



SAFE STATES

Making the Case for Injury and Violence Prevention

A Conversation Starter for State Injury and Violence Prevention Directors
to Use with State Health Officials and Other Leaders

“History has shown us that injury is very amenable to change. The data tells us that it must be done and that it can be done, and yet injury usually is not the number one public health issue in most state offices.”

Paul Halverson, DrPH, FACHE

2009-2010 ASTHO President

Director and State Health Officer

Arkansas Department of Health





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ASTHO PRESIDENTIAL CHALLENGE

2009 - 2010

"I challenge state health leaders to study the data, assess their state, and consider adopting at least one policy strategy this year that could lessen the burden of preventable injury and death in their home state."

— Paul Halverson, DrPH, FACHE
2009-2010 ASTHO President
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Injury and Violence Prevention: Unrecognized Opportunities

In April 2011, National Public Health Week featured an injury prevention theme: Safety is NO Accident. Coming on the heels of a 2009-2010 Presidential Challenge from incoming Association of State and Territorial Health Officials (ASTHO) President Paul Halverson to reduce preventable injuries and deaths, the National Public Health Week theme seemed an opportune moment to capitalize on Dr. Halverson's words:

"I challenge state health leaders to study the data, assess their state, and consider adopting at least one policy strategy this year that could lessen the burden of preventable injury and death in their home state."

As National Public Health Week approached, state injury program directors from across the country gathered data and compelling examples, prepared talking points for their State Health Officials (SHOs) and state health department communications staff, issued press releases, and coordinated events with advocates from the many corners of the injury arena.

In many states, the events were successful, helping to rebut the idea that injuries are "just accidents" and replacing that notion with evidence that many of the nation's annual toll of 50 million injuries can and should be prevented.

But in at least a few of these states, state injury and violence prevention directors were disappointed when the opportunity to highlight these topics

through a coordinated campaign like National Public Health Week was overshadowed by other priorities, such as obesity prevention.



Obesity prevention and the many other priorities on a SHO's full plate are worthwhile public health goals, to be sure. Still, the fact that injury and violence prevention is crowded out of a top perch on SHO priority lists is puzzling to those who work in the field. They see firsthand the burden of injuries, not only in terms of death and disability for individuals and families, but also in terms of the hefty (and largely avoidable) costs that accrue to states in these acutely budget-conscious times: soaring Medicaid costs, expanded state employee health benefits, emergency care for the uninsured, child welfare expenditures, costs to maintain public safety, and even lost tax revenues when the injured (and their caregivers) can no longer work.

It's critical that national organizations, including the American Public Health Association (APHA) and ASTHO, are raising injury and violence prevention as key public health issues through the Presidential Challenge and National Public Health Week. It's even more critical that state injury and violence prevention directors are spending time in their states to build awareness and support of the burden and the activities their programs (and partners) engage in to keep state residents safe and healthy.

About This Document

This guide is a companion piece to a recent ASTHO guide for SHOs, *Spotting Injury and Violence Prevention on Your Radar Screen — Creating a Legacy in Public Health*, co-authored by Dr. Halverson, Denise Osborn, Albert Terrillion, and Leslie Erdelack. Without repeating the sound advice and examples from that publication, this document focuses instead on advice that state injury and violence prevention directors offer to one another — especially to those in the more than 30 states that experienced a recent turnover in their SHOs (and, for many, in their gubernatorial administration and legislatures as well).

The strategies and tips were gathered in a series of interviews conducted in April and May 2011 with eight state injury and violence prevention directors and three SHOs, augmented with document reviews.

After a brief overview of some of the obstacles and challenges that state injury and violence prevention directors face in elevating injury and violence prevention as priorities within state health departments, the guide moves quickly into descriptions of strategies that the injury and violence prevention directors who participated in interviews for this guide have found useful.

