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Please visit the Journal page of our website at http://www.texaspha.org for author information and instructions on submitting to our journal. Texas Public Health Association PO Box 201540, Austin, Texas 78720-1540 phone (512) 336-2520 fax (512) 336-0533 Email: txpha@aol.com
President’s Message

Adriana Babiak-Vazquez, M.A., M.P.H.

Come one and all to the TPHA 87th Annual Educational Conference, held this year in Houston April 13-15, 2011. Earn continuing education credit while hearing experts discuss diverse topics including: the BP Gulf Oil Spill, cutting edge public health topics such as Human Trafficking, Health Care Reform at the national and state levels, Aging in our Society, Infectious Disease Outbreak Updates, Ethical Dilemmas in Public Health, Psycho-Social-Spiritual Interventions and Public Health in Space.

Our conference features plenary sessions, multiple concurrent sessions and vast opportunities for attendees to network. New this year is a special Student Orientation. This is your chance to share thoughts, ideas, contact information and explore future collaborations and/or job opportunities. Plan to join us at the evening receptions, including the Grand Opening of Exhibits and Poster/Educational Materials and the Awards Presentation and Reception. This year we feature game-night and an open mic for those budding Public Health “stars”. Visit our website www.texaspha.org for more details.

I am quite partial, don’t just take my word that this will be an exceptional, educational and fun conference that you should attend. Read what a few of our past conference attendees had to say during an e-poll and on facebook:

• “Earn professional continuing educational credits (CEU’s)!” Bobby Schmidt, Diana Brooks, Terri Pali
• “Students, meet and get to know the person who will be interviewing you for a job some day soon”;
• “Practitioners, learn the latest developments in research and practice in public health”;
• “Researchers, network with practitioners and make the links that will turn into community-based partnerships in research or evaluation.” James Swan
• “To learn from the experience of other public health practitioners” Kaye Reynolds
• “Networking!!!” Charla Edwards and Diana Brooks

• “Come to the Annual Meeting and get your annual opportunity to ....” Gloria McNeil
• “Great Conference!” Carol McDonald Davis
• “A wise investment of both time and money to insure growth in your chosen profession!” Robert Drummond
• “Because you will make new life-long friends, you will eat great food, and you will increase your professional knowledge!!! It’s the best ticket in town, people!!!!!!!!” Melissa Stanford Oden

This is a brief glimpse of our upcoming educational conference to entice you to join us. If you’ve never attended one of our conferences or have not done so in some time, please consider this meeting. We know you have many professional meetings to choose from, but ask that you decide to attend this dynamic Texas Public Health Association Educational Conference. By registering, you will support the only public health professional association in our fine state and one of the oldest in the United States. Please visit our website, www.texaspha.org for all the details and register online today.

From the Editor: The Texas Public Health Journal celebrates National Public Health Week with the theme, “Safety is No Accident: Live Injury Free”. This issue features: articles related to safety; safety tips from the American Public Health Association; accomplishments of an established Texas public safety program; columns focused on safety and a tribute to public health professionals in Texas who are planning events to celebrate with their community. Since Spring in Texas this year also includes a busy legislative session, several opinion/editorial articles highlighting the public health needs of Texas are included. Please distribute to state leaders in your area to keep public health in the forefront. As always, this issue would not be possible without the hard work of our volunteer editorial team and reviewers. We thank all who contribute to our journal.
Commissioner’s Comments

A Healthy Texas

David L. Lakey, M.D.
Commissioner, Texas Department of State Health Services

National Public Health Week is celebrated in April and this year’s theme is “Safety is NO Accident.” I want to use a variation on that theme by saying a healthy Texas does not happen by accident. The successes of the public health system are the result of our collective and deliberate work in public health.

The road to a healthy Texas is a journey, not a destination. Along the way, there are turns, bumps and the occasional detour. Yet, as public health employees, professionals and colleagues, we can acknowledge that while we are surpassing many milestones along the way, we remain steadfast in our determination to continue to improve health and well-being in Texas.

We as public health professionals continually work to inform and affect policies, practices, environments and available choices, to improve health outcomes in our communities. Our work makes a difference. Our work saves lives.

Some successes the public health system and its partners can point to over the course of recent history are:

• A reduction in smoking rates among teens and Texans 18-24
• Improved disaster preparedness, response, and recovery efforts
• Increases in childhood immunization rates (Texas was recently recognized by the CDC for its improvement in immunizations.)
• A decline of the HIV transmission rate
• An increase in the use of car seats for children
• A decrease in the cardiovascular disease death rate

Public health works. Results may not be immediate, but through the perseverance of many individuals and communities, the results are there – and will be there – for all to see and experience.

That said, we know there are challenges – or opportunities, depending on your point of view – to further influence and improve health in Texas.

For example, we all know that infectious diseases remain a persistent threat. Specifically, there were 1,385 cases of tuberculosis reported in Texas in 2010. Flu, a more common disease, is a serious illness that kills an average of 23,600 Americans each year. We work hard to prevent and control these and other diseases through surveillance, immunizations, education and other interventions, but challenges remain.

While we’ve seen improvements in the prevention of some chronic diseases, their burden is increasing and is a major driver of health care costs. About one out of every 10 adult Texans has diabetes. In 1990 the prevalence of obesity was only 12.3 percent. In 2009, the rate was 29.5 percent, which illustrates the power of the epidemic we face in Texas. Tobacco use in Texas among adults and youth, though currently in decline, remains a serious public health problem, contributing to or causing many preventable illnesses and deaths. In Texas, smoking is responsible for 24,500 annual deaths and $12.2 billion in excess medical care expenditures and lost productivity. Prevention programs can help mitigate these costs.

Substance abuse contributes to injuries, accidents, aggressive behavior and poor job performance. For example, while the numbers are improving, about 40 percent of all traffic fatalities in Texas involve alcohol. Drug and alcohol abuse are factors in poor overall health and increased health care costs. We know that substance abuse can be effectively prevented and treated.

Clearly challenges remain, but we have made tremendous progress in public health in Texas, and it has not been by accident. We’ve worked toward success by implementing effective, evidence-based programs, whether resources were available or constrained. We know that resources always are finite. And we understand that we are – and must continue to be – resourceful in Texas.

My thanks to everyone involved in this continuing journey toward a healthier Texas.

Come Hear Dr. Lakey
“STATE OF TEXAS: KEY PUBLIC HEALTH ISSUES 2011”
At the Opening Session of the Upcoming TPHA Annual Education Conference
April 13, 2011

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Community-based participatory approach to reducing perinatal disparities in Tarrant County: The Aintie-Tia Program

Kathryn M. Cardarelli, Ph.D.\(^1\),\(^2\)*, Kim Parish Perkins\(^3\), Miesha Beamon, M.S.H.S.\(^1\),\(^2\), Ralph Anderson, M.D., F.A.C.O.G.\(^4\), Jamboor K. Vishwanatha, Ph.D.\(^2\), Scott B. Ransom, D.O., M.B.A., M.P.H.\(^1\),\(^4\)

\(^1\)Center for Community Health, University of North Texas [UNT] Health Science Center
\(^2\)Texas Center for Health Disparities, UNT Health Science Center
\(^3\)Fort Worth/ Dallas Birthing Project
\(^4\)Department of Obstetrics and Gynecology, UNT Health Science Center

ABSTRACT

**Background:** Disparities in pregnancy outcome by race and ethnicity remain one of the most persistent, costly, and challenging public health problems in Texas. Strategies to reduce such disparities are numerous, but few interventions overtly incorporate the wisdom and experience of community members in their development and implementation. Because successful approaches to eliminating health disparities require participation on the part of the affected communities, academic investigators and community partners collaborated to design and evaluate the Aintie-Tia Program, with the goal of reducing perinatal disparities in Tarrant County. This paper describes the significance of a community-based participatory approach in targeting disparities and shares the experiences of the Aintie-Tia Program.

**Methods:** Community-based participatory research [CBPR] is a collaborative approach to research that emphasizes community capacity-building strategies to bridge the gap between knowledge produced through research and what is practiced in communities to improve health. CBPR has been successfully used to address perinatal disparities in developing nations but may deserve greater attention in the United States.

**Results:** This report does not provide results for the efficacy trial. Rather, it discusses the challenges and enabling factors related to conducting CBPR and provides examples from the Aintie-Tia Program. CBPR provides an opportunity for community members to invest in the processes and products of research, but must be executed carefully in order to succeed.

**Conclusions:** CBPR holds much promise for mitigating perinatal outcome disparities, and the experiences of the Aintie-Tia Program may assist other Texas communities to build similar successful endeavors.

**BACKGROUND**

Racial disparities in adverse pregnancy outcome remains one of the most persistent, costly, and challenging public health problems.\(^1\) Infant mortality rates have consistently been at least twice as high for African American women compared with White women, and this disparity is widening, despite major advances in medical care, technology, and services.\(^2,3\)

Mitigation of this challenging public health problem requires creative approaches that target potential causal pathways and interventions at multiple levels. Community-based participatory research (CBPR), defined as “a collaborative approach to research that combines methods of inquiry with community capacity-building strategies to bridge the gap between knowledge produced through research and what is practiced in communities to improve health,”\(^4\) offers a unique approach to addressing these disparities. While CBPR has been employed in multiple developing nations to address infant mortality challenges,\(^5,7\) its use in the United States has been more limited.

Efforts to reduce infant mortality in Tarrant County have not resulted in declining rates in the previous decade.\(^8\) County leaders determined that a multisector, community-based participatory approach should be developed to reduce disparities in pregnancy outcomes.\(^9\) This paper describes the Aintie-Tia Program, an effort bridging academic and community partners to address poor birth outcomes in Tarrant County. While the efficacy of the program continues to be evaluated, this paper addresses the challenges experienced and provides recommendations for nurturing such endeavors in other communities.

**POPULATIONS AND METHODS**

Addressing perinatal disparities requires innovative approaches that empower the community and researchers in a collaborative effort toward improving maternal health.\(^10\) Most programs to improve health in underserved communities are developed and implemented by persons outside the target communities, using a top-down approach whereby researchers inform communities about their needs. In contrast, CBPR involves equitable participation between researchers and those affected by the issues under study in all aspects of the research process,\(^11\) increasing the opportunity for “buy-in” from the community and for success. Moreover, the CBPR approach promises a more comprehensive understanding of the issues that community members find particularly salient, allowing research to be driven by participants’ concerns. In order to build on local cultural beliefs and practices related to pregnancy and birth outcomes, a community-based participatory approach to address such disparities in Tarrant County was selected.

