

An Assessment of the Texas Department of State Health Services

**Assessment conducted
December 8-12, 2008
by the
State and Territorial
Injury Prevention Directors Association**



BACKGROUND

Injury is the leading cause of death during the first four decades of life and the fourth leading killer in the United States overall. In 2005, more than 173,000 people died from injuries and violence. Each year, nearly 30 million people are treated for injuries in U.S. emergency departments; injuries account for over 35 percent of emergency department visits annually. The financial costs of injury/violence are staggering – an estimated \$406 billion annually. These estimates do not include the emotional burden resulting from the loss of a child or loved one, or the toll of severe disability, chronic pain or a profound lifestyle change on the injured person and his or her family.

Injury/violence – from car crashes and falls to homicides, child maltreatment and other violent deaths – are so common that they are reported in the media daily. However, many people view them as accidents and thus not preventable. But when a public health approach is applied to the problems of injury/violence, these events can be predicted, and in most cases, prevented. In the U.S., the primary health jurisdictions are the states and local entities where such authority may be delegated by state law. Thus it is up to the states – often with guidance, technical assistance and financial support from the federal government, but even in its absence – to assure its residents a healthy and secure environment.

Each day, state health department injury and/or violence prevention programs utilize scientific methods like those used to prevent infectious and chronic disease in order to reduce injuries and save tens of thousands of lives. Much of this work is done through coordination and collaboration between injury/violence prevention programs within the health department and outside of the agency. Unlike some other public health prevention activities where monitoring, intervention and evaluation all occur within the health sector (e.g., immunization against childhood diseases), injury/violence prevention may involve education, law enforcement, emergency medical services, traffic safety, fire safety; building codes, etc., and many other sectors in various components of its program, not to mention the important role of community-based coalitions and organizations.

In the late 1980s, the then-Center for Environmental Health and Injury Control (CEHIC) at the Centers for Disease Control and Prevention (CDC) began supporting states to build their capacity for injury/violence prevention. Some states built their programs without these grants, using funds from such sources as the Maternal and Child Health (Title V) Block Grant, the Preventive Health and Health Services Block Grant, state general or special funds, and others. CDC's National Center for Injury Prevention and Control's (NCIPC) current support for state health department injury/violence prevention programs includes the Public Health Injury Surveillance and Prevention Program (formally known as the Core State Injury Program). This program funds “core” capacity building and surveillance activities to prevent and control injuries—including traumatic brain injury (TBI). The program's three primary objectives are to build a solid infrastructure for injury prevention and control; collect, analyze and use injury data; and, implement and evaluate interventions. NCIPC also supports research efforts that can assist states in the implementation of best practices.

In 1993, a number of states' injury/violence prevention program directors developed the idea of forming a national organization of their peers, and the State and Territorial Injury Prevention Directors' Association (STIPDA) was formed. One of its most important products has been a document called *Safe States: Five Components of a Model State Injury/Violence Prevention*

Program. Soon thereafter, STIPDA entered into a Cooperative Agreement with the NCIPC. This cooperative agreement supports STIPDA in a number of activities.

In 1999, under the cooperative agreement, STIPDA developed a State Technical Assessment Team (STAT) project that supports the assessment of state health department level injury/violence prevention programs. STIPDA leads this process by assembling a team of technical experts who have experience in development and implementation of state and local injury/violence prevention programs. These experts demonstrate leadership and expertise through involvement in national organizations committed to the improvement of injury/violence prevention programs throughout the country. Experience in similar geographic, political and demographic situations is desirable.

The State Technical Assessment Team assembled in Austin, Texas on Monday, December 8, 2008. For the first two and a half days, over 40 presenters invited by the Texas Department of State Health Services provided in-depth briefings on injury/violence prevention activities in Texas. Topics for review and discussion included the following:

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

Coordination and collaboration are crosscutting issues and are addressed in each of these component areas. In addition, there is attention to eliminating health disparities in injury/violence outcomes.

The forum of presentation and discussion allowed the team the opportunity to ask questions regarding the status of injury/violence-related activities within the Texas Department of State Health Services, clarify any issues identified in the briefing materials provided earlier, identify barriers and facilitators to change, and develop a clear understanding of how injury/violence prevention functions throughout Texas. The team spent time with each presenter so as to review the status for each topic.

Following the briefings by presenters from the Texas Department of State Health Services, public and private sector partners, and stakeholders in the injury/violence prevention community, the team assessed the status of the Texas Department of State Health Services with respect to the STAT standards, summarized its findings, and developed a set of recommendations.

ACKNOWLEDGMENTS

The team would like to acknowledge the Texas Department of State Health Services for its support in conducting this assessment.

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

Special recognition and thanks should be made regarding the efforts taken by Linda Jones, Marcia Becker, the Trauma Registry staff, the Texas Planning Team, and the briefing participants for their well-prepared and forthright presentations. In addition, the team applauds the well-organized, comprehensive briefing material sent to the team members.

List of Presenters (in the order of their presentations):

- *Terry Pence, Traffic Safety Director, Texas Department of Transportation*
- *Johnny Humphreys, Safe Riders Team Lead, Texas Department of State Health Services*
- *Linda Hunter, Interpersonal Violence Prevention Collaborative Coordinator, Texas Association Against Sexual Assault*
- *Peggy Helton, Primary Prevention Specialist, Crime Victims Services Division, Office of the Attorney General*
- *Marissa Rathbone, Director of School Health, Texas Education Agency*
- *Jeff Kloster, Associate Commissioner for Health and Safety, Texas Education Agency*
- *Judy Whitfield, Coordinator, Texas Poison Center Network, Texas Department of State Health Services*
- *Matt Forrester, Epidemiologist, Texas Poison Center Network, Texas Department of State Health Services*
- *Dr. Vince Fonseca, State Epidemiologist, Texas Department of State Health Services*
- *Evelyn Delgado, Assistant Commissioner for Family and Community Health, Texas Department of State Health Services*
- *Dr. Fouad Berrahou, Title V, Maternal and Child Health Director, Family & Community Health Services Division, Texas Department of State Health Services*
- *Sam Cooper, III, Title V, Block Grant Administrator, Office of Title V & Family Health, Family & Community Health Services Division, Texas Department of State Health Services*
- *Kimberly Petrilli, Child Health Coordinator, Office of Program Decision Support, Family & Community Health Services Division, Texas Department of State Health Services*
- *Dr. John Villanacci, NREMTI, Manager, Environmental & Injury Epidemiology and Toxicology Branch, Texas Department of State Health Services*
- *Dr. Lucina Suarez, Director, Epidemiology & Disease Surveillance Unit, Texas Department of State Health Services*
- *Dr. Adolfo Valadez, Assistant Commissioner for Prevention and Preparedness, Texas Department of State Health Services*
- *Kathy Perkins, Assistant Commissioner for Regulatory Services, Texas Department of State Health Services*

