP programs with a full-time director were significantly more likely to implement the following methods of providing technical assistance and training:

- Offered practical experience to students (p=0.037)
- Responded to request for technical assistance (p=0.010)
- Offered courses for academic credit or CEUs (p=0.004)

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16. Core Competencies for Injury and Violence Prevention. Developed by the National Training Initiative for Injury and Violence Prevention (NTI) – a joint project of the Safe States Alliance and the Society for the Advancement of Violence and Injury Research (SAVIR). May 2005. Available at www.safestates.org/NTICoreCompetencies.

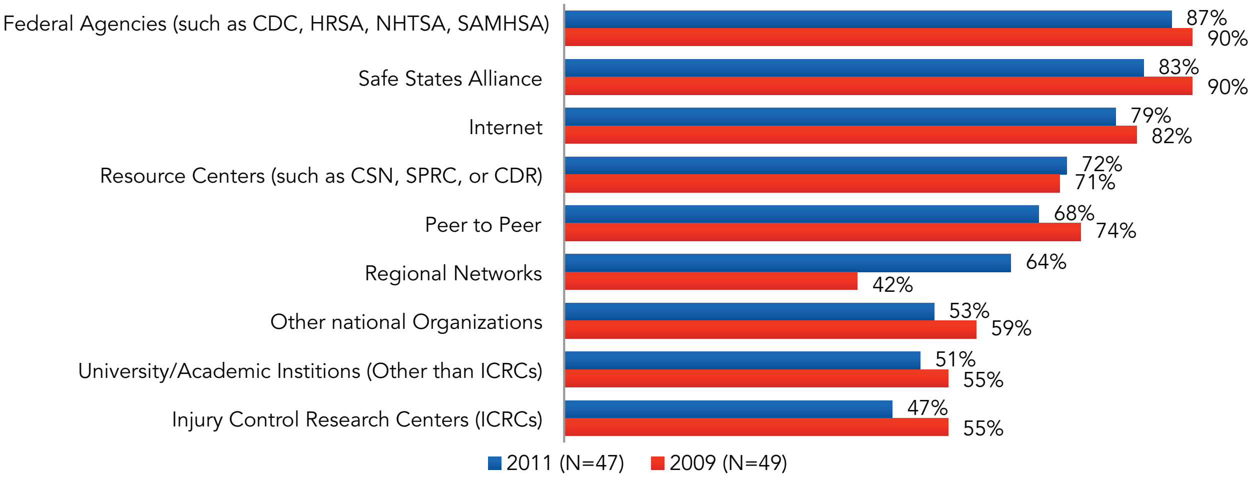
In the 2011 survey, state IVP programs were also asked questions regarding their awareness and use of the NTI *Core Competencies for Injury and Violence Prevention*. Eighty-seven percent (87%, N=41) of state IVP programs reported they were aware of the NTI Core Competencies. However, only six (6) states (13%) reported they always or frequently conducted trainings explicitly and consciously incorporating each of the Core Competencies.

National Training Initiative (NTI) Core Competencies
More information about the Core Competencies can be found at www.safestates.org/NTICoreCompetencies

- Ability to describe and explain injury and/or violence as a major social and health problem;
- Ability to access, interpret, use and present injury and/or violence data;
- Ability to design and implement injury and/or violence prevent activities;
- Ability to evaluate injury and/or violence prevention activities;
- Ability to build and manage an injury and /or violence prevention program;
- Ability to disseminate information related to injury and/or violence prevention to the community, other professionals, key policy makers and leaders through diverse communications networks;
- Ability to stimulate change related to injury and/or violence prevention through policy, enforcement, advocacy and education;
- Ability to maintain and further develop competency as an injury and/or violence prevention professional; and
- Demonstrate the knowledge, skills and best practices necessary to address at least one specific injury and/or violence topic and be able to serve as a resource regarding that area.