Tarrant County has experienced higher infant mortality rates than Texas or U.S. rates over the last decade.\(^8\) In 2007, Arlington (9.0 deaths per 1,000 live births) and Fort Worth (8.9) had the highest infant mortality rates among all large Texas cities.\(^8\) In comparison, the Texas rate was of 6.2 deaths per 1,000 live births, and the national rate was 6.8.\(^8\) Furthermore, just as across the United States, infants in Tarrant County born to African Americans are 2 to 3 times more likely to die within the first year of life than those born to Whites.

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These high rates brought together a community-based organization (the Fort Worth/Dallas Birthing Project) and a university (UNT Health Science Center) to develop and evaluate a unique program. FWDBP, an organization with over 12 years of experience working to improve birth outcomes, conceptualized the Aintie-Tia Program to focus on women over the age of 18 with historically poor pregnancy outcomes. The name of the program stems from the terms used to characterize an aunt ["aintie," or "tia" in Spanish] or other family member who may provide support during and after pregnancy. The Aintie-Tia Program expands on routine prenatal care by providing supportive, educational home visits and regular phone calls; helping women navigate the health care and human service systems; and providing prenatal education, parenting education, labor support, and breastfeeding education and support up to 4 months post-delivery.

In 2007, 10 women were recruited to train as potential Aintie-Tias. Selection criteria included personal warmth, successful personal parenting experience, knowledge of community resources, demonstrated ability to accept responsibility, and evidence of leadership. The FWDBP facilitated the identification of the potential Aintie-Tias, who then completed more than 60 hours of training in physiology and anatomy, nutrition, childbirth education, and how to navigate local health and social services.

In order to assess the efficacy of the Aintie-Tia Program, investigators and FWDBP jointly designed a randomized trial which was approved by an institutional review board (IRB). The trial aimed to assess whether the Aintie Tia Program reduces adverse pregnancy outcomes and improves breastfeeding practices. While this paper does not present the results of the trial, it does reflect on the role of the FWDBP in designing and implementing the trial.

RESULTS

CBPR Challenges. The FWDBP assisted in refining the survey used in the study, suggesting the inclusion of important contextual factors that may influence breastfeeding practices, for example, and the deletion of other scales that might be perceived as offensive to participants. Their input assured cultural relevance and sensitivity, which can increase response to survey questions.12 Furthermore, due to the FWDBP’s extensive experience in the local community, they provided critical cultural knowledge to enhance understanding of important contributing factors to pregnancy outcomes.

One potential advantage of CBPR is the improvement of study recruitment efforts.13 The Aintie-Tias constantly sought new methods of participant recruitment, and these methods were sometimes not consistent with the IRB-approved methods for recruitment. For example, the Aintie-Tias suggested visiting a potential participant in her home if her telephone was disconnected, to follow up on a referral, a method that was not included in the IRB-approved protocol. Consistent reminders to community partners as to the acceptable methods for recruitment helped overcome this issue.

Another challenge related to the passionate commitment of the Aintie-Tias toward the individuals associated with the control group. The initial protocol called for the Aintie-Tias to be involved in conducting brief telephone counseling for the control group, to which they were vehemently opposed, concerned that they would not be able to restrain their concern for the participant or refrain from offering advice, which would be a violation of the protocol. The agreed-upon compromise was for Aintie-Tias to direct all controls to the Program Coordinator at the FWDBP to conduct the counseling.

The enthusiasm of the community partners notwithstanding, one of the most frustrating challenges related to IRBs (the study was approved by four different IRBs). The original protocol excluded women who would not plan to deliver at one of two local hospitals. However, FWDBP suggested the addition of a new women’s hospital that opened after the study began. The addition of the new hospital required us to apply to another IRB, and that board would not accept the university-endorsed human subjects research training. Therefore, all study personnel had to complete another ethics training program, and it took several months to receive approval from the new IRB. In fact, the project experienced delays of several months due to IRB procedures, which prevented the project from proceeding as originally planned and was a source of frustration to all involved. Approval was eventually received by the additional IRB and the women’s hospital was added as an eligible hospital for delivery.

Finally, interruptions in funding caused a significant challenge to all study partners, particularly given the dependence on these funds for employment of the Aintie-Tias. The Program received funding from NIH and CDC as well as local foundations, but these project periods were truncated by hospital IRB challenges. Further challenging this issue was action of the FWDBP Board of Directors’ suspending the acceptance of referrals by UNT Health Science Center into the Program at one point until the next round of funding was received. The periodic funding lapses resulted in some of the Aintie-Tias leaving the FWDBP for more secure employment. Identification of multiple funding sources would have mitigated this issue.

CBPR Enabling Factors. The investigative team identified multiple key factors to maintaining a meaningful partnership, including trust, open communication, and flexibility. The dynamics of sharing power is important in CBPR,14 and beginning a study with partnership trust facilitates this arrangement. In the current project, the academic and community partners built a trusting relationship over a several-year period. Attentive listening, openness, caring, and identifying and addressing conflicts have been identified as facilitating factors that result in successful operating norms.14 Frequent communication occurred via email, and periodic face-to-face meetings allowed for resolution of any concerns related to study methodology or future funding searches. A willingness to disclose and discuss concerns among the academic and community partners allowed the trust to build. All budgets and protocols were shared in order to assure transparency. Academic inves-
tigators participated in fundraising events and other activities to support the FWDBP. In turn, FWDBP staff and the Aintie-Tias participated with investigators in local and state conferences to disseminate information about the program.

The community partner acknowledged the value of a scientific protocol which would require a lengthy investigation in order to assess the efficacy of the program, and this understanding buoyed them to persevere during the many IRB and funding delays. The academic partner acknowledged the history, neighborhood context, and cultural knowledge that the community partner brought to the study.

Ultimately, commitment to the reduction of adverse perinatal outcomes among African American women served to facilitate the continued partnership. Respect for the partners because of this commitment facilitated perseverance throughout the challenges.

DISCUSSION
The Aintie-Tia Program is a successful example of involving the community in every step of the research process. The FWDBP designed the intervention, helped design the randomized trial and related survey instrument, refined study eligibility criteria, delivered the intervention, and will play a key role in analyzing the data and disseminating the study findings. It is our hope that the approach will result in community member use of research findings and, in combination with other efforts, ultimately aid in the reduction of persistent and pervasive disparities.

As noted by others, innovative strategies to reduce inequities in infant health are urgently needed to mitigate pervasive poor outcomes. With demonstrated success in mitigating such disparities in developing nations, the CBPR approach deserves greater attention in perinatal disparity reduction efforts in the United States. Collaborating with community residents and organizations may provide a potentially more effective and less costly approach to improve perinatal outcomes. The community/academic partnership process described herein stands to inform the development of other CBPR approaches to improve maternal and child health in Texas. Future development and evaluation of CBPR interventions to improve perinatal health should reflect the experiences of community partners in order to add to the richness of the reported outcomes.

ACKNOWLEDGMENTS
This study was supported by 5P20MD001633-03 from the National Center on Minority Health and Health Disparities and 1H75MN000008-01 from the Centers for Disease Control and Prevention. The views expressed herein do not necessarily reflect the official policies of the Department of Health and Human Services. We thank the Aintie-Tias—Nikia Lawson, Chiquita Preston, Wendy Jones, and Norma Bogan—for their dedication to assuring healthy birth outcomes, and Dr. Nykiconia Preacely for her early work in coordinating the study. We also thank Cassandra Muth, Brenda Shumway, and Wandy Hernandez for their contribution to the Aintie-Tia training. Finally, we are grateful for the support of John Peter Smith Health Network staff and the work of the research assistants.

REFERENCES
Pediatric Brain Injury: A Study of Prehospital Transport in a Rural Texas County

Brian D. Robertson, PhD, MPH1 and Charles E. McConnel, PhD2

1Perot Brain and Nerve Injury Center, Children’s Medical Center Dallas.
2UT Southwestern Medical Center, Dallas, Texas

Key Words: Rural Health, Traumatic Brain Injury, Children, Mobile Emergency Units

Note: This work was supported by a grant from the Perot Family Center for the Care of Brain and Nerve Injuries at Children’s Medical Center Dallas.

ABSTRACT

Introduction: Time and distance are two key factors in delivering effective emergency medicine. The purpose of this study was to obtain an overview of pediatric traumatic brain injury in a rural county, examining severity of injury, method of transportation, response times, transport times, outcome, and physical location in which the injury was sustained.

Methods: Patients were identified using a hospital trauma registry for all patients admitted with head injuries between 2005 and 2009. Data was collected on response times, distance, mode of transport, and whether the transport was direct or indirect.

Results: No statistical differences could be found for mode of transport, time, or distance on patient outcome. Helicopters were utilized primarily for severe and moderate brain injuries and had consistently faster response times. Helicopter crews spent less time at the scene, spent less time in transit, and arrived at a trauma center faster. Despite the advantages of speed and the fact that Henderson County is approximately 100 miles from a Level I pediatric trauma center, the average time between the injury and admission to the trauma center was two hours and forty-nine minutes for helicopter transports, and eight hours and twenty-eight minutes for ground ambulances.

Conclusion: This study provides a unique snapshot of traumatic brain injury in a rural county and the EMS systems available to rural county residents. While inadequately powered to show evidence for immediate public health intervention, it provides a sound benchmark for future public health research on traumatic injuries in rural areas, and in trying to improve the delivery of emergency medical services to rural areas.

INTRODUCTION

Pre-hospital care is a central component in improving the outcome of traumatic injuries. One of the key arguments in improved pre-hospital trauma care falls within the idea of the “golden hour,” a hypothetical benchmark referring to the period of time immediately following a critical injury in which medical care is vital. Although there is no magical balance between life or death at the one-hour mark, the general idea is that outcome from traumatic injuries improves with the speed at which medical care is received. The ability to provide quick care is an obstacle in treating rural-area traumatic injuries, and treating traumatic injuries in children provides additional obstacles. When looking specifically at pediatrics, many of the traumatic injuries sustained by children may only be treated at a specialized pediatric trauma facility, forcing children to endure longer travel distances and additional time before receiving adequate medical care. An estimated 17 million rural children live more than an hour away from a pediatric trauma facility, further isolating rural-area children when emergency medical care is crucial.