- *Kelly Harrell, Manager, Stakeholder Relations, Office of EMS and Trauma Services Coordination, Texas Department of State Health Services*
- *Dr. Ralph Frankowski, Professor of Biostatistics, University of Texas School of Public Health, Houston*
- *Dr. Linda Lloyd, Associate Dean for Public Health Practice and Associate Professor for Management Policy and Community Health, University of Texas School of Public Health, Houston*
- *Dr. Luis Escobedo, Texas Department of State Health Services Regional Medical Director, Region 9/10 (El Paso)*
- *Dr. Tom Betz, Texas Department of State Health Services Regional Medical Director, Region 7 (Central Texas)*
- *Dr. Paul McGaha, Texas Department of State Health Services Regional Medical Director, Region 4/5N (East Texas)*
- *Dr. H. Mark Guidry, Director, Galveston County Health District*
- *Dr. James Morgan, Director, Williamson County & Cities Public Health District*
- *Shelli Stephens-Stidham, Director, Injury Prevention Research Center of Greater Dallas*
- *Dr. Eric Levy, Chair, State Child Fatality Review Team, Amarillo*
- *Dr. John Hellsten, Epidemiologist, Injury Surveillance Group, Texas Department of State Health Services*
- *Susan Rodriguez, State Coordinator, Child Fatality Review*
- *Michelle L. Cook, Coordinator, Behavioral Risk Factor Surveillance System, Texas Department of State Health Services*
- *David Zane, Epidemiologist, Strategic Preparedness Branch, Community Preparedness Section, Texas Department of State Health Services*
- *Tareka Wheeler, Texas State Safe Kids and Austin Safe Kids*
- *Paula Yuma, Injury Prevention Manager, Trauma Services, Dell Children's Medical Center of Austin*
- *Jennifer Northway, Executive Director, Mothers Against Drunk Driving, South Texas*
- *Margaret Petrozza-Meraz, Safe Communities Coordinator, El Paso*
- *Dr. Joanne McGee, Former Chair, Texas Traumatic Brain Injury Advisory Council*
- *Dr. Todd Maxson, Medical Director of Trauma, Dell Children's Medical Center of Austin*
- *Dr. Mary Carlile, Medical Director, Brain Injury Rehabilitation, Baylor Institute for Rehabilitation*
- *Tom Valentine, Senior Policy Advisor, Texas Health and Human Services Commission*
- *Amanda Summers-Fox, Suicide Prevention Officer, Texas Department of State Health Services*
- *Dr. Isaac Martinez, Director, Texas Youth Suicide Prevention Project*
- *Merily Keller, Consultant, Mental Health America, Texas*
- *Esther Betts, Prevention Lead, Program Implementation Unit, Substance Abuse and Mental Health and National Prevention Network Representative, Texas Department of State Health Services*
- *Mike Maples, Assistant Commissioner for Mental Health and Substance Abuse Services, Texas Department of State Health Services*

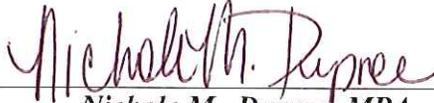
The statements made in this report are based on the input received. All team members agree with the recommendations as presented.



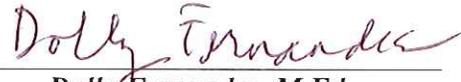
Barb Alberson, MPH



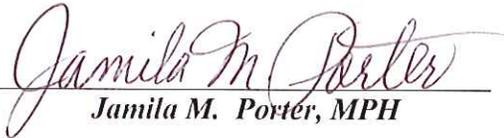
Pam Archer, MPH



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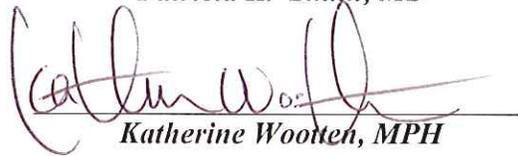
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EXECUTIVE SUMMARY

Injury and violence prevention should be a public health imperative in Texas. Injury is the leading cause of death in Texas between the ages of 1 and 44 and the third leading cause of death for residents of all ages. In response, the Texas Department of State Health Services (DSHS) has implemented a broad array of injury/violence prevention and control programs over the years. Activities are currently conducted within all five Divisions of the DSHS, including: Prevention and Preparedness, Family and Community Health Services, Mental Health and Substance Abuse Services, Regional and Local Health Services, and Regulatory Services. However, there has been very little communication or collaboration among programs, and as a result, there exists a patchwork of categorically-funded activities rather than coordinated data-driven efforts that inform and support each other. The Injury and EMS/Trauma Registry Group (IETRG), formerly called the Environmental Epidemiology and Injury Surveillance Group (EEIS) within the Prevention and Preparedness Division, has a long-standing interest and commitment to being the catalyst for more collaborative action.

Both internal and external stakeholders have recognized the need for overall leadership for and coordination among the Department's injury/violence prevention programs. For example, in 2003, the Governor's Emergency Medical Services and Trauma Advisory Council (GETAC) Injury Prevention Committee developed the "Texas Injury Prevention Plan," which helped to coalesce support. The IETRG used this foundational document when applying for a core program grant from the Centers for Disease Control and Prevention (CDC) in 2005 to conduct strategic planning and capacity building. Unfortunately, the grant was approved but not funded. Last year, staff from the Maternal and Child Health Program and IETRG began meeting to discuss ways to coordinate their injury prevention efforts. This group soon evolved to include other programs and is now comprised of 21 staff members throughout DSHS. This group requested a State Technical Assessment Team (STAT) visit to help formulate a concerted plan of action. This cross-program planning group spent several months working together on a briefing binder, creating a roster of stakeholders to be interviewed, and compiling program descriptions and examples of educational materials. In doing so, the group quickly began to demonstrate the value of collaboration.