Compared to 2009, fewer state IVP programs reported using various technical assistance resources available to their programs in 2011, with the exception of Resource Centers, such as Children's Safety Network or Suicide Prevention Resource Center, (72%), and Regional Networks (64%), (Figure 21). The most commonly reported resources for technical assistance used by state IVP programs in 2011 were federal agencies (87%) and the Safe States Alliance (83%). In 2011, Regional Networks were supported and funded through the Centers for Disease Control and Prevention Core Violence and Injury Prevention Program (Core VIPP) grant as an expanded component from the Base Integration Component (BIC). Eleven (11) additional states reported using Regional Networks as a technical assistance resource in 2011, compared to 2009.

Figure 21.
Top Technical Assistance Resources Used by State Injury and Violence Prevention Programs, 2011 and 2009



Communication Methods

All (100%) of the 47 state IVP programs surveyed provided some form of communication to target populations, program partners, local groups, and others engaged in injury and violence prevention in 2011. This is very similar to the results from the 2009 and 2007 surveys, in which 100% (49) and 98% (49), respectively, reported providing such communication.

State IVP programs used multiple methods to communicate injury and violence-related information. The most commonly reported method was participation in steering committees and meetings (94%); this was also the most commonly used method cited in the 2009 and 2007 surveys (86% and 96%, respectively). Websites were also cited as a common communication method (72%). Less than a third of states used newsletters or regular mailings as regular communication methods – a finding consistent with results documented in 2009 (20%) and 2007 (30%).

Affect Public Policy

Understanding Policy Approaches to Injury and Violence Prevention

Policy interventions are effective community and societal level strategies for improving population health. Injury and violence prevention (IVP) professionals can use policies to influence systems development, organizational change, social norms, and individual behavior to promote improvements in the health and safety of entire communities.

The most effective policy changes are grounded in scientific evidence, embraced by a variety of stakeholders, and championed by policy makers. It is important for a state IVP program to have established methods of informing policy decisions, which may impact rates of injuries and violence.

Methods to Inform Policy†

State IVP programs used multiple methods to inform public, regulatory, and/or organizational policies, both directly and through collaboration with partners (Table 12).

The most common methods used by state IVP programs in 2011 to inform policy included:

- Working to create/encourage adoption of organizational policies for injury and violence prevention (64%);
- Working to increase public awareness of laws (64%);
- Participating in boards and/or commissions (59%); and
- Recommending health department positions on bills (59%).

Most methods used directly by state IVP programs to inform policy decreased in 2011 compared to 2009. However, three methods – developing and enforcing regulations, inviting state or local legislators to meetings/events, and inviting Congressional delegates to meetings/events – had a net increase of 6%, 3%, and 11%, respectively (as indicated by up arrows in Table 12). Additionally, 11% of state IVP programs invited congressional delegates to meetings and events; no states reported using this method in 2009.

Overall, a higher percentage of methods for informing policy were used in collaboration with partners compared to those used directly by the state IVP program. The most common methods used through collaboration with partners were:

- Working to increase public awareness of laws (80%);
- Participating in boards and/or commission (73%);
- Sending materials to policy makers (73%); and
- Working to develop/enforce regulations for injury and violence prevention (71%).

Between 2009 and 2011, the greatest net increases in methods used through collaboration with partners included inviting state or local legislators (net 27% increase) and inviting congressional delegates (net 16% increase) to meetings and/or events (as indicated by up arrows in Table 12). The methods used through collaboration with the greatest net decrease were recommending health department positions on bills (net 37% decrease) and requesting opportunities to review bills (net 33% decrease).

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† There is immense variability in how state health departments engage in legislative activities. States have varying guidelines and prohibitions that govern their interactions with legislators, which impact the type of activities that are legally allowable in each state. The findings published here are aggregate data reflecting survey responses.

Table 12.
2011 Methods Used by State Injury and Violence Prevention Programs to Inform Public Policy and Net Changes from 2009