Previous research on rural traumatic brain injury in Texas children found Henderson County to have the highest number of rural county admissions to Children’s Medical Center Dallas. Henderson County is a rural county located in North Texas approximately 100 miles southeast of Dallas. The county is 949 square miles, and the population in 2009 was 78,921 with the city of Athens having the largest population at 12,320 people. Henderson County has one hospital, a 117-bed acute care facility. The purpose of this retrospective case series study was to obtain a broad overview of traumatic brain injury in children residing in a rural county. In addition, Henderson County provides an excellent laboratory for exploring the typical rural experience with pre-hospital service provision to pediatric trauma victims.

METHODS

After receiving Institutional Review Board (IRB) approval, patients were identified through the trauma database at Children’s Medical Center Dallas using ICD-9 Codes 800, 801, 803, 804, 850-854, and 959.01 for those patients admitted between January 1, 2005 and December 31, 2009. Data was only collected on patients who were injured in Henderson County, Texas.

Once inclusion criteria were met, patient demographic information was collected retrospectively to include gender, age, date of injury, and cause of injury. Information on the injury severity was also collected to include on-scene Glasgow Coma Score (GCS), arrival GCS, Trauma-Injury Severity Score (TRISS), ISS, Trauma Scores and whether the injury was localized to the head or if other parts of the body were also injured.

TRISS scores are measures of projected survivability where higher numbers are associated with better projected outcomes. Trauma Scores are clinical measures of injury severity where higher numbers are also associated with better scores. ISS scores are another clinical measure on the severity of injury where high scores are associated with more severe injuries.

Additionally, information was collected on the EMS provider, the time of the injury, the time of EMS notification, the loca-
tion of the injury, the time of arrival at the scene of the injury, the time of transport to the hospital, the method of transporta-
tion, and whether the patient was transported direct or indirect
from the scene. Outcome variables included the patient’s total
length of stay, discharge status, and discharge location.

All data was analyzed using t-tests and Analysis of Variance
(ANOVA) for continuous variables, and Chi-square analysis
for nominal data. Correlation, linear regression, and multiple
regression analyses were used to determine relationships and
predictive values of severity, time, distance, and outcome. All
data was analyzed using SPSS version 15.0 with p-values <
0.05 considered statistically significant.

Calculating Time
Time from Injury to Calling EMS is defined as the time inter-
val between injury occurrence and EMS being dispatched to
the scene. Time from Injury to EMS Arrival is the time inter-
val between injury occurrence and EMS arriving on the scene
of the injury. Time Spent at the Scene is defined as the time
from EMS arriving at the scene to the start of transporting
the patient to the hospital. Time Spent in Transit is the time
from leaving the scene to arriving at the hospital. Time from
Injury to Children’s Medical Center, Dallas arrival is defined
as the total time from injury occurrence to receiving care at
the Level I pediatric trauma center.

Calculating Distance
If possible, the exact location of the accident or the zip code
in which the accident occurred was extracted from the EMS
run sheet located in the patient’s medical record. Distance
was calculated by using Google maps to calculate distance
from the scene of the injury to Children’s Medical Center Dal-
las. Using the “get directions” feature, the zip code of the
injury was utilized as the starting point, and the zip code at
Children’s Medical Center Dallas was utilized as the destina-
tion. The total mileage was documented as driving distance
to allow for more accurate mileage in ground transportation.
In patients where the city in which the injury occurred was
known, but the zip code was not, the zip code for that city’s
City Hall was utilized. This provided a rough estimate of
the closest EMS provider to the place in which the injury oc-
curred.

RESULTS
Overall, 25 patients were identified for inclusion in this study.
One patient was excluded because no measures of injury se-
verity could be identified beyond the trauma score, and two
patients who reside in Henderson County were excluded be-
cause they were not injured in Henderson County. As a result,
22 patients were included in this analysis.

The demographic breakdown of these patients is seen in Table
1. Males account for 54.5 percent of the total patents (n =12)
versus 44.5 percent female (n = 10). The average age at
admission was 5.3 years. Over one-third of the total patients
were admitted with severe traumatic brain injury (n = 8), 13.6
percent had moderate traumatic brain injury (n = 3), and half
of the study sample had mild Traumatic brain Injury (n =11).
Nineteen patients included in this study lived in Henderson
County, whereas three patients lived in other counties, but
were injured in Henderson County.

Injury and Outcome
A breakdown of the mechanism of injury is also seen in Table
1. Most of the injuries received were caused by accidental
means (n = 20), with only two injuries sustained by purposeful
means. Motor vehicle collisions caused 41 percent of the total
injuries in this group (n = 9), followed by falls (n = 6), motor
pedestrian collisions (n = 3), and abuse (n = 2). The mecha-
nism of injury was unknown in one patient, and a television
tipped over onto the head of another.

<p>| Table 1. Demographic Information by Traumatic Brain Injury Severity |
|---------------------|--------|-------|-----|-------|</p>
<table>
<thead>
<tr>
<th></th>
<th>Severe</th>
<th>Moderate</th>
<th>Mild</th>
<th>Total</th>
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<tbody>
<tr>
<td>Total Patients</td>
<td>8</td>
<td>3</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Average Age</td>
<td>4.36</td>
<td>3.69</td>
<td>6.43</td>
<td>5.3</td>
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<tr>
<td>Mechanism of Injury</td>
<td></td>
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<td></td>
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<tr>
<td>Motor Vehicle Collision</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Fall</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Motor Pedestrian Collision</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Abuse</td>
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<td>1</td>
<td>0</td>
<td>2</td>
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<tr>
<td>Television Tipover</td>
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<td>Unknown</td>
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<tr>
<td>Town Size</td>
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<td>Large</td>
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<td>Helicopter</td>
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<td>Ground EMS</td>
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<td>Type of Transport</td>
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<tr>
<td>Direct</td>
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<td>Indirect</td>
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</tr>
<tr>
<td>Localized</td>
<td>2</td>
<td>1</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Multi-system</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Type of Injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental</td>
<td>7</td>
<td>1</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>Non-Accidental</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Data represents means (± sd) or n (%).
*p < 0.01
Localized injuries account for 59 percent (n = 13) of the to-
tal injuries, while 41 percent of the injuries were multi-sys-
tem (n = 9). Seventy-five percent of the patients with severe
traumatic brain injury received multi-system injuries (n = 6),
sixty-six percent of the moderate traumatic brain injuries re-
ceived multi-system injuries (n = 2), and nine percent of the
mild traumatic brain injuries included multi-system injuries
(n = 1). No patients died in this study. Nineteen patients were
discharged to their homes, while three were discharged to di-
rectly to inpatient rehabilitation services. Two of the patients
who were discharged to rehabilitation services received se-
vere injuries. The average length of hospital stay was 4.09
days for the entire group.

No significant differences were found for mechanism of in-
jury, size of the home town, type of transport, or type of injury
as accidental or non-accidental. Significant differences, how-
ever, were found for the mode of transport (p < 0.01), and the
severity of injury (p < 0.01), highlighting that multi-system
injuries are more common in patients with severe traumatic brain injury, and severe injuries are associated with helicopter transport.

Measures of injury severity are found in Table 2. For the sample, the average Trauma Score was 8.76, the average GCS was 10.8 at the scene of the injury and 10.3 on admission to the Emergency Room at Children’s Medical Center Dallas, and the average projected survivability rate was 0.87. As expected, measures of injury severity were progressively worse across all variables with the worsening degree of traumatic brain injury, with significant differences found for GCS both on scene (p < 0.001) and arrival (p < 0.001), Trauma Score (p < 0.001), TRISS (p < 0.001), and length of stay (p < 0.05). Patients with severe traumatic brain injuries had significantly worse GCS scores at the scene of the injury and on arrival to Children’s Medical Center Dallas. More severe injuries had significantly worse Trauma Scores, and lower projected survivability. In contrast, those patients with mild traumatic brain injury had the best measures of severity.

Table 2. Severity and Outcome by Traumatic Brain Injury Severity

<table>
<thead>
<tr>
<th>Injury Measures</th>
<th>Severe</th>
<th>Moderate</th>
<th>Mild</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCS on Scene*</td>
<td>5.83</td>
<td>10.5</td>
<td>14.3</td>
<td>10.8</td>
</tr>
<tr>
<td>GCS on Arrival to CMCD*</td>
<td>4.38</td>
<td>10.0</td>
<td>14.6</td>
<td>10.3</td>
</tr>
<tr>
<td>Trauma Score**</td>
<td>3.88</td>
<td>10.67</td>
<td>14.3</td>
<td>8.76</td>
</tr>
<tr>
<td>Injury Severity Score</td>
<td>0.69</td>
<td>0.97</td>
<td>0.99</td>
<td>0.87</td>
</tr>
</tbody>
</table>

Table 3. Transportation Information by Traumatic Brain Injury Severity

<table>
<thead>
<tr>
<th>Time Measures</th>
<th>Severe</th>
<th>Moderate</th>
<th>Mild</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time from Injury to Calling EMS</td>
<td>0.56</td>
<td>0.25</td>
<td>1.04</td>
<td>0.57</td>
</tr>
<tr>
<td>Time from Injury to EMS Arrival</td>
<td>1.12</td>
<td>0.48</td>
<td>1.25</td>
<td>1.16</td>
</tr>
<tr>
<td>Time Spent at the Scene</td>
<td>0.23</td>
<td>0.30</td>
<td>0.24</td>
<td>0.24</td>
</tr>
<tr>
<td>Time Spent in Transit</td>
<td>0.49</td>
<td>0.39</td>
<td>0.47</td>
<td>0.47</td>
</tr>
<tr>
<td>Time from Injury to CMCD Arrival</td>
<td>2.49</td>
<td>4.05</td>
<td>6.04</td>
<td>4.42</td>
</tr>
</tbody>
</table>

Transportation and Distance

Transportation information is presented in Tables 3, 4, and 5. No significant differences were found for transportation and response times by level of severity. The average time between the injury occurrence and notifying EMS was 57 minutes. EMS arrived at the scene an average of 1 hour and 16 minutes after the injury occurred, and the average time spent treating patients at the scene was 24 minutes. The average time of transporting patients from the scene to the hospital was 47 minutes, and the average time between receiving the injury and being admitted to Children’s Medical Center Dallas was 4 hours and 42 minutes. The average time from injury to admission at Children’s Medical Center Dallas in direct transported patients was two hours and eleven minutes, compared to seven hours and twenty-eight minutes in indirect transport (data not shown).