The group also sought involvement and endorsement from upper-level administrators. Luanne Southern, Deputy Commissioner charged with implementing integrated approaches, agreed that injury/violence prevention was a prime example of such intersection and agreed to formally sponsor the group as the Injury Prevention Integration Initiative.

In some ways, this movement forward reflects a rich past. As early as 1982, the Texas Department of Health established an Injury Prevention Program (IPP) within its Bureau of Epidemiology. It was incorporated into the Department's Bureau of Disease Control and Epidemiology in 1987. By 1998, the IPP had grown to include 19 staff positions and a budget of \$1.6 million, providing both epidemiologic and statistical support, as well as a complement of innovative traffic safety interventions (e.g., grants to promote car seats for infants and toddlers, bike helmets for youth, and safe driving for seniors). A number of significant safety laws were also enacted during this period.

In 1999, the IPP's focus on prevention suffered a substantial setback when, as a result of a department-wide reorganization, its child passenger safety program (Safe Riders) was redirected to the Bureau of Chronic Disease. The ability to conduct interventions was further eroded with the

introduction of two new mandates. Although the *Injury Prevention and Control Program Act* enacted in 1992 authorized the Department to investigate the causes of injuries and methods of prevention, it focused on surveillance. The Act made spinal cord injuries and submersions reportable conditions [with traumatic brain injury (TBI) added in 1997] and also created a perceptual shift by formally changing the name of the program to the “Injury Epidemiology and Surveillance Program.” The focus on epidemiology was further solidified that same year when the program was given the responsibility to establish the Trauma Reporting, Analysis, and Collection in Texas (TRAC-IT) project—an EMS/Trauma Registry.

Establishing the EMS/Trauma Registry has been a difficult and frustrating experience for all involved. Stakeholders cannot obtain trauma data as the state program struggles with a lack of resources, staff turnover, aging equipment, and software deficiencies. The Registry appears to be on the road to recovery, however, with the infusion of funds under a new Texas Department of Transportation grant. And, although it is still just a proposal, the Department has submitted a formal Legislative Appropriations Request (LAR) that would greatly enhance the program’s ability to maintain the Registry.

Nevertheless, bringing the EMS/Trauma Registry online should not preclude movement towards creating a robust and comprehensive focus on injury epidemiology, policy, and program development. The Department should designate a coordinator with expertise in policy and program development that has the authority, support, and staff to lead—and be accountable for—comprehensive injury/violence prevention efforts. Working with its internal partners and stakeholders, the first priority would be to conduct a department-wide injury/violence prevention needs assessment and to craft a strategic plan to inform the creation of a fluid infrastructure, in which partners would work together to embed and sustain injury/violence prevention activities within the spectrum of related DSHS programs. Broader and more inclusive strategic thinking should then be set in motion, working with other state agencies as well as local, regional and state-level private sector partners to create systems-level changes to reduce the risk of injury/violence for Texans across the age span. Once in place, Texas Injury/Violence Prevention has the potential to become a premiere model to be emulated by other states with similar strengths and challenges.

The following recommendations are entrepreneurial but realistic in scope. Most importantly, these recommendations strongly support the need for a coordinated vision that was voiced by presenters who graciously spent time with the STAT team this week.

Recommendations

Infrastructure

DSHS should:

1. Designate and support an injury/violence prevention coordinator to harmonize, integrate, and facilitate communication among surveillance and prevention activities across the Department and serve as a liaison to all external partners.

2. Develop and implement a two-step strategic planning process. The first step would be an internal process of describing the scope of injury/violence in Texas and providing a unified vision for a Department-wide coordinated approach to injury/violence surveillance and prevention. The plan should include goals and objectives, interventions, indicators for evaluation, and strategies for effective communication and marketing. The second step would expand the process to include external statewide efforts. Key stakeholders in the public and private sectors should be involved in this segment of plan development and implementation.
3. Build the momentum and strengthen the membership of the DSHS Injury Integration Initiative Group to enhance communication and share resources and lessons learned related to program development, implementation, and evaluation. This group should lead the Department's injury/violence prevention internal and external strategic planning processes.
4. In conjunction with the strategic plan, conduct a comprehensive, statewide needs assessment.
5. Build public-private partnerships to strengthen injury/violence prevention in Texas.
6. Serve as a knowledge broker for injury and violence-related information. Activities can include the development of an online website/portal with links to data, reports, program descriptions, and contact information.
7. Pursue state, federal, and foundation funding opportunities, such as the Public Health Injury Surveillance and Prevention Program from the CDC, to strengthen and integrate injury/violence surveillance and prevention efforts.

IETRG should:

1. Support the retention of knowledgeable and diverse injury epidemiology staff by institutionalizing professional development and mentoring opportunities.
2. Pursue the creation of internships, assistantships, and paid employment opportunities for graduate students attending the schools of public health in Texas.
3. Monitor funding opportunities and work collaboratively to secure new resources.

Data Collection, Analysis, and Dissemination

IETRG Registry Operations staff should:

1. Develop an effective online EMS/Trauma Registry to collect, clean, and analyze injury data (including reportable injuries) and provide timely feedback to data contributors and other partners.
2. Request that the Assistant Commissioner's office identify and secure a neutral third party mediator to assist in rebuilding the relationships with EMS/Trauma Registry stakeholders.