A final section provides insights from both SHOs and state injury and violence prevention directors about how they would approach a new SHO with less institutional history within a given state health department and less familiarity with injury and violence prevention programs as well. It should be noted that although the guide focuses on the interaction between state injury and violence prevention directors and SHOs, the tips and strategies apply to others within state health department leadership teams as well (e.g., deputies, legislative liaisons, and communications staff).



A Challenging Context for Raising Injury and Violence Prevention's Profile

Both state injury and violence prevention directors and SHOs interviewed for this guide agreed that many factors contribute to injury and violence prevention's lower-than-expected profile within state health departments — and elsewhere. For SHOs, injury and violence prevention is but one of many competing priorities, expectations, and crises that demand constant attention and leadership. The information flow alone can be overwhelming, not to mention the decisions, political nuances, managerial tasks, and communications challenges that arise (often unexpectedly) on a daily basis. “To an injury director it’s all injury all the time,” said one SHO, “but to a SHO, it’s 15 minutes for injury before you’re off trying to put out the next fire.” SHOs advise that injury and violence prevention directors take this context into account in framing their approach. In addition to the environment in which SHOs are operating, there are other challenges and obstacles that state injury and violence prevention directors face. These include:

- Injury and violence prevention is “hard to get your arms around,” as several noted, because it encompasses so many different mechanisms, constituencies, partners, bodies of research and evidence, and policy solutions. For small and un- or under-funded injury and violence prevention programs, keeping these many aspects of injury and violence prevention elevated is a tough sell. The broad scope can make injury and violence prevention seem scattered or fragmented, but some state injury and violence prevention directors see this diversity of issues and strategies as a strength — especially for connecting to many different partners.
- Despite many efforts to communicate the value and relevance of injury and violence prevention over the past two decades, a need for increased awareness about injury and violence prevention persists among SHOs — including its role within public health and the potential benefits that could accrue from investing in injury and violence prevention using a public health approach. Too often, one SHO commented, injury and violence prevention is still seen as an extra, rather than one of the main responsibilities of the state health department. The case for a connection between decreasing injuries and violence and increasing population health — a stated priority for almost every state health agency — has to be made repeatedly and requires consistent leadership from injury and violence prevention program directors.
- At the same time, SHOs already have many other priorities vying for their attention — their own, and their Governors’. The bandwidth that injury is jostling for is already crowded. This makes it difficult for injury and violence prevention to break through, if it is not already a priority.
- Injury and violence prevention often are buried within the structure of state health departments, two or more layers away from the senior leadership team. While some state injury and violence prevention directors have found ways to work around this, others feel that a campaign to elevate injury’s profile with SHOs might be more effective coming from their peers within ASTHO, from others who influence them (e.g., Governors and state cabinet members), and federal agencies and funders (particularly the National Center for Injury Prevention and Control, NCIPC, within the Centers for Disease Control and Prevention, CDC).
- Within state health departments, many injury and violence prevention programs are finding it difficult to connect with other state-level programs and agencies, including chronic disease programs (within or alongside which they are often housed), maternal and child health, aging, substance abuse and mental health programs (e.g., for suicide prevention initiatives).

- Even though the broad scope of injury issues, policies, and practices sometimes draws in different partners, it also can make these partnerships more complicated. For example, many important partners (such as law enforcement or traffic safety agencies) are not familiar with a public health or population-based approach to identifying problems and potential solutions. Likewise, within state health agencies, injury and violence prevention may be seen as belonging in someone else's domain. If another agency or group is addressing an injury problem, this line of thinking might go, why should the health agency also focus on it?
- Turnover in state health departments has brought in new SHOs, some of whom have little familiarity with injury and violence prevention. Moreover, some have a clinical or health administration background that is not particularly steeped in the public health approach on which many injury and violence prevention policies are predicated — so some injury and violence prevention directors find themselves struggling to place injury and violence prevention within that framework as well. In many cases, the turnover has affected not only SHOs, but also other key staff — legislative liaisons, communications directors — who also may be new and unfamiliar with the agency and its programs, including injury and violence prevention.
- The prolonged economic recession has affected every state government. The backdrop of drastic budget cuts has made it even more difficult to argue for investments in injury and violence prevention programs at all levels, especially new ones. Instead, legislatures and agencies are seeking ways to cut administrative costs and streamline programs. Adding to the challenge is the fact that many (e.g., in the legislature) do not understand the role of state-level programs and staff, because key functions such as surveillance and coordination remain invisible to them. Politically, some SHOs and injury programs worry that they are vulnerable to accusations of a “nanny state” that interferes with individual liberties. More generally, SHOs and other state leaders may be reluctant to step into conflict-prone policy debates.