Public Policy Method	Used Directly by the State IVP Program in 2011	Net Change in Method Used Directly by the State IVP Program from 2009	Net Change in Method Used Through Collaboration with Partners from 2009
Worked to create encourage adoption of organizational policies for IVP	64%	0%	▼ 4%
Worked to increase public awareness of laws	64%	▼16%	▼ 2%
Participated in boards and or commissions	59%	▼10%	▲ 2%
Recommended health department positions on bills	59%	▼19%	▼37%
Requested opportunity to review bills	53%	▼18%	▼33%
Worked to develop/enforce regulations for IVP	48%	▲ 6%	▲ 9%
Evaluated/assessed/monitored impact of laws	45%	▼23%	▼33%
Sent materials to policymakers	42%	0%	▲ 9%
Met with policymakers	34%	▼ 6%	▲ 4%
Testified at state and local hearings	30%	▼ 4%	▲ 4%
Invited state or local legislators to meetings/events	27%	▲ 3%	▲27%
Conducted cost benefit analyses of IVP policies	24%	▼ 4%	▼20%
Drafted and submitted potential policies to policymakers	16%	▼15%	▲ 9%
Invited Congressional delegates to meetings/events	11%	▲11%	▲16%

State IVP programs with access to an evaluator were significantly more likely to engage in more methods to inform policy. States with access to an evaluator were significantly more likely to:

- Work to create/encourage adoption of organizational policies for IVP (p=0.033);
- Participate in boards and/or commissions (p=0.009);
- Request opportunity to review bills (p=0.041); and
- Invite state or local legislators to meetings events (p=0.042).

Similarly states with access to an epidemiologist, statistician, or other data professional were significantly more likely to:

- Send materials to policymakers (p=0.018);
- Testify at state and local hearings (p=0.025); and
- Invite state or local legislators to meetings events (p=0.047);

States with a full-time director on staff were significantly more likely to:

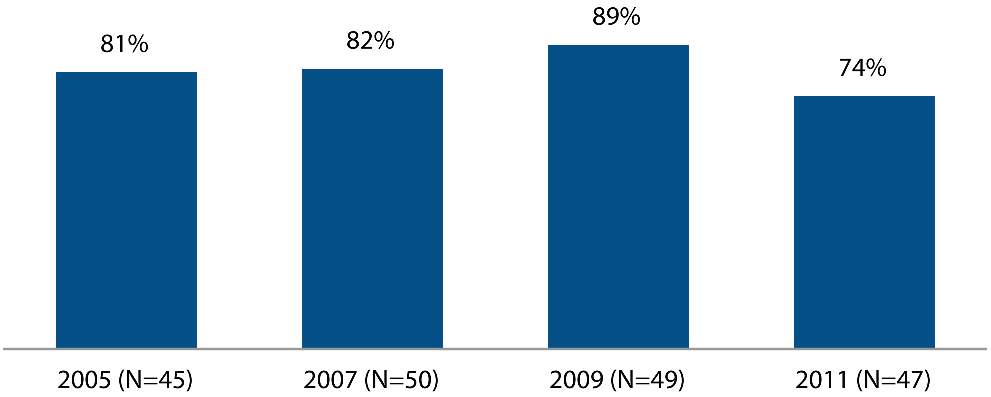
- Work to increase public awareness of laws (p=0.037);
- Request opportunity to review bills (p=0.008); and
- Invite state or local legislators to meetings.

State IVP programs with access to an evaluator, epidemiologist, and/or a full-time director were significantly more likely to engage in specific methods to inform public policy.

Seventy-four percent (74%, N=35) of state IVP programs holding a legislative session in 2011 (or during a similarly recent period) reported having mechanisms or protocols for communicating with policy makers about IVP (Figure 22). This represents a decrease in the percentage of states reporting having mechanisms or protocols for communicating with policy makers in 2009, 2007, and 2005 (89%, 82%, and 81%, respectively). In particular, these results indicate a 15% net decrease between 2009 and 2011.

However, 47% of state injury and violence prevention programs indicated they maintained a record of existing state policies (e.g., laws, regulations, etc.) related to injury and violence prevention in 2011. This was an increase from 2009 and 2007 (38% and 43%, respectively).