IETRG Injury Epidemiology staff should:

1. Produce a series of injury data reports using Texas hospital discharge data and vital statistics data for dissemination to a wide audience of partners. Examples of reports include:
 - a. One-page fact sheets on specific injuries
 - b. Annual morbidity and mortality reports (age, sex, race, county/regional patterns, trends, rate comparisons within the state and with national rates, etc.)
2. Analyze and contribute hospital discharge data and vital statistics data to the CDC's *State Injury Indicators Report* each year.
3. Conduct a resource and needs assessment to determine data sources, data needs, and readiness of internal stakeholders throughout DSHS.
4. Establish relationships with internal and external data owners and users, including university partners, and participate in data user group meetings such as the Behavioral Risk Factor Surveillance System. The staff should also explore developing an injury data user group.
5. Create relationships with the Texas schools of public health to obtain data consultations and practicum students.
6. Utilize innovative methods to increase efficient reach to partners for training and collaboration regarding data-related issues (e.g., videoconferencing).
7. Establish a web-based query system for easy access to quality data by injury/violence prevention partners and others.
8. Build readiness to apply for National Violent Death Reporting System funding to compile data to enhance violence surveillance activities and prevention programs.

DSHS should:

1. Obtain authorization to access personal identifiers from the hospital discharge database and to conduct linkages with other databases to allow comprehensive data which can drive targeted prevention programs.
2. Investigate the feasibility of establishing an emergency department discharge database within the DSHS.

Intervention Design, Implementation, and Evaluation

DSHS should:

1. Use the results of the needs assessment and strategic planning to determine critical programming needs for ongoing statewide injury surveillance activities.

2. Make data-driven decisions when planning and implementing injury/violence prevention interventions.
3. Ensure that evaluation is an integral part of any injury/violence prevention program.
4. Implement injury/violence prevention programs that are comprehensive and go beyond awareness and information dissemination activities to approach behavioral, social, and environmental change.
5. Coordinate existing internal programs funding streams to address critical issues for all populations.
6. Actively seek opportunities for programs and advisory bodies in all DSHS divisions to work within and across program lines on injury and/or violence prevention issues.
7. Work with internal and external partners to ensure that underserved, at-risk populations (e.g., working-age and older adults, African-American men) are involved in strategic planning.
8. Provide training on the core components of a public health approach to injury/violence prevention for local and regional colleagues, in concert with external partners (e.g., the Texas AgriLife Extension Service).
9. Learn from comprehensive, successful Texas state public health initiatives (e.g., tobacco reduction) about what has and has not worked in establishing their programs.
10. Conduct a statewide environmental scan of injury/violence prevention programs, training opportunities, and educational materials that would be of value to stakeholders.
11. Build on the political opportunities created as a result of high-level attention in areas such as TBI, child passenger safety, and suicide. DSHS should use these programs as models to demonstrate the impact of establishing a broader injury/violence prevention program.

Public Policy

DSHS should:

1. Identify a champion at the highest level at DSHS to help drive policy initiatives within the Department and across state government.
2. Ensure that the injury/violence prevention strategic plan includes a policy platform.
3. Identify staff across programs to analyze injury/violence prevention legislation and encourage programs to proactively seek to do such analyses.
4. Cultivate and strengthen relationships with governmental and non-governmental partners. DSHS should share data and technical information with partners to assist in their advocacy efforts.

5. Develop an informational packet or media kit that includes fact sheets, data on death and disability, associated costs, and best practices. DSHS should seek opportunities to inform stakeholders, media, legislators, advocates, hospitals, universities, and others on injury/violence issues.
6. Use the resources of local, regional, state, and national associations to further policy goals. Examples of national organizations include STIPDA, Association of State and Territorial Health Officials, Children's Safety Network, Council of State and Territorial Epidemiologists, Governors Highway Safety Association, Suicide Prevention Action Network USA, Economics and Data Analysis Resource Center, Injury Control Research Centers, CDC, and others.
7. Continue to seek authorization to utilize personal identifiers in linking hospital discharge data with other data sets.
8. Strengthen injury/violence prevention public policies in areas such as booster seats for children, seat belt use in the back seat of vehicles, helmet use, graduated licensing, and sobriety checkpoints.

INFRASTRUCTURE

Standards

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

Status

The Texas Department of State Health Services (DSHS) has great potential for growth. DSHS has implemented a broad array of injury/violence prevention and control programs over the years. Activities are currently conducted within all five Divisions of the DSHS including: Prevention and Preparedness, Family and Community Health Services, Mental Health and Substance Abuse Services, Regional and Local Health Services, and Regulatory Services. However, there has been very little communication or collaboration among programs, and as a result, there exists a patchwork of categorically-funded activities rather than coordinated data-driven efforts that inform and support each other.

Both internal and external stakeholders have recognized the need for overall leadership for and coordination among the Department's injury/violence prevention programs. For example, in 2003, the Governor's Emergency Medical Services and Trauma Advisory Council (GETAC) Injury Prevention Committee developed the "Texas Injury Prevention Plan," which helped to coalesce support. The IETRG used this foundational document when it applied for a core program grant from the Centers for Disease Control and Prevention (CDC) in 2005 to conduct strategic planning and capacity building. Unfortunately, the grant was approved but not funded. As of yet, there is still no strategic plan in place.

Last year, colleagues from the Maternal and Child Health Program and the IETRG staff began meeting to discuss ways to coordinate their injury prevention efforts. This group soon evolved to include other programs and is now comprised of 21 staff throughout DSHS. This group requested a State Technical Assessment Team (STAT) visit to help formulate a plan of action to grow capacity. This cross-program planning group spent several months working together on the briefing binder, creating a roster of stakeholders to be interviewed, and compiling program descriptions and examples of educational materials. In doing so, the group quickly began to demonstrate the value of collaboration.

The group also sought involvement and endorsement from upper-level administrators. Luanne Southern, Deputy Commissioner charged with implementing integrated approaches, agreed that injury/violence prevention was a prime example of such intersection and agreed to formally sponsor the group as the Injury Prevention Integration Initiative.

Establishing the EMS/Trauma Registry has been a primary function of IETRG. Unfortunately, it has been a difficult and frustrating experience for all involved. Stakeholders cannot obtain trauma data as the state program struggles with a lack of resources, staff turnover, aging equipment, and software deficiencies. The Registry appears to be on the road to recovery, however, with the infusion of funds under a new Texas Department of Transportation grant. And, although it is still just a proposal, the Department has submitted a formal Legislative Appropriations Request (LAR) that would greatly enhance the program's ability to maintain the Registry.