Strategies and Advice

What's worked? What have state injury and violence prevention directors tried?

1. Using data.

“The injury data are really startling,” said one state injury director, echoing the comments of many. Still, the fact that injuries are a leading cause of morbidity and mortality for ages 1-44 remains hidden, even from data-savvy SHOs. So, too, are specific comparisons within the broader story, such as the fact that in many states, suicides are responsible for more morbidity and mortality than homicides.

State injury and violence prevention directors noted that understandably, SHOs are particularly interested in and concerned with data about what's going on in their state. Whether a state injury director gets help packaging injury and violence data internally, within the department (which is not always easy, several noted), or gets help from other state injury epidemiologists outside the department, interpreting state injury data and linking them to a SHO's interests and priorities are key. Some felt state epidemiologists are a relatively untapped resource for analyzing and presenting state-specific injury and violence data.

In Florida, where pool drownings are the leading cause of death among children aged 1-4, a pool safety campaign makes the numbers real: every year in Florida, four preschool classrooms full of children drown before their fifth birthdays. The state's Safe Kids program includes 10 coalitions and 7 chapters, covering 80 percent of Florida children under 14. Comparing fatality rates in Safe Kids counties to those without a Safe Kids coalition or chapter, the group found that fatality rates for children were 30 percent lower in the counties with Safe Kids — translating into 116 fewer child deaths from injury, if all counties had had similar programs in place.

2. Playing up partnerships.

“Partnerships are what you do when you don’t have any funding,” noted one injury director, somewhat ruefully — but they’re effective, and a key strategy for all kinds of injury programs. Partnerships with other agencies and groups are effective in their own right, but they also benefit SHOs by demonstrating collaboration, another noted. Whether it’s a partnership with a state department of transportation, education, or law enforcement groups, or many others, there’s strength in numbers and collaborative effort — and an opportunity for visibility and good PR. One injury program created an inventory of all its active partners — a list that ran to two single-spaced pages and reflected a solid network of communication and collaboration on behalf of injury and violence prevention. Many states already have Injury Community Planning Groups with diverse representation; others have sought to expand trauma-centric groups to reflect a broader spectrum of injury and violence prevention partners.

3. Being part of the plan.

In some states, the path to visibility and more equal footing led to specific agency and division strategic plans — plans that required active review and participation from agency leaders. These plans also represent opportunities to highlight the added value of state-level core functions such as surveillance, coordination, and dissemination of evidence-based practices. Florida’s Injury Prevention Strategic Plan 2009-2013 is one example; New York’s State Department of Health Division of Chronic Disease and Injury Prevention plan is another. Both are available on the Web as free downloads. (Please see the resource section on page 17 for links.)

4. Joining the performance standards bandwagon.

Performance improvement — tied to both health care reform and accreditation — was seen as a potent tool for bolstering injury and violence prevention by both SHOs and state injury program directors. “All states have a performance improvement manager and at least some funding for this,” said one, “and injury plays well into both effectiveness and cost pressure themes of performance improvement initiatives.” In Iowa, “the adoption of model standards was the best thing to happen to injury,” highlighting the program’s surveillance, best practices, and evidence-based interventions to audiences inside and outside the health department.