Figure 22.
Injury and Violence Prevention Programs with Mechanisms or Protocols for Communicating with Policy Makers about Injury and Violence Prevention Issues: 2005, 2007, 2009, and 2011



Application of Policy Efforts to Injury and Violence-Related Topic Areas

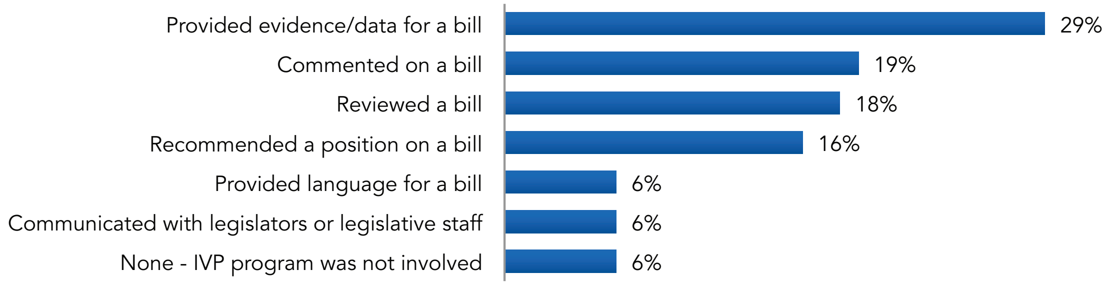
The majority of state IVP programs addressed injury and violence-related topics using a variety of policy strategies in 2011 (92%, N=44). As shown in Table 13, policy strategies were most commonly used to address the following topics: motor vehicle injury prevention (34 states), child passenger safety (25 states), and prevention of injuries to children (18 states). All states working on motor vehicle injury prevention and child passenger safety implemented policy strategies in 2011.

Table 13.
Top Programmatic Focus Areas and State Injury and Violence Prevention Programs Implementing Policy Strategies, 2011

Topic Area	Number of States Selecting Area as Primary Focus, (N)	IVP Program Implementing Policy Strategies, N (%)
Motor vehicle injury	34	34 (100%)
Fall injuries	29	12 (41%)
Sexual assault/rape	28	17 (61%)
Injuries to children	26	18 (69%)
Child passenger safety	25	25 (100%)

In particular, motor vehicle injury prevention was a topic area in which strong evidence existed to support policy strategies as a means of reducing crashes, injuries, and roadway fatalities. Of the 36 states with programs or activities related to motor vehicle injury prevention in 2011, 86% (31) of states reported having bills either drafted or proposed during the 2011 (or most recent) legislative session. However, only two states had bills eventually passing with modifications during these sessions. As shown in Figure 23, 29% of state IVP programs participating in motor vehicle policy work also provided evidence or data for a bill and 19% commented on a bill.

Figure 23.
Policy Activities Conducted by State Injury and Violence Prevention Programs Related to Motor Vehicle Prevention



Acknowledgements

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This document would not have been possible without the participation of injury and violence prevention professional across the United States. The states completing the 2011 survey and providing data will help inform the development and growth of future state injury and violence prevention efforts. Furthermore, the implementation of this survey would not have been successful without the contributions of the states piloting the survey in advance of the full implementation: Kentucky and Maryland. This report was developed with editorial support from Linda Scarpetta, MPH Michigan Department of Community Health; Shelli Stephens Stidham, MPA, Injury Center of Greater Dallas; Michael Bauer, MS, New York Department of Health; Dolly Fernandes, M.Ed, Washington State Department of Health; Carol Thornton, BA, MPA, Pennsylvania Department of Health; Carlene Pavlos, MTS, Massachusetts Department of Health; and, Lori Haskett, Kansas Department of Health and Environment.

Shenee Bryan, MPH/MPA, Safe States Evaluation Manager, conducted the analysis of the 2011 survey data, as well as analyses comparing 2011 data to previous surveys. Mrs. Bryan developed the *State of the States: 2011 Report* with editorial support from Amber N. Williams, Safe States Executive Director; Jamila M. Porter, MPH, Safe States Assistant Director of Programs; and, Amirah Patterson, MPH, Safe States Program and Evaluation Specialist.

Appendix A: Glossary of Terms

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, the Safe States Alliance developed a list of working definitions for common injury and violence prevention terms.

It is important to note 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. 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.

Data sets

In 2007, the Safe States Alliance publication, *Consensus Recommendations for Injury Surveillance in State Health Departments*[17], provided an update to the 1999 version of the recommendations report[18] , and reaffirmed the 11 core data sets for injury surveillance previously identified to support injury and violence prevention programs and policies. The 1999 recommendation report also provided data set definitions, which are presented below. If available, updated information was included in these definitions. The National Violent Death Reporting System (NVDRS) also included in these definitions.