Table 4. Demographics by Transport Method

<table>
<thead>
<tr>
<th></th>
<th>Helicopter</th>
<th>Ground</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patients</td>
<td>15</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>Patient Age</td>
<td>4.4</td>
<td>7.25</td>
<td>5.3</td>
</tr>
<tr>
<td>Mechanism of Injury</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motor Vehicle Collision</td>
<td>8</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Fall</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Motor Pedestrian Collision</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Abuse</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Television Tipover</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Type of Transport</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct</td>
<td>9</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Indirect</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Type of Traumatic Brain Injury*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>4</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Severe</td>
<td>8</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Severity of Injury*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Localized</td>
<td>6</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Multi-system</td>
<td>9</td>
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<td>Non-Accidental</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Distance was only estimated in 14 patients in which the zip code of injury could be determined. If the zip code was unavailable on the EMS run sheets, the home zip code was used for injuries occurring in or near the home, and the zip code of City Hall was utilized for those injuries in which the city was known. The average mileage was estimated to be approximately 80 miles.

All patients included in this study were transported by either ground ambulance or helicopter. Helicopter transportation was utilized 68.2 percent of the time (n = 15), while ground
ambulance accounted for 31.8 percent (n = 7). Chi-square analysis yields significant differences in the level of injury severity and the mode of transportation (p < 0.01). All patients with moderate and severe traumatic brain injuries were transported by helicopter, and four patients with mild traumatic brain injury were transported by helicopter. All patients receiving ground transportation had mild traumatic brain injuries. Eleven patients were sent directly to Children’s Medical Center Dallas from the scene of the injury, while eleven were seen at an outside hospital first.

Patients traveling by helicopter had worse measures of injury severity on all collected measures, with significant differences found for both on-scene and on-arrival GCS scores (p < 0.01), Trauma Scores (p < 0.05), TRISS measures (p < 0.001), and length of stay (p < 0.05). Patients transported by helicopter also had more multi-system injuries, although this was not statistically significant.

Transport and response times between helicopter and ground transportation were consistently faster for helicopters, but significant differences were only found for total travel time. The time from injury to calling EMS was faster, the response times were faster, EMS personnel spent less time at the scene of the injury, these patients had faster transit times, reached Children’s Medical Center Dallas quicker and were more often transported directly from the scene.

Assessments on Outcome
No significant correlation exists for total transport time or distance on the length of hospital stay. GCS at the scene of the injury and trauma score were also not related to overall length of hospital stay. However, significant negative correlations were present for on-arrival GCS scores and length of stay (r = -0.555, p < 0.01), and TRISS and length of hospital stay (r = -0.701, p < 0.01). These only highlight that worse measures of injury are associated with longer hospital stays.

DISCUSSION
Few studies exist on pre-hospital care in rural environments. While some studies examined mode of transportation relating to age, mechanism of injury, and payor source, the current study looked specifically at time, distance, and injury severity in a rural county. The results of this study are similar to that of a study conducted in Salt Lake City, Utah in which ground and helicopter transport and response times were assessed. The Utah study, however, examined helicopter and ambulance times within a 15-mile radius of a Level I trauma center. Despite differences in the target population and the proximity to a trauma center between these studies, both studies show that helicopter transportation was technically a more efficient modality, i.e., helicopters can transport faster and crews spent less time at the scene of the injury when compared to ground transportation. Where the Utah study shows faster transport times, the transport times are essentially equal between ground and helicopter transport within a 15-mile transportation radius. The present study, by contrast, has an average transportation distance of 80.14 miles and shows over 50 percent more time is required to travel by ground transportation.

When assessing time within the confines of the “golden hour,” moderate and severe traumatic brain injuries received emergency medical care much quicker than mild traumatic brain injuries. Only one patient with severe traumatic brain injury reached the trauma center within one hour of sustaining the injury. No clear explanation exists for the extended time period between receiving the injury and calling EMS, but mild injuries will have an understandable delay given the lesser degree of injury. One patient in the severely-injured group had a time gap of over two hours between the injury occurring and calling EMS. Removing this patient from the analysis drops the average time between injury and calling EMS from 56 minutes to 46 minutes for the severely-injured group. Because the details surrounding the delays were not examined, further research must be conducted to determine why there are extended delays between receiving an injury and calling EMS for the severely-injured patients. With time as a vital component to receiving adequate trauma care, the time difference in this cohort of injured patients must be both understood and decreased.

This study has several limitations including a low sample size. Previous research on severe traumatic brain injury in children yielded thirteen patients from Henderson County. ICD-9 codes were more limited in scope for this study, but included all levels of traumatic brain injury severity. As such, this study is not adequately powered to draw statistical significance.

Additionally, the generalizability of this study is limited with the use of a single, albeit typical rural county, and methodological difficulties remain in comparing rural and urban areas. Another key limitation in this study is the inability to consistently collect pre-hospital data, namely the location of injury. This is a key facet of this study, and the exact location of injury was known in some cases and speculated in others based on EMS transport records. As such, assumptions were made on imperfect data, including location of injury and mileage distance. In these cases, the address of City Hall was used as a substitute injury site, and Google Maps was used to calculate distance. Despite the fact that helicopters do not follow road routes, and the exact path of transportation was not known, these methods seemed to provide the best possible means of collecting unreliable data. More accurate data on pre-hospital information is needed to better study the effects of pre-hospital care and outcome.

CONCLUSION
In conclusion, this study provides a unique snapshot of traumatic brain injury in a single county by examining severity, mechanism, pre-hospital transport time, method, distance, and outcome. It shows that helicopters, while able to respond and transport patients rapidly, were not able to transport patients to a high-level trauma center within one hour of injury. There are unknown reasons for the delaying calls to EMS in those patients with severe injuries, but despite being ap-
proximately 100 miles away from a Level I pediatric trauma center, patients traveling via helicopter arrived at the center almost three hours after the injury occurred. Forty percent of the severely-injured patients were indirectly transported to the trauma center, which can significantly increase transport time, however, the speed at which high-level care is provided to these patients is a critical element in providing good emergency medical care.

This study is inadequately powered to show strong statistical evidence for public health intervention, but it provides a sound benchmark for future research in rural-area emergency research. More research is needed in the causes of rural injuries, in studying the effects of time and distance between rural and urban areas, and in understanding the delays in contacting EMS personnel in emergency situations.

Acknowledgement: The Trauma Registry of Children’s Medical Center Dallas, Dallas, Texas was the source of the data.

REFERENCES:
objective: To investigate the relevant cultural norms and beliefs of cellular phone use among African American young adults while driving.

participants: Eighty African American students, aged 18 to 34 years, attending a historically black university comprised the study population.

methods: Focus groups were conducted among a student population by trained researchers and were audio tape-recorded and transcribed verbatim. Transcripts were coded and abstracted to identify themes related to beliefs and perceived norms related to texting and driving.

results: Themes revealed that male participants believed that zealous response to opposite sex and intimate partner pressure are major barriers to not texting while driving vehicles. Among females, high perceived importance and intimate partner pressure are major contributors to perceived urgency allowing texting while driving. Students reported that stronger penalties for texting while driving could help transform this potentially dangerous behavior.

conclusions: Future interventions are recommended for young adults to educate them about hands free technological alternatives to texting and driving and stricter penalties may prove useful in reducing the dangers associated with texting and driving.

introduction
Throughout the united states, the use of cellular phones while driving motor vehicles has become a very important public safety concern. This includes talking on the cellular device, but most importantly relates to reading and sending text messages while driving. Early research conducted by Redelmeier & Tibshirani showed that cellular telephone use quadrupled the risk of collision. A meta-analysis conducted to evaluate the effects of cellular phone use on driver performance found a mean increase in reaction time of a quarter-second to all types of phone related tasks with both hand-held and hands free devices. Because texting requires drivers to redirect their vision and to concurrently remove their hands to write and read messages, it is a particularly dangerous behavior. According to the National Highway Traffic Safety Administration, approximately 1,000,000 vehicles on the road on any day during daylight hours are driven by individuals who are concurrently using hand-held phones. Additional research conducted by the Fatality Analysis Reporting System reported a rapid increase, nationally, in distracted driving deaths from 1999 to 2008 that is consistent with monthly texting volume trends rather than with the steady and significant increase in cellular phone subscriptions.

Recent studies have revealed that a large majority of young adults have texted while driving. Research conducted by Atchley, Atwood and Boulton revealed that while driving their motor vehicles, 92% of young adults read and initiate text messages. Among the participants in this study, 70% reported that they had developed motor skills to actually text while driving without looking at their cellular telephones. This behavior is not limited to young adults in the United States, but is also true of young adults in Australia where they are more likely to use a cellular phone in general, including for texting, and they are more likely to have a motor vehicle accident due to their driving inexperience.

Subjective norms, reported in studies, have been found overall to be extremely important in people’s decisions to text while driving. Riquelme and colleagues measured the influence of injunctive, subjective, verbal and behavioral norms communicated by law enforcers regarding intention to continue cellular phone use while driving. Their results showed that participants’ concerns with what others think they should do paired with lack of enforcement (subjective and verbal norms, respectively) are important in maintenance of cellular phone use while driving. Although some research has been conducted with regard to cellular phone use and driving in general and some research has been conducted among young adults, the scientific research conducted among specific subgroups of the US population, specifically African Americans, that addresses the social norms and beliefs of texting while driving and their perceptions about motivating strategies that will change this dangerous behavior is limited. To address this research gap and to enhance understanding of cultural beliefs and perceived social norms, a qualitative study was undertaken among a sample of African American young adults attending a historically black university near Houston, Texas.
METHODS

Recruitment and consent

The study sample was drawn from students attending a large, historically black university near Houston, Texas. After meeting with university administrators to secure approval for conducting the study, members of the project team afforded notification about focus group recruitment to students enrolled in health education classes. A two-step process was used to identify participants for the study. First, college students in a health education class were asked, “Do you have your own car?” Secondly, students were asked “Have you texted on your cell phone while driving your car in the past month?” Students who self-reported their agreement to both statements were asked to volunteer and met with graduate students later that day at another school location independent of faculty or other students where they received additional information about the qualitative study. Eight-four out of 121 (69%) students stated “yes” to both questions. Of that number, 80 agreed to participate in the study.