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5. Starting at the top, but pushing from all sides.

Under Governor Kathleen Sebelius (before she became Secretary of the U.S. Department of Health and Human Services), senior leaders from the Kansas departments of health and environment, transportation, and the highway patrol were convened to address motor vehicle crashes in 2005. Knowing this was among the Governor's priorities, the group conducted a "Driving Force" tour of Kansas to talk about motor vehicle crashes and highway safety issues; developed a plan; and adopted model booster seat laws, graduated licensing, and primary seatbelt laws as its goals.

After achieving those, the group turned to pushing a primary seatbelt law. Although the "Driving Force" initiative started at the top of state government, it was advanced significantly by grassroots groups, who were vocal about the need for booster seat laws for Kansas kids. "It was helpful to start from the top," says the state's injury program director, "but the push came from both directions — that's what made it really effective." Next up? A similar approach to preventing falls among older adults.

6. Issuing invitations — over and over.

Can the injury program prompt or ghostwrite an op-ed piece for the newspaper on an injury topic, with the SHO's byline? How about a brief televised message? A keynote address at an injury conference? A greeting to the visiting CDC Injury Center team? Attendance at a State Technical Assessment Team (STAT) briefing? (STAT visits were singled out as particularly useful opportunities for collecting and presenting information about disparate injury-related activities.) Injury and violence prevention directors keep issuing these invitations and making them as easy as possible.

7. Finding effective conduits for injury and violence prevention messages, inside and outside the department.

Who else does the SHO listen to? Are colleagues within the chronic disease, mental health, and substance abuse teams aware of injury and violence prevention initiatives? Has the state public health association been approached? A public-private partnership? In Iowa, the state Public Health Association was an important ally in submitting injury prevention bills to address concussions and TBI through training for school coaches, and promoting policy changes for graduated driver's licensing — both of which ultimately were successful in the state legislature.

8. Jumping into the loop.

Are the deputy(ies), communications staff, and legislative liaison up-to-date about injury and violence prevention data and trends, and policy options from other states? Is there a calendar of injury-related events that could provide opportunities for positive press? (Note that this is not arguing for end-runs around the SHO or department/division leadership teams, but rather noting that there are important audiences in the chain of command to inform alongside the SHO, who may have more daily and intensive contact with him or her.)

9. Keeping Websites up-to-date.

It may seem like a lower priority and a small thing, but several state injury and violence prevention directors observed that their SHOs routinely check department home pages for information and updates. Consider your injury program's Web page an information channel not only to the outside world, but internally as well.

10. Reaching out.

State injury and violence prevention directors shouldn't feel they're in this alone, advised several, suggesting reaching out to counterparts through national organizations like Safe States and launching or strengthening regional networks to share ideas and strategies.

11. Knowing your SHO.

State injury program directors have had varying degrees of success influencing their SHO's priorities to include injury and violence prevention — but even if these are not included on a priority list, there are still many opportunities to link injury and violence prevention to other interests and to specific populations. (See the list on page 13 for some ideas.)

12. Helping to build injury and violence prevention capacity within local health departments.

Even in tight budget environments, no- or low-cost strategies could be used to increase injury and violence prevention knowledge and skill levels — such as Webinars, sharing interesting new data or innovative research, or providing links to reports, best practices, and other tools.

Emerging Opportunities — What are state injury and violence prevention directors planning to try next?

New prevention-oriented funding included in the Patient Protection and Affordable Care Act — particularly the Prevention and Public Health Fund, Communities Putting Prevention to Work (CPPW) and Community Transformation Grants — are seen as an opportunity in at least two important ways. First, they give injury and violence prevention a seat at the table (that it might not otherwise have in some states). Second, they add CDC's clout to fostering better connections between injury and violence prevention and maternal and child health and chronic disease.