1. *Vital records* include birth certificates and death certificates. Death certificates classify injuries by external cause of death (E-codes). All fatal injuries with E-code classifications can be monitored with death certificate data. The residence of the deceased is recorded on the death certificate, so population-based injury cause-of-death data can be generated from this data set for large or small geopolitical units. Death certificate data capture the most severe injuries, and therefore are important for creating and evaluating programs and policies, but they do not capture less serious and more common injuries. Risk factor information is not generally recorded on death certificates.

2. *Hospital discharge data* are generated from uniform hospital billing forms used in many states to bill for hospital services. This form has a dedicated field for recording an E-code. According to a recent MMWR[19], as of 2007:
    - 46 (90%) of the 50 states and the District of Columbia had a statewide hospital discharge data system (HDDS) in place;
    - 41 (89%) of the 46 states and the District of Columbia had a statewide HDDS routinely collect some level of E-codes in their statewide HDDS; and
    - 26 (63%) of the 41 states and the District of Columbia routinely collect some level of E-codes had mandated E-coding in their statewide HDDS.

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[17] Injury Surveillance Workgroup 5, Consensus Recommendations for Injury Surveillance in State Health Departments. Atlanta (GA): State and Territorial Injury Prevention Directors Association, 2007.

[18] Injury Surveillance Workgroup 1, Consensus Recommendations for Injury Surveillance in State Health Departments. Atlanta, GA: State and Territorial Injury Prevention Directors Association; 1999.

[19] Centers for Disease Control and Prevention. Strategies to Improve External Cause-of-Injury Coding in State-Based Hospital Discharge and Emergency Department Data Systems. Recommendations of the CDC Workgroup for Improvement of External Cause-of-Injury Coding. MMWR 2008;57(RR01):1-15.

Statewide hospital discharge data sets, like vital records, provide population-based injury data. Like vital records, these data can be stratified by county and city. Hospital discharge data may be more useful than vital records for surveillance in less-populated areas where some causes of injury death occur infrequently. Risk factor information is not recorded on hospital billing forms. Incidence rates may sometimes be inaccurate because of measurement problems in the hospital discharge data system. For example, if an injured person is treated at more than one hospital, the injury may be counted more than once, or if a person has multiple concurrent injuries some of them may not be counted. Also, hospital discharge data are affected by changes in the health care system influencing hospital admissions and coding practices. These changes may compromise the utility of these data for monitoring trends in injury morbidity.

3. *Fatality Analysis Reporting System* (FARS) data describe in detail all fatal motor vehicle injuries occurring on public roads. This data set contains a wealth of risk factor information on drivers, passengers, vehicles, and driving conditions at the time of the crash. FARS is population-based at state, county, and city levels. Some states also have centralized crash report data sets for non-fatal motor vehicle injuries. A few states have linked crash data to other data sets, including emergency medical services data, emergency department data, hospital discharge data, medical examiner and coroner data, and vital records. These linked data systems are known as Crash Outcome Data Evaluation Systems (CODES). CODES can be used to assess the effects of multiple risk factors such as seat belt and safety seat use on motor vehicle injury outcomes.

4. *Behavioral Risk Factor Surveillance System* (BRFSS) data are obtained by household telephone surveys. Specific questions on the surveys address the use of seat belts, safety seats, bicycle helmets, and smoke alarms, as well as risky behaviors such as drinking and driving. BRFSS data are representative of the population of the state collecting the data, but the data cannot be stratified by county or city without modifications of the survey sampling strategy. Survey respondents are limited to adults in households with telephones.

5. *Youth Risk Behavior Surveillance System data* are obtained from school-based surveys conducted every two (2) years to monitor risk behaviors for students in grades 9-12. Specific questions address seat belt use, suicide attempts, fighting, weapon carrying, and riding with a drunk driver. These data are representative of the national population of students in grades 9-12, which excludes only about five (5) percent of adolescents in this age group (who do not attend school).