Students were informed that focus group participation was voluntary and that all data collected would remain confidential. Active consent was obtained for all focus group participants. The Institutional Review Board at the Prairie View A and M University approved all research materials and protocols.

Focus groups

Focus group methodology, as suggested by Krueger13 was used for this study. All of the interviews were audio tape-recorded. Graduate students with experience in conducting qualitative research conducted all of the focus groups. All focus group interviews were transcribed verbatim. Transcripts were coded and subsequently abstracted to identify themes related to beliefs and perceived norms related to texting and driving.

Each session began with a general introduction and an overview of the confidential and anonymous nature of the focus group. This was followed by a brief participant assessment of participants’ ages and racial/ethnic group. Four major open-ended questions were asked to identify the participants’ subjective norms and salient beliefs related to texting and driving. The four questions were as follows: (1) Why do you believe people text while driving vehicles?, (2) What do your friends feel about texting and driving vehicles?, (3) What are the consequences or barriers of not texting while driving vehicles?, and (4) What interventions can be done to stop people from texting and driving vehicles?

Comments from focus group discussions were classified into content categories. This process was done iteratively to test, revise, and refine the thematic classifications. Comparisons and contrasts of the categorizations by sex were conducted to discover similarities and differences between men and women.

RESULTS

Among the 80 study participants, all were African American ranging in age from 18 to 34 years: 18 years (5); 19 years (12); 20 years (17); 21 years (21); 22 years (10); 23 years (8); 25 years (3); 28 years (2); 31 years (1); and 34 years (1). Among participants, 50% (n=40) were female. Most were anxious to tell their stories about the topic. There were 8 focus groups conducted, each of which was approximately 30 minutes in duration. There were 10 participants in each of the 8 groups. Comments from focus group discussions were classified into content categories. This process was performed iteratively to test, revise, and refine the thematic classifications.

The thematic analysis of the focus groups yielded 12 coded themes. Table 1 provides verbatim illustrative quotations portraying salient beliefs related to themes associated with texting with driving vehicles. Comparisons of the themes with the actual number and percentiles are shown in Table 2.

Why do you believe people text while driving vehicles?

When asked why they believe people text while driving vehicles, the majority of male participants stated it was because of low perceived danger (60%) followed by high perceived importance (22.5%) of the text being sent or received and habitual behavior (12.5%). Among female participants, most stated that high perceived importance of the message (32%), intimate partner pressure (30%), and habitual behavior (22.5%) were the reasons they believe that people text while driving motor vehicles.

What do your friends feel about texting and driving vehicles?

A great majority of male (92.5%) and female (87.5%) participants felt most of their peers had a positive attitude about texting and driving vehicles. However, among females one other important response involved the habitual nature of the behavior.

What are the barriers to not texting while driving vehicles?

Among males, zealous response to opposite sex (57.5%) and intimate partner pressure (27.5%) were stated as the primary barriers to not texting while driving. High perceived importance was an additional response given by males. High perceived importance (52.5%) and intimate partner pressure (40%) were the responses afforded by female participants.

What interventions can be done to stop people from texting while driving vehicles?

A majority of male participants stated that severe penalties (57.5%) would impact or halt people from texting and concurrently driving. Other responses to this question included providing applications for texting and driving, one that would allow a person to speak the text they wish to have sent via cellular telephone (20%), and that there were no useful interventions that could be provided to address this issue (20%). Among females, most believed that texting and driving applications (47.5%) could be used to intervene on texting and driving followed by no useful intervention” (27.5%) and severe penalties (25%).
DISCUSSION
The study utilized a qualitative approach to investigate the beliefs and social norms associated with texting and driving among a group of young adults attending a historically black university. Overwhelmingly, males believed that zealous response to opposite sex and intimate partner pressure were the major barriers to stopping texting while driving. In addition, females stated high perceived importance and intimate partner pressure as barriers to stopping the behaviors.

Ecological contexts such as family processes, peer influences, and community context combined with socialization serve as risk factors involving issues of power and trust in African American relationships. Examples of participants’ comments were, from a female, “My boyfriend get mad if I don’t text back, he’ll be like, ‘I texted you’ and I’ll say ‘I was driving’ and then he’ll say, ‘What does that mean?’” A male participant stated, “So my girlfriend won’t get mad, when I say ‘I’m driving’, she say ‘It’s an excuse.’” Regardless of race, the struggle for power is a main characteristic in basically all of our relationships. However, when intimate partners are controlling or dominating to a point of putting themselves and others in danger in order to meet their partner’s communication needs, such as an immediate “text back during driving,” this is a form of abuse that necessitates further exploration.

Overwhelmingly, most youth in our study reported high social reinforcement and support from their friends concerning texting while driving. Young adults are more likely to perform learned behaviors if the specific action results in a valued outcome. Specifically, if the modeled behavior has highly rewarding and non-punishing effects, young adults are motivated to execute these actions. Examples of participants’ comments were “My friends feel it’s okay, they would rather text and drive than talk and drive. Texting is less distracting than driving and talking on the phone.” (female) “I don’t have a friend who don’t text and drive. My friends feel that texting is our only means of communicating with each other.” (male) Based on these alarming comments, it is clear that the social approval related to texting and driving may be leading to the prevalence of this potentially dangerous behavior among African American young adults.

When asked about interventions that could be implemented to stop texting and driving, both males and females stated that the provision of stronger penalties and implementation of an application for talking while texting would be useful. Studies in the past have shown that increased texting laws have not had an effect on texting and driving. However, recent cellular phone applications have been invented that allow drivers to not use their hands or eyes to read incoming messages, but rather to speak the messages they wish to use to reply and to post messages on Facebook, Twitter, and other social networking sites while driving. Future studies should be conducted to investigate the effects of these applications on decreasing risk for and frequency of motor vehicle accidents. While this study provides insight into norms and perceived beliefs of historically black university students on texting while driving motor vehicles, there are three methodological limitations. Firstly, the nature of the study precludes any conclusions about the prevalence of the dangerous multi-tasking activity. Accurate prevalence estimates are critical before any policy-related recommendations could be proffered. Secondly, the generalizability of our findings is unknown because the respondents were recruited from one historically black university in the southern United States. Larger studies with a more diverse geographic sample are needed to more precisely estimate the beliefs and norms among young adults. Thirdly, the data are exclusively qualitative. Some research has been conducted on texting and driving among young adults in the US, however, more etiological and quantitative research should be conducted to understand the social, cultural, and intra-personal forces that promote texting and driving among youth adults.

Despite these limitations, our qualitative study provides a glimpse into the normative influences that encourage texting while driving. More research is warranted among diverse populations so that these influences can be further explored. Interventions are recommended for teenagers and young adults to educate them about the dangers of texting and driving as well as alternative hands and eyes free cellular telephone applications for those who will continue texting while driving. In addition, further research is needed on the cultural dynamics of power and control relative to texting in intimate relationship among African Americans. While this issue may not be relevant to all African American young adults, this study may provide early insight into a potential problem among those who text and drive.

REFERENCES
10. Atchley P., Atwood S., Boulton A. (2010). The choice to text and drive in younger drivers: Behavior may shape attitude. Accident Analysis & Prevention, 43(1),134-42.

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**Table 1.** Examples of Beliefs from Major Themes

<table>
<thead>
<tr>
<th>Zealous response to opposite sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Girls, girls and more girls you can miss out on a lot of things good if you don’t text or reply quickly”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Habitual Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>“It’s a habit, texting is popular so they are hooked to their phones and can’t stop”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High Perceived Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>“It may be an important text message, like getting directions”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High Social Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Because they can’t wait to send a text message so they can prove how many friends they got”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intimate Partner Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>“My boyfriend get mad if I don’t text back, he’ll be like, ‘I text you’ and I’ll say ‘I was driving’ and then he’ll say, ‘What does that mean?’”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low Perceived Danger</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Some people don’t see the dangers of it. They think it’s alright to do both.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Negative Peer Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>“They don’t like it when I text and drive, but I do it anyway.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No Useful Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Nothing can be done to stop texting and driving because this way of communication is easy and fun and I never want to ignore my phone.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Positive Peer Attitude</th>
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</thead>
<tbody>
<tr>
<td>“My friends feel it’s okay, they would rather text and drive than talk and drive”</td>
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<table>
<thead>
<tr>
<th>Private Form of Communication</th>
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<tr>
<td>“You be with somebody and don’t want them to know your conversation”</td>
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<thead>
<tr>
<th>Severe Penalties</th>
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<tbody>
<tr>
<td>“Law should be set where the fines are very severe if you get caught texting and law enforcement should enforce it”</td>
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<thead>
<tr>
<th>Texting and Driving Application</th>
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<tbody>
<tr>
<td>“Create an app for voice texting, I can tell my phone what to text”</td>
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</table>
Table 2. Salient beliefs related to texting while driving among African American youth adults (N=80)

<table>
<thead>
<tr>
<th>Why do you believe people text while driving vehicles?</th>
<th>Males N (%)</th>
<th>Females N (%)</th>
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<tbody>
<tr>
<td>Low Perceived Danger 24 (60.0%)</td>
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<tr>
<td>High Perceived Importance 9 (22.5%)</td>
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<tr>
<td>Habitual Behavior 5 (12.5%)</td>
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<td>No Response 2 (5%)</td>
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<tr>
<td>High Perceived Importance 13 (32.5%)</td>
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<tr>
<td>Intimate Partner Pressure 12 (30.0%)</td>
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<td>Habitual Behavior 9 (22.5%)</td>
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<td>Low Perceived Danger 3 (7.5%)</td>
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<tr>
<td>High Social Status 2 (5%)</td>
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<tr>
<td>No Response 1 (2.5%)</td>
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<tr>
<td>What do your friends feel about texting and driving vehicles?</td>
<td>Males N (%)</td>
<td>Females N (%)</td>
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<tr>
<td>Positive Peer Attitude 37 (92.5%)</td>
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<tr>
<td>Negative Peer Attitude 2 (5%)</td>
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<td>Habitual Behavior 1 (2.5%)</td>
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<tr>
<td>Positive Peer Attitude 35 (87.5%)</td>
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<tr>
<td>Habitual Behavior 3 (7.5%)</td>
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<td>Negative Peer Attitude 2 (5%)</td>
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<tr>
<td>What are the barriers to not texting while driving vehicles?</td>
<td>Males N (%)</td>
<td>Females N (%)</td>
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<tr>
<td>Zealous response to opposite sex 23 (57.5%)</td>
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<tr>
<td>Intimate Partner Pressure 11 (27.5%)</td>
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<tr>
<td>High Perceived Importance 4 (10%)</td>
<td></td>
<td></td>
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<tr>
<td>No Response 2 (5%)</td>
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<tr>
<td>High Perceived Importance 21 (52.5%)</td>
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<tr>
<td>Intimate Partner Pressure 16 (40%)</td>
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<tr>
<td>No Response 3 (7.5%)</td>
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<tr>
<td>What interventions can be done to stop people from texting and driving vehicles?</td>
<td>Males N (%)</td>
<td>Females N (%)</td>
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<tr>
<td>Severe Penalties 23 (57.5%)</td>
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<tr>
<td>Texting and Driving Applications 8 (20%)</td>
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<td>No Useful Intervention 8 (20%)</td>
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<td>No Response 1 (2.5%)</td>
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<td>Texting and Driving Applications 19 (47.5%)</td>
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<td>No Useful Intervention 11 (27.5%)</td>
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<td>Severe Penalties 10 (25%)</td>
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<tr>
<td>No Response 2 (5%)</td>
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The Texas Public Health Journal brings you our tribute to National Public Health Week, April 4-10, 2011