CDC Director Dr. Thomas Frieden's "winnable battles" list of priorities for CDC and its public health partners focuses on areas where a feasible, evidence-based public health strategy can be applied; where it can then have a high likelihood of having a significant, positive impact on health outcomes; and where it reaches a high proportion of those at risk. According to these criteria, motor vehicle injury prevention made the cut (along with nine other domestic and global public health battles).

In addition to capitalizing on CDC's attention to this particular priority, some suggested the "winnable battles" language and concepts can be applied to other injury and violence prevention issues as well. Indeed, CDC's National Center for Injury Prevention and Control has identified its own top injury priorities: motor vehicle crashes, falls among older adults, and child maltreatment. Both SHOs and state injury and violence prevention directors mentioned unintentional drug poisonings as an escalating problem across the country that also may lend itself to the "winnable battles" framework.

Just as pressure from the top is more effective when it is amplified at the grassroots and advocacy levels, so too can CDC's and ASTHO's efforts to promote injury and violence prevention priorities at the state level be amplified at the local, county levels. A stronger injury and violence prevention partnership between ASTHO and the National Association of County and City Health Officials (NACCHO) was mentioned as a relatively untapped opportunity.

Health care reform offers some specific opportunities for injury and violence prevention — particularly in terms of renewed emphasis on bending the cost curve and on shared accountability. As a bonus to highlight in tough budget times, both SHOs and state injury and violence prevention directors pointed out that a number of injury prevention activities (such as primary seatbelt laws and graduated licensing) are relatively budget neutral, yet offer the potential for major impact.

One SHO suggested that Accountable Care Organizations (ACOs), which are local or regional networks of hospitals and doctors with shared responsibilities for caring for patients, might be particularly interested in investing in injury and violence prevention as a mechanism for promoting good health while reducing costs.

Some state injury and violence prevention directors see opportunities for engaging new partners in injury and violence prevention efforts — especially in states where SHOs, governors, and others are seeking more public-private partnerships and highlight private-sector and business-oriented solutions to problems. The insurance industry was noted as one such potential partner. In addition, an injury director has formed a new partnership with a statewide veterans advocacy organization, which serves a population of returning veterans and their families struggling with TBIs and their lifelong effects, as well as post-

Motor Vehicle Injury Prevention: A Winnable Battle

- 4,000 lives could be saved each year if everyone used seat belts
- 8,000 lives could be saved each year through attainable reductions in impaired driving
- 175 lives could be saved and 350,000 non-fatal injuries prevented every year with enhanced graduated drivers license policies

According to CDC Director Tom Frieden, preventing injuries related to motor vehicle crashes is one of six "winnable battles" for public health officials, measured by the following criteria:

- A public health strategy that can be applied to the problem that is evidence-based and feasible
- A strategy that has a significant impact on health
- A strategy that is scalable (that is, it can reach a high proportion of those at risk)



Preventing falls among older adults (whether these occur in nursing homes and hospitals, or at home) is a proven way to prevent serious injuries (such as hip fractures and head trauma) as well as the hospitalization and rehabilitation costs associated with them.

traumatic stress disorder (PTSD) and increased risk for suicide. “We owe it to them to ensure they are well,” she noted, adding that this population and advocacy community may not be on SHOs’ — and public health’s — radar.

Despite decades of trying to make the case for a public health approach to preventing injuries and violence, many feel this remains a somewhat hard sell. Still, many feel there are opportunities to do a better job of “connecting the dots.” Because it affects every age group and population, many feel it should be possible to connect injury and violence prevention to other shared priorities. These include:

- **Obesity and chronic disease risk factors** — without safe and accessible playgrounds, parks, and streets, the message to “move more” and incorporate more physical activity into daily living is moot for many at risk. (As one state injury director put it, “It’s unethical to recommend increased outdoor exercise, if it isn’t safe for people.”) Some chronic disease and injury risk factors may be intertwined — for example, if a senior’s fall at home is a result of poorly managed hypertension or diabetes. Coordination between injury and chronic disease programs (such as conducting home visits that address both types of risk factors) are one way to strengthen both programs and support healthier outcomes for those at risk.