In terms of staffing, IETRG includes the only designated "injury" positions: a manger, two epidemiologists, two program specialists, a public health technician, and a research specialist.

Strengths

- The Department has skilled, motivated, and dedicated staff conducting injury epidemiology, policy, and program development.
- A DSHS Injury Integration Initiative Group, with 21 members from programs across the Department, has been established with formal support from the Deputy Commissioner charged with promoting integration.
- During the STAT visit, all Assistant Commissioners voiced support for injury/violence prevention.
- Partnerships have been formed with multiple stakeholders at all levels.
- Relationships exist with public universities, including the schools of public health, which can serve as a rich resource for injury/violence prevention.

Challenges

- There is no comprehensive internal/external strategic plan for injury/violence prevention to serve as a catalyst for more coordinated efforts across the Department and across the State.
- Injury/violence prevention lacks leadership and visibility within the Department.
- No central point of contact exists for internal and external stakeholders and consumers seeking information on injury/violence surveillance and prevention activities within DSHS.
- There is a lack of both internal and external collaboration and coordination of injury/violence prevention efforts.
- IETRG has experienced significant personnel issues, including a high degree of staff turnover.
- Without expertise in health promotion and program development, the IETRG is unable to lead injury/violence prevention efforts.

- No evidence was provided to show that existing injury/violence prevention efforts take advantage of distance-learning and other technology-based resources (e.g., videoconferencing for training and technical assistance).

Recommendations

DSHS should:

1. Designate and support an injury/violence prevention coordinator to harmonize, integrate, and facilitate communication among surveillance and prevention activities across the Department and serve as a liaison to all external partners.
2. Develop and implement a two-step strategic planning process. The first step would be an internal process of describing the scope of injury/violence in Texas and providing a unified vision for a Department-wide coordinated approach to injury/violence surveillance and prevention. The plan should include goals and objectives, interventions, indicators for evaluation, and strategies for effective communication and marketing. The second step would expand the process to include external statewide efforts. Key stakeholders in the public and private sectors should be involved in this segment of plan development and implementation.
3. Build the momentum and strengthen the membership of the DSHS Injury Integration Initiative Group to enhance communication and share resources and lessons learned related to program development, implementation, and evaluation. This group should lead the Department's internal and external injury/violence prevention strategic planning processes.
4. In conjunction with the strategic plan, conduct a comprehensive, statewide needs assessment.
5. Build public-private partnerships to strengthen injury/violence prevention in Texas.
6. Serve as a knowledge broker for injury and violence-related information. Activities can include the development of an online website/portal with links to data, reports, program descriptions, and contact information.
7. Pursue state, federal, and foundation funding opportunities, such as the Public Health Injury Surveillance and Prevention Program from the CDC, to strengthen and integrate injury/violence surveillance and prevention efforts.

IETRG should:

1. Support the retention of knowledgeable and diverse injury epidemiology staff by institutionalizing professional development and mentoring opportunities.
2. Pursue the creation of internships, assistantships, and paid employment opportunities for graduate students attending the schools of public health in Texas.
3. Monitor funding opportunities and work collaboratively to secure new resources.

DATA COLLECTION, ANALYSIS, AND DISSEMINATION

Standards

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

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

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

Status

Injury and violence prevention, like other areas of public health, requires sound information for planning, designing, and evaluating interventions. In Texas, the need for injury/violence data has been recognized and supported by way of legislative mandate and institutional commitment within DSHS. Additionally, IETRG staff recognizes that quality data are a critical component for setting priorities and developing evidenced-based injury prevention programs; however, there is not currently the mechanism to translate data into program development. The staff has access to and has analyzed seven of the 11 core data sources identified by the STIPDA for comprehensive injury surveillance (e.g., vital statistics, hospital discharges, and medical examiner records). In addition, three types of injuries are mandated by law as reportable conditions in Texas: traumatic brain injury, spinal cord injury, and submersions.

As a mandated function, the IETRG established an online EMS/Trauma Registry in 2002. The Registry has been designed to include web-based data entry, automatic data validation, automatic duplicate deletion, user-defined data reports, and the capacity for each reporting source to access, update, and delete its own data. Prior to the implementation of the online system, the EMS/Trauma Registry manually processed approximately 275,000 records each year. With the online system, nearly two million records can be processed annually.

Unfortunately, during the past five years, the online system has fallen behind on repairs and upgrades due to a lack of information technology support causing the system to be non-functional for two different periods of time, each extending 6-8 months. Currently, the system is functioning at a minimal level in which data can be collected and IETRG personnel can run reports or provide raw data to stakeholders upon request. EMS data for 2006 and 2007 will soon be available, as will trauma data for 2005-2007. Currently the completeness and quality of the data are less than optimal, with approximately 50% of the EMS agencies and 60% of hospitals reporting.

Technological difficulties and delayed data availability have strained relationships with stakeholders. Funds from the Texas Department of Transportation have been committed to upgrade the system, and a Legislative Appropriations Request (LAR) will be submitted to the Legislature during the 2009 session. It is anticipated that it will take at least two years to establish a new system, which is expected to be compliant with the National Emergency Medical Services Information System (NEMSIS). IETRG staff is committed to making these improvements to create and maintain a functional EMS/Trauma Registry.

There are four schools of public health in Texas, some of which have expressed interest in collaborating on projects and placing practicum students in the IETRG for data analysis as well as injury research in regional and local health jurisdictions. In addition, there are non-governmental organizations that have expressed interest in collaborating with the IETRG.

Strengths

- The *Injury Prevention and Control Act* mandates surveillance for reportable injuries, and Chapter 92 of the *Health and Safety Code* requires submission of EMS and trauma data.
- Basic relationships have been established within the state government and university system, as well as among a variety of injury prevention organizations at the state and national level.
- With the new IETRG structure, there are two staff members dedicated specifically to Injury Epidemiology and four staff members dedicated to Registry Operations. Additional staff positions are anticipated with the receipt of the Texas Department of Transportation grant.
- The IETRG has access to important data sets such as vital statistics and hospital discharge records.
- IETRG is committed to web-based reporting system and migration from the paper-based reporting for submersions.