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About NPHW
Since 1995, when the first full week of April was declared as National Public Health Week (NPHW), communities across the country have celebrated NPHW to recognize the contributions of public health and highlight issues that are important to improving the public’s health.

The American Public Health Association (APHA) serves as the organizer of NPHW and develops a national campaign to educate the public, policy-makers and practitioners about issues related to that year’s theme. APHA creates comprehensive planning, organizing and outreach materials that can be used during and after the week to raise awareness.

Monday: At Home
You can protect yourself, your family and community by taking action, both big and small, to prevent injury. Here are just a few examples:

Start small...
• Assess your home for potential hazards such as poor lighting and uneven surfaces to prevent falls.
• Install and maintain smoke alarms and carbon monoxide detectors in your home.
• Establish a plan for how you would evacuate from your home in the event of an emergency.
• Make sure all electrical outlets are covered and inaccessible to children.
• Supervise young children whenever they’re near cooking surfaces and never leave food unattended on the stove.
• Program emergency numbers, such as the Poison Control Hotline (1-800-222-1222), into your phone to call in the event of a poisoning emergency.
• Install four-sided isolation fencing at least five feet high and equipped with self-latching gates to prevent drownings in home swimming pools.
• Store cleaning supplies and medicines in locked cabinets out of the reach of children.
• Check your hot water heater periodically and adjust the thermostat to 120 degrees Fahrenheit or lower to avoid burns.

Think big...
• Organize Tai Chi classes to help promote physical activity and prevent falls among older adults.
• Invite local firefighters to a community event to promote fire safety.
• Form a coalition that supports consumer protection policies to reduce the use of toxins in household products.
• Partner with your poison center to visit schools to talk about poison safety.
• Submit a letter to the editor of your local paper that stresses the importance of living injury-free during NPHW and beyond.

Tuesday: At Work
Employers and employees can work together to build safer and healthier work environments. Taking action, both big and small, to prevent injury in the workplace is common sense and effective. Here are just a few examples:

Employers start small...
• Understand and follow all workplace safety regulations and best practices. Go beyond the minimum required by the Occupational Safety and Health Administration.
• Educate employees about workplace regulations and train employees to recognize unsafe or unhealthy settings. Create an employee reporting system to allow workers to report hazardous working conditions.
• Provide required or recommended protective equipment and reflective gear to reduce employee exposure to hazards.
• Create safe work environments by identifying and fixing workplace hazards such as unstable surfaces and malfunctioning vehicles.
• Maintain a working sprinkler system and schedule fire drills to practice safe evacuation.
• Promote workplace safety by offering tips on your company bulletin board, website or newsletter.
• Conduct personal safety training programs that teach employees how to recognize, avoid or diffuse potentially violent workplace situations.
• Invite health care professionals to the workplace to discuss how to prevent injuries.

Employees start small...
• Wear all personal protective equipment required or recommended for your occupation.
• Participate in worksite safety training programs and follow all workplace laws and safety rules.
• Ensure vision is not obstructed when operating heavy machinery.
• Hold a brown-bag lunch at work to focus on workplace safety.
• Use your rights to advocate for safety and health.

Think big...
• Write a letter to the editor of your local paper about the importance of preventing workplace injuries during National Public Health Week (NPHW) and beyond.
• Invite local policymakers and others to a community roundtable to discuss injury prevention in the workplace and fol-
low-up with specific actions.

• Support your family, friends and neighbors when they try to improve health and safety at their workplace.

**Wednesday: At Play**

You can protect yourself, your family and community by taking action, both big and small, to prevent injury. Here are just a few examples:

**Start small...**

• Wear a helmet and other properly fitted protective gear.
• Use proper form and accept your body’s limits.
• Have a physical before starting a new sport and warm-up each time before beginning.
• Play it safe and strictly enforce rules that prevent injury.
• Monitor children while they are at play to ensure safety.
• Drink plenty of water to avoid becoming dehydrated.
• Educate coaches on how to ensure the health and safety of youth athletes.

**Think big...**

• Educate policymakers about ways to prevent youth athletic injuries. Invite a local student that has suffered from a traumatic brain injury to speak on the importance of safety.
• Form a group in your community that works to educate families about safe play for children.
• Work with local community leaders to build and support safe playgrounds.
• Host a concussion awareness event at a local high school for young athletes.
• Write a letter to the editor of your local paper that stresses the importance of preventing injuries during NPHW and beyond.

**Thursday: On the Move**

You can protect yourself, your family and community by taking action, both big and small, to prevent injury. Here are just a few examples:

**Start small...**

• Wear a seat belt on every trip, no matter how short.
• Make sure children are buckled up in a car seat, booster seat or seat belt.
• Be mindful of the environment and be cautious when crossing the road. Use sidewalks and avoid jaywalking.
• Walk facing traffic and make yourself visible when walking at night.
• Wear a helmet and reflective gear when on a bike, skateboard, scooter or other motor vehicle.
• Avoid texting, eating, using the phone or grooming while driving.
• Be a designated driver. Don’t drink and drive, let others drink and drive, or get into a vehicle with someone who has been drinking.
• Avoiding driving while you are tired.
• Discuss your rules of the road and ask your teen to pledge to avoid speeding, texting and having multiple passengers while driving.

**Think big...**

• Partner with law enforcement officials to offer traffic education classes for both motorists and non-motorists.
• Support graduated driver’s license laws for new drivers.
• Support alcohol screening and brief intervention programs in your community.
• Encourage the PTA to work with schools to implement teen driver safety programs.
• Hold a child safety-seat demonstration to help families ensure their safety seats are installed correctly.
• Work with community and urban design professionals to plan for and create safe walking and cycling conditions.
• Educate policymakers about the importance of traffic calming measures in residential and urban areas.
• Write a letter to the editor of your local paper that stresses the importance of preventing injuries during NPHW and beyond.

**Friday: In Your Community**

You can protect yourself, your family and community by taking action, both big and small, to prevent injury and violence. Here are just a few examples:

**Start small...**

• Join your Neighborhood Watch program.
• Work with school leaders to implement school violence and bullying programs.
• Keep weapons in a locked and safe place, away from children.
• Model respectful communication in your interactions with children, family members and in the community.
• Be a caring adult in the life of a young person.
• Call the police or local child protective services if you suspect an older adult has been abused or a child neglected.

**Think big...**

• Work with community leaders to establish a community safety task force.
• Work with local authorities to initiate violence intervention and prevention efforts.
• Develop a suicide prevention program that encourages community members to inquire and respond to potential suicide situations.
• Work with local officials to ensure access to services for youth and families living in communities most impacted by violence.
• Participate in programs that improve parent-child relationships and provide parents with social support.
• Write a letter to the editor of your local paper that stresses the importance of safety and injury prevention during NPHW and beyond.

There is much more you can do to prevent injuries beyond these actions. Raise awareness of safety and injury prevention within your community during National Public Health Week. You can help make your community a safer and healthier place to live.
Ruth Shults is a senior epidemiologist at the Injury Center of the Centers for Disease Control and Prevention (CDC) where she leads research in the areas of alcohol-impaired driving, seat belt use, and teen driving. In this role, she coordinates systematic reviews of interventions to reduce alcohol-impaired driving for the Guide to Community Preventive Services. Ruth’s other research interests include improving safety for young drivers and understanding community-level influences on alcohol-impaired driving. Ruth received her doctorate degree in epidemiology from the University of North Carolina.

Dr. Shults, more than 30,000 Americans die every year in vehicle-related accidents on American roads. While this number is huge, it represents a long trend of improvement both in absolute numbers and in rates per mile driven. Even so, the CDC has identified motor vehicle-related deaths and injuries as one of its “Winnable Battles,” an area where significant gains remain to be made by building on what we know today. What factors play into the optimism behind this characterization?

The topic of motor vehicle injury prevention was selected as a CDC Winnable Battle because it is a public health priority with a potential large-scale impact on health and with known, effective strategies to address it. All of CDC’s Winnable Battles were chosen based both on the magnitude of the public health problem and the ability to make significant progress in improving outcomes. The area of motor vehicle injury prevention has evidence-based, cost effective strategies – such as child safety seats, seat belts, ignition interlocks, and graduated drivers licensing systems for teens – that we can implement now and have a significant impact on our nation’s health.

Of the three areas you mention as part of the Winnable Battle plan of attack, reduction in alcohol-impaired driving is one that is dear to your heart. Over time we have made good headway in alcohol-impaired driving but alcohol still plays a role in one-third of fatal crashes. In this area, what state level policies really work?

We’ve seen impressive reductions in alcohol-impaired driving crash deaths in the past few years. As you point out, however, the proportion of all traffic crash deaths that are due to alcohol-impaired driving has remained stubbornly constant at about one-third. To address this problem, CDC recommends that states widely implement strategies that are known to work. A variety of state level policies have proven to reduce alcohol-impaired driving (AID) crashes, including .08% blood alcohol concentration (.08 BAC) laws; minimum legal drinking age (MLDA) laws; “zero tolerance” laws, that set a lower illegal BAC threshold for drivers ages 20 years or younger; and administrative license suspension laws. Lastly, one of the most important actions that states can take to reduce deaths due to AID is to implement and actively enforce a strong primary seat belt law that requires all occupants to be properly restrained on all trips.