- **Childhood violence and adult chronic disease** — several state injury and violence prevention directors pointed to the Adverse Childhood Experiences (ACE) study's findings, in which an insured population of middle-aged Southern Californians receiving care from Kaiser Permanente showed a dose-response relationship between childhood trauma and a range of chronic disease, mental health, and substance use problems in adulthood. The childhood trauma list includes many of the events that violence prevention programs address (including experiencing physical, emotional, and sexual abuse; the presence of an alcohol and/or drug abuser in the household; an incarcerated household member; someone with mental health problems; a mother treated violently; having one or no parents; and experiencing emotional or physical neglect). The link to chronic disease and overall wellness is understood by their colleagues in chronic disease, state injury and violence prevention directors report, but the concrete next steps — how to translate this awareness into actual interventions that bridge injury and violence prevention and chronic disease — are not. Identifying and acting upon these opportunities was high on many lists of what could be done differently in the future.
- **Built environment** — lighting, walkability, access to public transportation, and mixed-use space that mingles residential and commercial activity affect not only physical activity but also violence prevention. In California, encouraging school districts to enact Joint Use policies and agreements has opened up school grounds after the school day to make it easier for neighborhood residents to gather and increase their physical activity in a safe, accessible, and familiar environment.
- **Cost containment** — preventing falls among older adults (whether these occur in nursing homes and hospitals, or at home) is a proven way to prevent serious injuries (such as hip fractures and head trauma) as well as the hospitalization and rehabilitation costs associated with them, as several states have discovered. Fractures in those over age 65 are significant contributors to Medicare expenditures. In Massachusetts, a successful three-step model to prevent falls in hospitals and nursing homes engaged these partners in identifying fall prevention strategies (especially those that avoided increased restraint use), which then led to voluntary reporting of falls as reportable medical errors and, ultimately, payment reform in which they would not be reimbursed by Medicare for treating injuries that resulted from a preventable fall.
- **Cost effectiveness** — home visits to prevent child abuse and neglect, booster seats for children, bicycle and motorcycle helmet use, smoke alarms, enforcing drunk driving laws, curfews for teen drivers, seatbelt laws, and some suicide prevention programs all have demonstrated significant returns on investments.
- **Health disparities** — addressing many injury and violence problems also addresses racial, ethnic, gender, and sexual orientation disparities. For example, American Indian/Alaska Native and African-American children aged 0-19 experience higher death rates from injury than white children — a disparity that has persisted for decades.
- **Violence against women and sexually transmitted diseases** — highlighting unequal gender relations and violence (or threats of violence) as a key factor preventing women from protecting themselves from sexually transmitted infections, including HIV/AIDS.

One injury director envisioned a case study or story that could help new SHOs (and others) connect the dots between injury and violence prevention and the many other health issues it touches — a sort of “social determinants of injury” scenario to parallel the social determinants of health.

For example, she suggested, the story could describe a child who grows up in a tough environment of neglect, with few caring and supportive adults to turn to. With no access to mental health services and few safe places to be outside, she retreats to her room after school and becomes another statistic in the childhood obesity epidemic, eating unhealthy foods at school and at home and steadily putting on

weight. Not surprisingly, she develops diabetes and struggles with both her weight and its health consequences her whole life. Perhaps a sibling is injured, riding a bike without a helmet or becoming a victim of violence in an unsafe neighborhood. Many of her schoolmates and neighbors could tell similar stories.

This scenario illustrates not only the connections of injury and violence prevention to many other systems invested in healthy people and places, but also the many missed opportunities to prevent these adverse health outcomes — starting with home visits to prevent child neglect and maltreatment in the first place.

A Story to Connect the Dots . . .

Between injury prevention and the many other health issues it touches: child neglect, unsafe neighborhoods, obesity, diabetes, injury, violence, and mental health, among others.