- There is support at the DSHS Commissioner level to secure an additional \$1.6 million for the EMS/Trauma Registry for the next two years.

Challenges

- Although the EMS/Trauma Registry is of vital importance to the State, it is only one sub-set of the injury epidemiology data that exist.
- Although numerous scholarly injury epidemiology reports have been published by DSHS personnel, most notably on poisonings, few other injury epidemiology reports have been recently produced. There is no systematic plan in place to produce reports based on currently available data to inform public health practice.
- The IETRG lacks knowledge of internal data sources across DSHS. This lack of knowledge limits analysis and reporting of state injury trends and/or sentinel events, as well as the ability to conduct rigorous program evaluation.
- Data for mandated reportable conditions are often delayed and/or incomplete.
- When compared to other smaller registries within DSHS, funding and staffing for EMS/Trauma Registry are not commensurate with the volume and technology requirements.
- Website information requests from the public and partners regarding the EMS/Trauma Registry are discouraged because the IETRG is not able to answer them in a timely manner.
- There are emergent technology issues regarding software, hardware, and connectivity problems which are hindering mandated programs.

Recommendations

IETRG Registry Operations staff should:

1. Develop an effective online EMS/Trauma Registry to collect, clean, and analyze injury data (including reportable injuries) and provide timely feedback to data contributors and other partners.
2. Request that the Assistant Commissioner's office identify and secure a neutral third party mediator to assist in rebuilding the relationships with EMS/Trauma Registry stakeholders.

IETRG Injury Epidemiology staff should:

1. Produce a series of injury data reports using Texas hospital discharge data and vital statistics data for dissemination to a wide audience of partners. Examples of reports include:
 - a. One-page fact sheets on specific injuries

- b. Annual morbidity and mortality reports (age, sex, race, county/regional patterns, trends, rate comparisons within the state and with national, etc.)
2. Analyze and contribute hospital discharge data and vital statistics data to the CDC's *State Injury Indicators Report* each year.
3. Conduct a resource and needs assessment to determine data sources, data needs, and readiness of internal stakeholders throughout DSHS.
4. Establish relationships with internal and external data owners and users, including university partners, and participate in data user group meetings such as the Behavioral Risk Factor Surveillance System. The staff should also explore developing an injury data user group.
5. Create relationships with the Texas schools of public health to obtain data consultations and practicum students.
6. Utilize innovative methods to increase efficient reach to partners for training and collaboration regarding data-related issues (e.g., videoconferencing).
7. Establish a web-based query system for easy access to quality data by injury/violence prevention partners and others.
8. Build readiness to apply for National Violent Death Reporting System funding to compile data to enhance violence surveillance activities and prevention programs.

DSHS should:

1. Obtain authorization to access personal identifiers from the hospital discharge database and to conduct linkages with other databases to allow comprehensive data which can drive targeted prevention programs.
2. Investigate the feasibility of establishing an emergency department discharge database within the DSHS.

INTERVENTION DESIGN, IMPLEMENTATION, AND EVALUATION

Standards

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

Status

Texas does not have a designated injury/violence prevention program within state government, specifically within DSHS. This, however, does not mean that important injury/violence intervention work is not being done both within and external to state government. Examples of DSHS injury/violence prevention-related programs include:

- Safe Riders (child passenger safety)
- Texas Youth Suicide Prevention Project
- Poison safety education
- Risk assessment and tailored communication by physicians with parents about pediatric injury

In addition, public information dissemination efforts are ongoing for issues such as emergency and disaster planning for children with special health care needs, safe sleep for infants (in conjunction with the Department of Family and Protective Services), poisoning prevention, and the prevention of shaken baby syndrome.

Other departments within state government are major players in injury/violence prevention, undertaking activities in areas such as violence against women (VAW), child abuse, and highway traffic safety. For example, the Office of the Attorney General is a leader (in concert with Maternal and Child Health) for VAW planning efforts and distributing federal funds to local programs, providing in-kind administration for those efforts. The Texas Department of Transportation has a long history of promoting and administering a multitude of motor vehicle-related injury prevention programs. The Texas Education Agency (TEA) administers the Safe and Drug Free Schools program and provides leadership on strengthening injury/violence prevention efforts within local school districts. The Texas Department of Family and Protective Services addresses the prevention of child abuse, elder and vulnerable adult abuse, and juvenile delinquency. All three of these Departments have substantial working relationships with programs housed in DSHS.

External to state government, many substantive statewide, regional, and local prevention efforts are being undertaken, including:

- The efforts of 11 active Safe Kids coalitions in the State of Texas (unintentional injuries to children ages 0–14)
- The Southwest Center for Health, Injury Prevention, and Education (agricultural health and safety)
- The Injury Prevention Center of Greater Dallas
- The State’s mandated injury prevention efforts of the trauma system Regional Advisory Councils and trauma centers
- Injury Free Coalitions for Kids in Austin and San Antonio
- The Texas Suicide Prevention Council
- The Texas Children’s Center for Childhood Injury Prevention in Houston

Strengths

- There are many established injury/violence prevention efforts in place across the State.
- External partners at all levels clearly recognize the need for state leadership, coordination, and expertise on implementation and evaluation of evidence-based injury/violence prevention programs.

- The programs, professionals, and research currently available in the state internal and external to state government are enormous assets.

Challenges

- Leadership and infrastructure do not exist to support a coordinated injury/violence prevention effort within DSHS.
- Efforts addressing important issues often have not moved beyond awareness and information into behavioral, social, and environmental change.
- Major gaps in programming appear to exist in the state in areas such as:
 - Driving, suicide, and falls among older adults
 - Violence/homicide among young African-Americans males
 - Suicide and TBI among veterans
 - Unintentional poisoning deaths among working-age adults
- There is no mechanism in place to identify and address programming gaps or critical emerging issues.
- It was not evident during the STAT visit if violence is considered a public health issue by the State.