6. *Emergency department data* are available in some states through a statewide hospital emergency department data system (HEDDS). According to a recent MMWR[20] as of 2007:
   - 27 (54%) of the 50 states and the District of Columbia had a statewide HEDDS;
   - 25 (93%) of the 27 states and the District of Columbia with a statewide HEDDS routinely collected some level of E-codes in their statewide HEDDS; and
   - 18 (72%) of the 25 states and the District of Columbia routinely collected some level of E-codes had mandated E-coding of their statewide HEDDS.

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[20] Centers for Disease Control and Prevention. Strategies to Improve External Cause-of-Injury Coding in State-Based Hospital Discharge and Emergency Department Data Systems. Recommendations of the CDC Workgroup for Improvement of External Cause-of-Injury Coding. MMWR 2008;57(RR01):1-15.

Injuries treated in emergency departments, not severe enough to require hospital admission, are more common than injury hospitalizations. Therefore, emergency department data are superior to hospital discharge data for tracking injuries, which are common, but not severe. Because injuries requiring emergency treatment but not hospitalization are common, emergency department data may be useful for assessing injury and violence prevention priorities in sparsely populated areas where injury deaths and hospitalizations may occur too infrequently to be useful. Moreover, emergency department visits are less likely than overnight hospital admissions to be affected by changes in the health care system. Therefore, emergency department data systems, if they are population-based, may be superior to hospital discharge data systems for injury morbidity surveillance. Unfortunately, risk factor data such as the circumstances of injury and the use of safety devices, are not often captured on emergency department records or hospital discharge records.

7. *Medical examiner systems* existed in 21 states and the District of Columbia in 2001, while 10 states had coroner-based systems and 19 states had a mixed medical examiner and coroner system.[21] A medical examiner is usually a licensed physician, but a coroner does not have to be a physician and may have little or no formal medical training. For surveillance purposes, the ideal medical examiner system is statewide, population-based, and has standardized systems of death certification and data management. Since 1987, the national Medical Examiner and Coroner Information Sharing Program has been working to improve the quality of data on death certificates and to increase the availability of these data for injury and violence prevention. Medical examiner and coroner reports are medico-legal documents, and therefore, the circumstances of intentional injuries are often well described. Information is often available on the use of alcohol and other drugs. The Institute of Medicine has recently recommended expanding medical examiner and coroner systems to create a fatal intentional injury surveillance system for all homicides and suicides, modeled after the Fatality Analysis Reporting System (FARS). Currently, state medical examiner and coroner systems do not capture all deaths, although a few capture all injury deaths.

8. *Child death review data* are gathered and analyzed by child death review teams to explore the circumstances surrounding the deaths of children for the purpose of preventing future deaths. All states have state and/or local child death review teams. Many child death reviews focus on the prevention of child abuse deaths, but child death review teams have also applied their findings to the prevention of motor vehicle injuries, suicides, firearm injuries, traumatic brain injuries, fall injuries, fire and burn injuries, and poisonings.

9. *National Occupant Protection Use Survey* (NOPUS) data are obtained from direct observations of passenger vehicle occupants to evaluate shoulder-belt use, motorcycle helmet use, and child safety seat use. These data are used primarily to monitor compliance with safety standards for the purpose of awarding federal funds to states. The data are assumed to be representative of the state where they were collected, but cannot be further stratified by county or city.

10. *Uniform Crime Reporting* (UCR) System data are based on voluntary reports from law enforcement agencies. The Supplementary Homicide Report to the UCR System collects information on homicide incidents, although detailed information on the homicide weapon is not available.

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21. Centers for Disease Control and Prevention. Medical examiners, coroners, and biologic terrorism: a guidebook for surveillance and case management. MMWR 2004; 53 (No. RR-8):1-27.

11. *Emergency medical services* (EMS) data are collected from ambulance run reports for injuries and other medical emergencies. The data are most useful for assessing EMS transport times and the medical condition of the injured person upon EMS arrival and during subsequent transport to definitive care. EMS data may provide useful information for submersion injuries, such as the location of the submersion incident, duration of the submersion and neurologic status of the submersion victim.