Seizing Opportunities to Communicate with a New SHO . . .

Some state injury and violence prevention directors had the good fortune to work with SHOs who shared their enthusiasm for investing in injury and violence prevention and worked to support their efforts. Others had experienced this in the past, but were unsure of what the future might hold with a new SHO and his or her new priorities. Across the board, their advice to other state injury and violence prevention directors about how they would make the case for injury and violence prevention to new SHOs was consistent and reflected many of the strategies described above. It included:

- Using state-specific data about the burden of injury, highlighting the gap between the burden and the resources devoted to addressing that burden. “Here are the leading causes of injury and violence-specific morbidity and mortality in our state.” As one SHO put it, “Our state health departments ought to be working on the leading health problems in our communities — and that means working on injuries.”
- Describing successes to date, including making the business case for the return on investment or “bang for the buck” nature of many investments in injury and violence prevention. “Here’s what we’ve been able to accomplish so far (in many cases, with limited resources but great partnerships).”



The built environment — including lighting, walkability, access to public transportation, and mixed-use space that mingles residential and commercial activity — affects not only physical activity but also violence prevention. In California, encouraging school districts to enact Joint Use policies and agreements has opened up school grounds after the school day to make it easier for neighborhood residents to gather and increase their physical activity in a safe, accessible, and familiar environment.



Some chronic disease and injury risk factors may be intertwined — for example, if a senior’s fall at home is a result of poorly managed hypertension or diabetes. Coordination between injury and chronic disease programs (such as conducting home visits that address both types of risk factors) are one way to strengthen both programs and support healthier outcomes for those at risk.

- **Painting a vivid, compelling (but succinct) picture of what else could be done, and with which partners and allies.** “Here’s what more we could accomplish to have an even greater impact than we’ve had — the low-hanging fruit as well as the more ambitious policies and programs. Here’s the potential impact on morbidity, mortality, and costs. Here are the allies and partners already engaged in this issue and ready to do more. And here’s how other states have addressed this same problem, successfully.”
- **Linking to a new SHO’s existing priorities.** “Here’s how what we’re proposing could help advance your own goals to improve health in our state . . . [e.g., obesity prevention, child health, seniors, health care reform, cost containment].”
- **The “ask.”** “What we need from you in order to have this impact is . . . X.” Several noted that while additional resources would be extremely helpful, this is not realistic in the current budget climate in many states. However, other types of assistance from SHOs could still be sought, such as using his or her influence to approach new partners and engage them, to shift (even if temporarily) resources within the health department, and/or to promote better collaboration (e.g., with chronic disease and mental health/substance abuse divisions) from the top.

Page 17 lists some resources that state injury and violence prevention directors and SHOs have found useful in trying to make the case for injury and violence prevention as state health department priorities.

Resources

Association of State and Territorial Health Officials (ASTHO)

www.astho.org

Spotting Injury and Violence Prevention on Your Radar Screen — Creating a Legacy in Public Health — A Guide for State and Territorial Health Officials

This recent ASTHO publication, supporting Dr. Halverson's Presidential Challenge, is the most relevant and comprehensive resource geared specifically to SHOs. It includes summaries of the public health approach, messaging strategies, success stories, and concrete examples of state-level accomplishments in addressing motor vehicle crashes, falls among older adults, child maltreatment, and prescription drug overdoses. In addition, ASTHO's Website includes links to lists of interventions, state and federal legislation, fact sheets and data for these topics as well as substance abuse and suicide, teen dating violence, home and recreation safety, elder maltreatment, child safety, and TBI.

Preventing Injury and Death Due to Motor Vehicle Crashes: Strategies for the States

This meeting summary lists recommendations from a May 2010 meeting convened by ASTHO and CDC, bringing together health and transportation stakeholders to discuss how they can join forces at the state level to decrease preventable motor vehicle crash-related injuries and deaths (one of CDC's "winnable battles").