Recommendations

DSHS should:

1. Use the results of the needs assessment and strategic planning to determine critical programming needs for ongoing statewide injury surveillance activities.
2. Make data-driven decisions when planning and implementing injury/violence prevention interventions.
3. Ensure that evaluation is an integral part of any injury/violence prevention program.
4. Implement injury/violence prevention programs that are comprehensive and go beyond awareness and information dissemination activities to approach behavioral, social, and environmental change.
5. Coordinate existing internal programs funding streams to address critical issues for all populations.
6. Actively seek opportunities for programs and advisory bodies in all DSHS divisions to work within and across program lines on injury and/or violence prevention issues.
7. Work with internal and external partners to ensure that underserved, at-risk populations (e.g., working-age and older adults, African-American men) are involved in strategic planning.

8. Provide training on the core components of a public health approach to injury/violence prevention for local and regional colleagues, in concert with external partners (e.g., the Texas AgriLife Extension Service).
9. Learn from comprehensive, successful Texas state public health initiatives (e.g., tobacco reduction) about what has and has not worked in establishing their programs.
10. Conduct a statewide environmental scan of injury/violence prevention programs, training opportunities, and educational materials that would be of value to stakeholders.
11. Build on the political opportunities created as a result of high-level attention in areas such as TBI, child passenger safety, and suicide. DSHS should use these programs as models to demonstrate the impact of establishing a broader injury/violence prevention program.

PUBLIC POLICY

Standards

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

Status

Reaching consensus on public policy is difficult in Texas, a large and diverse state with a history protective of personal freedoms and civil liberties. Adding to these challenges, DSHS has gone through a series of reorganizations that pose difficulties for advancing public health policy. Commendably, however, the Department has contributed to several key policies, including the establishment of an Office of Acquired Brain Injury and an operational edict for a Suicide Prevention Officer.

Texas has enjoyed some early policy successes, including passage of one of the first seat belt laws in the nation. The *Injury Prevention and Control Act*, passed in 1992, was also a significant policy accomplishment. The Act authorized the investigation of causes of injuries and methods of prevention and made spinal cord injuries and submersions reportable conditions. A third reportable condition, TBI, was added shortly thereafter.

Most recently, the Department submitted a Legislative Appropriations Request (LAR) to obtain funding needed to support the EMS/Trauma Registry and to enhance other injury-related activities.

Strengths

- Each of the DSHS Assistant Commissioners and the Office for Program Coordination, Policy, and Innovation voiced their support to the STAT team for injury/violence prevention, which is essential for promulgating public policy.
- Texas has a history of enacting injury-related laws (e.g., requiring child safety seats, primary enforcement of seat belts).

- Many influential constituencies are committed to advancing injury policy. For example, the TBI Advisory Council continues to provide broad-based support for injury/violence prevention. Other existing and potential advocates include Child Death Review Teams, Safe Kids coalitions, Suicide Prevention Council, GETAC, and the Drug Demand Reduction Advisory Committee.

Challenges

- External partners have difficulty identifying injury/violence prevention programs and contacts to request data and technical information for their policy deliberations.
- The lack of a coordinated injury/violence prevention program at DSHS has made it difficult to have a unified voice for injury/violence prevention policy.

Recommendations

DSHS should:

1. Identify a champion at the highest level at DSHS to help drive policy initiatives within the Department and across state government.
2. Ensure that the injury/violence prevention strategic plan includes a policy platform.
3. Identify staff across programs to analyze injury/violence prevention legislation and encourage programs to proactively seek to do such analyses.
4. Cultivate and strengthen relationships with governmental and non-governmental partners. DSHS should share data and technical information with partners to assist in their advocacy efforts.
5. Develop an informational packet or media kit that includes fact sheets, data on death and disability, associated costs, and best practices. DSHS should seek opportunities to inform stakeholders, media, legislators, advocates, hospitals, universities, and others on injury/violence issues.
6. Use the resources of local, regional, state, and national associations to further policy goals. Examples of national organizations include STIPDA, Association of State and Territorial Health Officials, Children's Safety Network, Council of State and Territorial Epidemiologists, Governors Highway Safety Association, Suicide Prevention Action Network USA, Economics and Data Analysis Resource Center, Injury Control Research Centers, CDC, and others.
7. Continue to seek authorization to utilize personal identifiers in linking hospital discharge data with other data sets.
8. Strengthen injury/violence prevention public policies in areas such as booster seats for children, seat belt use in the back seat of vehicles, helmet use, graduated licensing, and sobriety checkpoints.

THE STATE TECHNICAL ASSESSMENT TEAM BIOGRAPHICAL INFORMATION

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Barb Alberson is a public health educator with over 34 years of experience in public policy and program development. Currently, she is the Chief of the State and Local Injury Control Section in the California Department of Health Services. Over the last 18 years, Ms. Alberson's Section has implemented a broad range of injury prevention projects, and her program is now one of the most productive injury prevention programs in the nation.

On the national level, Ms. Alberson often serves as faculty at major conferences and as a consultant for a number of federal agencies and national associations, including the Centers for Disease Control and Prevention, the National Program for Playground Safety, the National Council on Aging, and the National Highway Traffic Safety Administration.

Ms. Alberson was also a part-time faculty member at California State University at Sacramento for 16 years, teaching community health courses in leadership, management, and education. She has her BA from University of California at Los Angeles, and her MPH from California State University at Northridge.

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Pam Archer has worked at the Oklahoma State Department of Health for 26 years, including 18 years in the Injury Prevention Service. She has extensive experience in surveillance of reportable injuries in Oklahoma, including burns, submersions, spinal cord injuries, traumatic brain injuries, occupational fatalities, and suicides/attempts. In addition, she has assisted in the development, implementation, and evaluation of smoke alarm and bicycle helmet distribution programs. Before coming to the Injury

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Nichole M. Dupree is the Program Manager of the Injury Research & Prevention Program in New Orleans, Louisiana. She has a Masters degree in Public Administration and a Bachelors degree in Business Administration. Ms. Dupree has worked in the public health arena for over 10 years in the areas of rural health, HIV, and early intervention services for children with disabilities. Her experience includes program design and implementation, infrastructure development, and providing technical assistance and training at both the state and community level.