The work of enforcing these state level policies occurs at the community level. Community level strategies that are not necessarily implemented through state level policy also have a crucial role to play in reducing AID. Examples include sobriety checkpoints, supportive mass media campaigns, and alcohol ignition interlock programs for convicted AID offenders. Also, interventions to reduce excessive drinking, including increases in the price of alcohol; enforcing MLDA laws; and maintaining limits on hours of alcohol sale in bars and restaurants have been effective in reducing alcohol-impaired driving in some settings. By incorporating strategies to reduce excessive drinking into comprehensive programs to reduce AID, communities can better protect all road users and reduce other negative health outcomes associated with alcohol misuse.

Another area in the Winnable Battle is the emphasis on state policies that implement graduated driver licensing for teens. Graduated licensing helps ensure that the teen driver skills are not overwhelmed by putting them in circumstances for which they are not ready. Is there a similar issue with our population of aging drivers whose driving skills may be diminishing?

There are some states that issue restricted licenses to older drivers, but we’re not aware of any evaluation of those programs. You may want to speak with Essie Wagner at NHTSA: Esther.Wagner@dot.gov about older driver policies.

What puts teen drivers at such high risk for crash involvement, and what can be done to keep them safe?

Teen drivers lack driving experience, and this makes them more likely to be involved in crashes than more experienced drivers. Risk factors, such as night driving and driving with other teen passengers, further increase teens’ risk of being involved in a crash. To help parents address this issue, CDC has developed the “Parents Are the Key” communications campaign. Campaign materials explain the leading causes of teen crashes and steps that can be taken to reduce these risks. All of the information is available free of charge at www.cdc.gov/parentsarethekey.
The faculty, staff and students of the Department of Preventive Medicine and Community Health and the Trauma Service of The University of Texas Medical Branch at Galveston plan to celebrate National Public Health Week during April 4-10, 2011 with the theme of “Safety Is No Accident: Live Injury-Free.” They will jointly sponsor a bike rodeo for the Galveston bicycling community. This will include stations for safety training, helmet fitting, bike inspection (tires, etc.), and an obstacle course. This planned community activity will focus on prevention of a significant cause of injury morbidity and mortality in the United States each year. For more information contact:

John J. Fraser, Jr., M.D., J.D., M.P.H.
Professor and Program Director
General Preventive Medicine Residency
Department of Preventive Medicine & Community Health
The University of Texas Medical Branch at Galveston
301 University Blvd.
Galveston, TX 77555-1110
Office: 409-772-9106 FAX: 409-747-6129

Department of Preventive Medicine and Community Health
2011 Public Health Week Symposium & Poster Competition
Safety is No Accident: Live Injury-Free
Injuries, unexpected accidents and violence affect people...at home...at work...at play...on the move...in their communities.
Thursday, April 7
Levin Hall Dining Room
2:00 - 6:00 PM
Event is free and open to the public. Please register by March 30, 2011.
Email smcarrol@utmb.edu or call 409-772-6635.

All UTMB students, postdoctoral fellows, medical residents, fellows and faculty are encouraged to share their public health related research projects and experiences by participating in the 2011 National Public Health Week poster session and competition.

The poster session and competition will be held in the Levin Hall Dining Room on Thursday April 7, 2011. The competition is open to UTMB students, postdoctoral fellows, medical residents and fellows. Three $200 prizes will be awarded based on poster content, impact to public health and response to questions.

The purpose of the poster session is to identify and recognize individuals and groups who are addressing public health issues by participating in a research, teaching or other project with a public health component. Poster submissions must relate to Public Health.

The Wichita Falls-Wichita County Public Health District will host its 5th Annual Health Fair, April 9, 2011 from 9:00 am to 1:00 pm at 1700 Third Street, Wichita Falls, TX. This will be a joint effort with the Wichita Falls Traffic Safety Commission and will feature a bicycle rodeo to promote bicycle safety. We will also have car seat checks and will be offering immunizations, HIV testing, and cholesterol and glucose screenings among many other fun activities for the whole family.

For more information contact:
Kerry Kea, R.N., B.S.N., WOCN, Nursing Administrator
Wichita Falls-Wichita County Public Health District
1700 Third St, Wichita Falls, Tx 76301
Phone (940) 761-7892 FAX (940)761-7623

Denton County Health Department will sponsor its 4th Annual Fun Run and Walk, April 9, 2011

Texas Chiropractic College will host Research Day during Public Health Week and will feature research in general as well as health promotion research in chiropractic. We will have a featured speaker who is a noted researcher in public health and is also a chiropractor who will speak on injury prevention; including fall prevention and spinal injury prevention. We will also be launching a tobacco cessation advising...
campaign and have a grand rounds for interns on prevention as well as injury prevention.
For more information contact:
Will Evans, DC, PhD, CHES, Director of Research
Texas Chiropractic College
5912 Spencer Highway
Pasadena, TX 77505
281.998.6076

The University of Texas School of Public Health
• The SPH Student Association will have a Healthy Dessert Cook-off
• The Student Society for Global Health will have a yoga class and a discussion on Antimicrobial Resistance for World Health Day, April 7, 2011
• The Student Epidemic Intelligence Society is coordinating the 2011 Field Day, April 9, 2011 with the assistance of the other student organizations. Field Day has a 2 mile beat-the-dean run, an obstacle course and several other competitions involving physical activities needed for public health service.

For more information please contact:
Shon Bower 713-500-9019
Photos from last years’ events

4th Annual North Texas Health Forum kicks off National Public Health Week 2011 in Fort Worth, Texas
Featured topic: Embracing our Community of African American Children March 10, 2011
According to a recent research brief presented by the Center for Community Health at the University of North Texas Health Science Center (UNTHSC), Fort Worth, in conjunction with Cook Children’s Health Care System and the Mental Health Association of Tarrant County, about 7 to 12 percent of North Texas children suffer from some type of emotional or behavioral issue. Children with emotional issues, the report notes, are more likely than their peers to have academic or behavioral problems at school, to have been arrested or in trouble with the police, to have been suspended, to have bullied other children, to have been in more than one fight in the last year, and to have been cruel to animals. These children are also significantly more likely to have ever attempted suicide, to have self-esteem and/or eating problems, to cut or
hurt themselves, to experience sleep problems, and to have obsessive thoughts. Boys are more likely than girls to suffer from these issues, and within racial/ethnic categories, the prevalence for the North Texas African American community is 8.5% (for the full November 2010 report, please visit www.centerforcommunityhealth.org).

To address these important issues as part of National Public Health Week 2011, the UNTHSC School of Public Health will present the fourth annual North Texas Health Forum, a free community symposium focused on the emotional well-being of African American Children in Tarrant County, Texas.

The program is titled, “Embracing our Community of African Children,” and will be held April 7 and 8 on the school’s campus.

The objective of the program is to define the problem and present the root causes of emotional issues among children in Tarrant County, Texas, and begin the investigation of approaches for a fully-implemented system of care. This program is open to all community members and is especially relevant for teachers/educators, professionals in the criminal justice system, health care workers, the faith community, non-profit agencies and social service organizations. The program is designed to help identify strategies to maximize opportunities for success among African American children in the local community; the program represents the second phase of community outreach targeted toward underserved Tarrant County populations as initiated at the 2010 North Texas Health Forum, which developed recommendations to improve infant mortality rates and improved overall quality of life.

The April 7 keynote speaker will be Alwyn Cohall, M.D., Director of the Harlem Health Promotion Center, one of 37 national Prevention Research Centers established by the Centers for Disease Control and Prevention to bridge academia and vulnerable communities. Dr. Cohall also serves on the faculty of both the Mailman School of Public Health and the Department of Pediatrics at New York Presbyterian Hospital. His clinical and research interests include adolescent health; reproductive health; access to health care, particularly for young men of color; and the use of technology for health communication/health promotion. Dr. Cohall has directed the creation of a number of community outreach initiatives for underserved populations in New York City.

Dr. Cohall’s keynote address will begin at 6 p.m. on April 7 in the UNTHSC Medical Education and Training Building (MET), South Auditorium, with a reception to follow.

Dr. Cohall will also lead a special Student Session on the afternoon of April 7, from 2:30 to 3:30 p.m. in Everett Hall on the UNTHSC campus, Research and Education Building (RES).

The following day, on April 8, from 8 a.m. to 12:30 p.m., the conference will feature panel presentations, roundtable breakouts, and a closing action session. This event will also be held in the university’s MET building.

Panelists will include the Reverend Kyev Tatum, pastor, Friendship Rock Baptist Church of Fort Worth, and Larry Tubb, senior vice president, Cook Children’s Health Care System, Fort Worth.

Registration is free by visiting http://ntxhealthforum.eventbrite.com. Seating is limited, and early registration is recommended.

The school’s Public Health Student Association (PHSA) also plans to recognize National Public Health Week through a series of student events, including local high school visits/community outreach on April 4; an April 5 presentation by U.S. Department of Health and Human Services Regional Director Marjorie McColl Petty, who covers Region VI across Arkansas, Louisiana, New Mexico, Oklahoma and Texas; a career conversation with the U.S. Public Health Service Commissioned Corps on April 6; and a Student Appreciation Day celebration on April 8.

The Texas A&M Health Science Center (TAMHSC) School of Rural Public Health will offer an array of events to the Bryan-College Station Community as well as McAllen, Texas during National Public Health Week beginning the first week in April. All are welcome to participate in the annual events that support student scholarships and education.

• The College Station Mayor Nancy Berry and Bryan Mayor Jason Bienski will present Dean Craig Blakely with a proclamation declaring Public Health Week in the twin cities at the Brazos Valley Council of Governments.
• The 8th Annual School of Rural Public Health Golf Tournament will kick off National Public Health Week 2011 on Monday, April 4, at Miramont Country Club. Tournament play begins at 12:30 PM followed by an awards reception. Information regarding registration and donations can be obtained by contacting SRPH-Golf@srph.tamhsc.edu.
• Students will participate in the 6th annual research poster symposium and student poster contest. The research posters will be on display throughout Public Health Week in the SRPH Classroom Building.
• The annual Public Health Week Blood and Bond Marrow Drive in College Station is on Tuesday, April 5, from 11:00 am until 4:00 pm in the SRPH Classroom Building, room C-109.
• Saturday, April 9, the School will host the annual 5K Fun Run at the SRPH complex on Adriance Road. Information regarding registration can be obtained by contacting adwilson@srph.tamhsc.edu.
• The week will conclude Saturday, April 9, with a gala sponsored by the Rural Public Health Student Association at Pebble Creek Country Club. The evening will be filled with awards, food, music, and dancing. Information regarding ticket sales can be obtained by contacting mattice@srph.tamhsc.edu.