National Conference of State Legislatures (NCSL)

www.ncsl.org

Injury and Violence Policy — Strategies for Prevention 2009

This publication, available from www.ncsl.org, compiles policy options for state legislators to consider in these areas: falls among older adults, child maltreatment, motor vehicle safety, prescription drug overdoses, trauma, unintentional child injuries, and teen dating violence.

Preventable Injuries Burden State Budgets

This January 2009 briefing paper highlights the public health approach, the preventable nature of major categories of injuries, and federal and state actions to address them.

State and Territorial Injury Prevention Directors Association (now Safe States)

www.safestates.org

Injury & Violence Prevention are Essential to U.S. Health Reform

This June 2009 brief summarizes why injuries are a public health problem, the cost of injuries, the links between injuries and chronic disease, why prevention is effective and saves money, the leadership role that state public health can and should take, and how injury and violence provisions should be part of comprehensive health reform proposals.

CDC National Center for Injury Prevention and Control

<http://www.cdc.gov/injury/>

Injury and Violence Prevention — A Pressing Public Health Concern

This publication presents the rationale for the Injury Center's top priorities — child maltreatment prevention, motor vehicle safety, and older adult falls prevention — and describes what the Injury Center is doing to address these priorities, within a public health framework.

Adding Power to Our Voices: A Framing Guide for Communicating About Injury

This guide presents research on positive, consistent messages that resonate with different audiences, including the theme that "we're in this together" and that injury and violence prevention is geared to helping people fulfill their potential. The guide includes suggestions on tailoring this overall framing and message to different injury topics (including TBI, older adult falls, and teen dating violence) and using techniques such as "social math" to get messages across.

Web-based Injury Statistics Query and Reporting System (WISQARS)

WISQARS is an interactive database system that makes possible customized queries and reports on injury-related data.

The Epidemic Information Exchange (Epi-X)

Epi-X is a Web-based communication tool for CDC officials, state and local health

departments, poison control centers, and other public health professionals, giving them opportunities to share and access preliminary health surveillance information. (Note that Epi-X participants must be officially designated by their healthy agency through an application process.)

Florida Department of Health

2009-2013 Florida Injury Prevention Strategic Plan — Injury Prevention for All

www.doh.state.fl.us/DEMO/InjuryPrevention/.../09-13StrategicPlan.pdf

Florida's award-winning plan lists vision, mission, goals, and implementation steps.

New York State Department of Health

Division of Chronic Disease and Injury Prevention Strategic Plan 2010-2013

http://www.health.state.ny.us/diseases/chronic/plans_reports/2010-2013_strategic_plan.htm

This plan is an example of how injury is integrated — and elevated — within a chronic disease division's strategic plan.



Prevention Institute

Resources for Preventing Violence and Reducing Injury

<http://www.preventioninstitute.org/focus-areas/preventing-violence-and-reducing-injury.html>

The Preventing Violence and Reducing Injury section of the Prevention Institute's Website includes projects, tools, and publications, such as:

- UNITY: Urban Networks Increase Thriving Youth (a CDC-funded initiative that supports the nation's largest cities in developing sustainable strategies for building community resilience and preventing violence).
- Addressing the Intersection: Preventing Violence and Promoting Healthy Eating and Active Living — explains the intersection between violence and healthy eating and activity, highlighting five key ways that these issues intersect.
- Collaboration Multiplier: Enhancing Multidisciplinary Partnerships
- Spectrum of Prevention: Developing a Comprehensive Approach to Injury Prevention
- Communities Taking Action: Preventing Violence & Reducing Injury Profiles
- The Transportation Prescription: Bold new ideas for healthy, equitable transportation reform in America
- Bridging the Gap: Bringing together Intentional and Unintentional Injury Prevention Efforts to Improve Health and Well Being



SAFE STATES

The Safe States Alliance is a 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. For more information, visit our Website:

www.safestates.org