POLICY

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Dolly Fernandes is a public health educator with over 21 years of experience in public policy, program development and evaluation. She was recently appointed Section Manager for EMS and Trauma and Injury and Violence Prevention for the Washington State Department of Health. Ms. Fernandes's section is responsible for overall EMS and Trauma System implementation as well as injury and violence prevention. Specific functions of her section include EMS Training, EMS technical support and credentialing, Trauma Hospital Designation and technical assistance to support the trauma services, trauma nurse coordinators and trauma medical directors. It also includes the Trauma Care fund reimbursement program. Ms. Fernandes has worked in the Office of EMS and Trauma in many different roles over the last 18 years. She started in EMS training, spent time providing direction to legislation and rules activities, and has been the manager of the Trauma Care Fund reimbursement program overseeing the distribution of \$41 million biennially. Most recently Ms. Fernandes has served as the manager for the Injury and Violence Prevention program. She has a Masters degree in Adult and Continuing Education with emphasis in Health Administration, a Bachelor of Science in Human Nutrition, and a Bachelor of Art in Cultural Anthropology.

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Jamila Porter is the Communications and Professional Development Coordinator for the State and Territorial Injury Prevention Directors Association (STIPDA). In this capacity, she is responsible for the creation, development, and production of all STIPDA communication tools, resources, programs, and publications. She is also responsible for enhancing the continuing education of STIPDA members through the organization and implementation of professional development programs and activities.

Ms. Porter brings her expertise in health communication and program coordination from the non-profit, government, and corporate sectors. Before joining STIPDA, Ms. Porter worked in the private sector as a Health Education/Media Specialist for the Georgia Families program. There she worked directly with the Georgia Department of Community Health (DCH), care management organizations, and other health, medical, and community-based organizations to develop health care awareness campaigns targeted toward underserved communities in Georgia. Additionally, Ms. Porter has worked with a variety of federal programs and non-profit organizations, including the TRIO/Talent Search program, Susan G. Komen Breast Cancer Foundation, and the U.S. Peace Corps.

Ms. Porter earned her Master of Public Health degree from Mercer University School of Medicine in 2005, where she was honored with the prestigious *Public Health Service Award*. Ms. Porter is also an honor graduate of Wake Forest University, where she earned her Bachelor of Arts degree in Communication and Health Policy & Administration.

PROGRAM

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Patricia Smith is currently serving as the Coordinator of the Violence Prevention Program with the Michigan Department of Community Health (MDCH). A major focus of her job is redevelopment of the violence prevention infrastructure and programming within the MDCH Injury & Violence Prevention Section. Two other components of the job are: a) program director for the department's Youth Suicide Prevention Program and b) working on the Section's efforts focusing on violence-related surveillance.

Ms. Smith is considered the MDCH expert on violence against women, providing consultation and technical assistance to other programs within the department and regularly serving on state-level advisory groups external to the department. She previously served in a key technical assistance/consulting role for the Michigan Emergency Department Community Injury Information Network (MEDCIIN), which was the state's emergency department injury surveillance system. From 1993–2001, MDCH received two million dollars annually in state general funds to develop and implement a Violence Prevention Section. Ms. Smith played a major role in the initial planning and design of the section and served as its coordinator for 4 ½ years.

Ms. Smith has held other roles at the state level related to injury prevention and control, including serving as a program consultant to the Disabilities Prevention Unit, providing technical assistance and consultation on firearm-related violence and injury, and serving as program director of the Michigan Bicycle Helmet Project. She is currently a member of the consultation team for the Department of Health and Human Services *Guide to Community Preventive Services* chapter on violence prevention. Ms. Smith was an invited participant in the National Conference on Violence and Reproductive Health in 1999 and was also an invitee to the DHSS and Department of Justice joint workshop on Building Data Systems for Monitoring and Responding to Violence Against Women in 1998. She served as a member of the work group developing an intimate partner violence module for the National Violent Death Reporting System and has also served on several grant proposal review panels for the National Institute of Justice and the CDC. Ms. Smith served on the Missouri STAT Team in 2005, the New Jersey STAT Team in 2006, and the Iowa STAT Team in 2007.

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Marlena Wald is an Epidemiologist in the Division of Injury Response of the National Center for Injury Control and Prevention at CDC. Her areas of research include acute care, traumatic brain injury, and substance issues related to both of these topics. While at CDC she has been the recipient of a CDC Honor Award for statistical research and services and has been a Charles C. Shepard award nominee. Prior to coming to CDC, she was the Research Program Director for the Department of Emergency Medicine at Emory University School of Medicine where she managed prospective clinical and public health studies in the emergency departments at Grady Memorial Hospital, Emory University Hospital, and Crawford-Long Memorial Hospital. While at Emory, she participated in a number of TBI clinical projects as well as, taught a graduate course on neurotraumatology. Ms. Wald holds both a Masters of Public Health from the Rollins School of Public Health at Emory University and a Masters of Library and Information Science from the University of Maryland – College Park. Her undergraduate degree was awarded by the George Washington University. She has received fellowships from the Hazelden Foundation and the Council on Library Resources. She has published in the areas of emergency

department surveillance and traumatic brain injury. Also, she frequently lectures on evidence-based medicine and online resources for biomedical research. Ms. Wald is a member of the American Public Health Association, the American Library Association, and the American Society for Information Science and Technology.

INFRASTRUCTURE

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In her current position as a Prevention Specialist at the Suicide Prevention Resource Center (SPRC), Katherine Wootten provides technical assistance, training, and prevention support to Garrett Lee Smith (GLS) youth suicide prevention grantees, state suicide prevention coalitions and planning groups, and other organizations and individuals engaged in suicide prevention. Her primary contacts on the state level are members of statewide suicide prevention coalitions, membership of which often includes representatives from state health department injury and violence prevention programs. Ms. Wootten works regularly with the Illinois Department of Public Health's Injury and Violence Prevention Program and the Michigan Department of Community Health's Injury and Violence Prevention Section – a GLS State grant recipient – around their statewide suicide prevention activities. In her previous position at the Centers for Disease Control and Prevention, Ms. Wootten collected and analyzed state-level incidence data on neural tube defects for the National Birth Defects Prevention Network and disseminated results among Network members. She also collected state-level data to be disseminated via the 2005 *Congenital Malformations Report: A Report from the National Birth Defects Prevention Network*.