12. *The National Violent Death Reporting System* (NVDRS) is an active, state-based surveillance system collecting information on homicides, suicides, deaths of undetermined intent (i.e., those for which available information is insufficient to enable a medical or legal authority to make a distinction among unintentional injury, self-harm, or assault), deaths from legal intervention (e.g., involving a person killed by an on-duty police officer), and unintentional firearm deaths. As of 2007, CDC funded 18 states to implement NVDRS. They are Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Michigan, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, and Wisconsin. NVDRS uses a multi-source approach (i.e., death certificates, coroner/medical examiner reports, law enforcement records, and crime laboratory data) for analysis of violent deaths. Using information from all of these sources, data abstractors in each state assign a manner of death (i.e., suicide, homicide, unintentional firearm deaths, legal interventions, and undetermined deaths) to each case. NVDRS also collects the International Classification of Diseases, 10th Revision (ICD-10) code for underlying cause of death (UCOD), circumstances contributing to the death, and characteristics of the death, including victim-suspect relationship and victim toxicology results. The UCOD is categorized as suicide or homicide using standard definitions from the National Vital Statistics System (NVSS).[22]

All of the injuries recommended for core surveillance can be monitored successfully with access to just two (2) core data sets: vital records and hospital discharge data. All states have vital records data, and as of 2007, 41 states routinely collected some level of E-codes in their statewide HDDS. Therefore state injury and violence prevention programs building state injury surveillance systems should begin by accessing death certificate data as well as E-coded hospital discharge data, if available. The remaining core data sets can then be added to strengthen these injury surveillance systems.

Evaluation Plan

An evaluation plan is designed to inform and provide evidence to stakeholders about progress being made within the program and its activities. The evaluation plan is carried out through the use of surveillance systems and routine monitoring, measurement, and assessment of interventions and activities supporting the strategic plan.

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[22] Centers for Disease Control and Prevention. Homicides and Suicides – National Violent Death Reporting System, United States, 2003–2004. MMWR 2006; 55: 721-724.

Injury

Injury is the physical damage resulting when a human body is suddenly subjected to energy in amounts exceeding 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.

Integration

Integration is the process whereby formal units jointly pursue a shared objective in order to improve the health of the population.[23] They do this through joint[24,25]:

- Decision-making, priority-setting, planning;
- Responsibility for program development, co-investment, resource sharing & development, implementation, evaluation, program improvement;
- Mutual accountability for results & stewardship; and
- Sharing of risks and rewards.

Guiding principles for integrating programs include:

- Do no harm to categorical program integrity;
- Clearly identify and state mutual benefits and opportunities;
- Be guided by efficiency-oriented processes;
- Be focused on health outcomes;
- Evaluate integration outputs and health outcomes;
- Engage stakeholders; and
- Mobilize leaders.

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23. Mark, Henry, and Julnes (2000). Evaluation: An integrated framework for understanding, guiding, and improving policies and programs. Jossey-Bass: San Francisco, CA. [Social betterment]

24. Himmelman, AT. Collaboration for a Change: Definitions, Decision-making models, Roles, and Collaboration Process Guide. http://depts.washington.edu/ccph/pdf_files/4achange.pdf. [Continuum from networking through collaboration]

25. Slonim AB, Callaghan C, Daily L, Leonard BA, Wheeler FC, Gollmar CW, Young WF. Recommendations for integration of chronic disease programs: are your programs linked? Prev Chronic Dis (serial online) 2007 Apr (cited 2007 Apr 9). Available from www.cdc.gov/pcd/issues/2007/apr/06_0163.htm.

Strategic Plan

A strategic plan is a written document outlining activities taking place and how they relate to programmatic goals and objectives. An implementation plan includes a timeline of activities, collaborating partners for each activity, logic models, and in some cases a budget for each activity. There are four (4) types of strategic plans captured in the 2011 State of the States Survey:

- Statewide Health Plan – A statewide plan produced by multiple state agencies; this plan includes multiple health issues that may include chronic diseases, infectious disease, injury, violence, and more.
- State Injury and Violence Prevention Plan – A statewide plan produced by multiple agencies only including health issues surrounding injuries and violence.
- Health Department Health Plan – A health department strategic plan produced by multiple departments and units within the health department; this plan includes multiple health issues, which may include chronic diseases, infectious disease, injury, violence, and more.
- Health Department Injury and Violence Prevention Plan – A health department strategic plan produced by the identified injury and violence prevention program only including health issues surrounding injuries and violence.

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