TPHA Journal Volume 63, Issue 2
The McAllen campus of the TAMHSC School of Rural Public Health will be hosting:

- A community wide event on April 6 beginning at 6:00 pm featuring Maria Teresa Cerqueira, M.S., Ph.D., Chief of the Pan American Health Organization/World Health Organization U.S.-Mexico Border Office speaking about “Chronic Disease, Chronic Effect: The Effect of Chronic Disease on the Border Region.” They will also have research poster presentations on April 6 as well as a blood drive on Friday, April 8.

Don’t miss these wonderful events and a chance to support the TAMHSC-School of Rural Public Health and National Public Health Week 2011!

Keeping Texans Safe

Safe Riders Program celebrates 26 years of traffic safety in Texas

For nearly a quarter of a century, Safe Riders has led traffic safety programs in Texas through the Texas Department of Health, later re-organized as Department of State Health Services, through funding from the Texas Department of Transportation. Safe Riders was created in 1985, following passage of the State’s first seat belt law.

Among Safe Riders’ 26-year milestones and accomplishments are the following:

- **Child seat distribution**: Provided over 130,000 child safety seats to low-income families in Texas. The distribution program has worked with hundreds of community partner agencies, which receive training and subsequently distribute seats in their communities in conjunction with educational programs.

- **CPS Technician training**: Conducted over 70 CPS technician training workshops. These workshops (each is about one week long) trained hundreds of nurses, police officers and others to be nationally certified CPS technicians and instructors. Subsequently, certified CPS technicians have provided thousands of parents with hands-on assistance to correctly install and use their children’s child seats. There are currently about 1200 certified CPS technicians and instructors in Texas.

- **Child seat checkups**: Conducted over 500 community child seat checkups, checking over 25,000 child seats with parents. These events are in high demand by parents. They have occurred throughout Texas, in shopping center parking lots, fire stations, courthouses, hospitals, stadiums, air force bases, churches, colleges, NASA Houston, and many others.

- **Safe Kids**: For about 12 years, Safe Riders served as the Statewide Safe Kids Coalition for Texas. General Motors and Safe Kids donated a new, brightly colored van in February 2000. Safe Riders has logged over 100,000 miles on the van, bringing CPS services to all areas of the State. Although Safe Riders no longer serves as the statewide coalition, it continues to work with Austin Safe Kids as an active coalition member.

- **Media campaigns**: including “Buckle Up Your Child, Always” and the airbag safety campaign “Nothing is Soft at 200 miles per hour.”

- **Presentations and training programs**: Over 2000 presentations were conducted to audiences ranging from children in childcare centers and schools to professionals at national conferences.

- **Older driver and bicycle helmet programs**: Though not currently funded to conduct these activities, hundreds of presentations, training sessions and educational materials were provided for older drivers. Over 50,000 bicycle helmets and education were provided for children in low-income families.

- **Partnerships formed**: Texas Department of Transportation, National Highway Traffic Safety Administration, Centers for Disease Control, SAFE KIDS Worldwide, Austin Safe Kids, General Motors, Wendy’s Hamburgers, NAACP, USAA Insurance, Ford Motor Company, Texas Transportation Institute, Texas Dept of Public Safety, Texas Cooperative Extension, Texas Municipal Police Officers Association, National Latino Children’s Institute, United Way, and hundreds of local community agencies.

Program Overview and Purpose

Safe Riders is a Texas-wide child passenger safety (CPS) program dedicated to preventing deaths and reducing injuries to children due to motor vehicle crashes. Authorized by Texas Health & Safety Code 45.

- **Child seat education & distribution program for low-income families.**
  - Safe Riders manages about 80 local community agencies that, in turn, offer classes and seats to low-income families.
  - After attending a one-hour class, a family receives a new child seat. Following this, the family is referred to a local inspection station or technician.
  - A State-managed child seat distribution program was authorized by the Texas Legislature effective in 1995.
  - From 10,000 to 15,000 seats are distributed each year in conjunction with educational programs.

- **CPS Technician training courses**
  - Safe Riders organizes and teaches in-depth CPS workshops. Successful students receive national certification as CPS technicians (there are currently about 1200 CPS technicians and instructors in Texas). Technicians offer child seat checkups to parents and caregivers.
  - Refresher training courses are conducted and other support is offered for existing technicians.
  - Safe Riders coordinates a statewide CPS Advisory Committee, composed of traffic safety specialists, grantees, and other community partners.

- **Safety seat checkups and inspection stations**
  - Checkups offer parents and caregivers the opportunity to
have their child’s safety seat checked to make sure it is safe and used correctly. - During FY2009, Safe Riders conducted 25 checkups, 13 inspection stations, and helped 4 other community groups establish inspection stations in Texas.

**Traffic Safety presentations & community awareness workshops**
- Presentations to schools and community groups are conducted each year.

**New pre-teen traffic safety intervention begins in FY2010**
- Will be based on Safe Kids Safest Generation curriculum, teaching occupant protection, safety in and around cars, and technology awareness.

**Free Traffic safety educational materials**
- Over 400,000 traffic-safety educational materials are provided each year to hospitals, health clinics, schools, social service agencies and many others. An on-line order form is available.

**Texans Saved by the Belt**
- Persons who credit restraints with saving lives or preventing injuries are recognized with a commemorative pin and certificate. Many go on to publicly share their stories at media events.

As you plan your National Public Health Week activities, keep Safe Riders in mind.

Safe Riders contact information: Telephone 800-252-8255
Website www.dshs.state.tx.us/saferiders
Email: saferiders@dshs.state.tx.us

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FOR COMPLETE CONFERENCE PROGRAM, EXHIBITOR, REGISTRATION & CEU INFORMATION VISIT WWW.TEXASPHA.ORG OR CALL 512-336-2520

PRE-CONFERENCE MORNING WORKSHOPS April 13, 2011:
- **Comparative Effectiveness Research on Cancer in Texas: Impact on Public Health in Texas**
- **Human Trafficking**

Student Orientation to TPHA NEW

AFTERNOON KEYNOTE & PLENARY PRESENTATIONS:
- **STATE OF TEXAS: KEY PUBLIC HEALTH ISSUES**
  David Lakey, MD, Commissioner, Texas DSHS
- **HEALTHCARE REFORM: A NATIONAL PERSPECTIVE**
  Georges Benjamin, MD, Exec. Dir., APHA
- **HEALTHCARE REFORM: A TEXAS PERSPECTIVE**
  Kenneth I. Shine, MD, Vice Chancellor, UT System
- **PREVENTION & WELLNESS**
  Kirk Smith, MD, UTMB, Stark Diabetes Center
- **AN OVERVIEW OF THE MEDICAL TOURISM INDUSTRY**
  Rosanna Gomez Moreno, J.D., Global3
- **PUBLIC HEALTH IN SPACE**
  Michael Reed Barratt, M.D., M.S., NASA Astronaut

CONCURRENT SESSIONS:
1. **ENVIRONMENTAL HEALTH-SUSTAINABILITY/GREEN**
2. **EPIDEMIOLOGY & MEDICINE**
3. **HEALTH POLICY**
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PUBLIC HEALTH POSTER & EDUCATIONAL MATERIALS DISPLAY
! SEE CEU INFORMATION ON PAGES 40-41!
The Texas Public Health Journal is pleased to bring you this summary from one of TPHA’s public health partners, the Texas Association of Local Health Officials. Please note, however that the opinions expressed in the following editorial are those of the authors and may not necessarily reflect those of TPHA.

A TALHO White Paper (abridged)
The Future of Public Health in Texas: A Summary Report
Catherine L. Troisi, Ph.D. 1,2, Stephen L. Williams, M.Ed., MPA 2, Lee Lane, 3 and the Board and Membership of the Texas Association of Local Health Officials
1University of Texas Health Science Center at Houston School of Public Health (current affiliation)
2Houston Department of Health and Human Services
3Texas Association of Local Health Officials

Background
Public Health has been defined as “activities that we, as a society, do collectively to assure the conditions in which people can be healthy”1. Public health is in the news every day – H1N1, childhood obesity, ozone levels, bioterrorism scares, diabetes, and contaminated lettuce. These events underscore the need for a strong public health system to prevent, mitigate, and/or control occurrences that threaten the public’s health. With the passage of health care reform legislation, we need to redefine what public health should look like in Texas in the 21st century, including a clarification of the relationship of public health to medical care. By assuring a basic level of public health support to every resident of the state, we can make great strides towards achieving a healthier Texas, enhancing the health of our children, workforce, and seniors, and reducing the need (and cost) of advanced medical treatment.

Although frequently confused with medical care for the indigent, public health involves two main activities at the community level - promoting health and preventing disease. Compared with medicine, public health is engaged primarily with prevention rather than treatment and it works at the population rather than individual level. Public health practitioners agree on ten essential services that all public health systems should provide for their constituents.2 These include investigating disease outbreaks, enforcing regulations, educating the public about health issues, and developing policies. These essential services were codified into the Texas Health & Safety Code, Subtitle F, in 1999.3 However, there is no assurance or accountability for implementation, a clear definition of what constitutes a bona fide local health department in Texas, or how local public health entities are to be funded.

Another important role of public health is to serve as a safety net for vulnerable members of society, particularly those without health insurance. The recent passage by the U.S. Congress of The Health Care and Education Affordability Act Reconciliation Act, (known colloquially as the Affordable Care Act) will have substantial effects on public health. There are many unknowns about this legislation with hundreds of misconceptions, ambiguities, and missing information that will need to be addressed in the coming years. While primarily an insurance improvement act, there are many terms relating to public health prevention and wellness activities. Included in the bill are provisions that encourage prevention activities by primary care providers, requiring insurance companies to cover the cost of recommendations from the U.S. Prevention Services Task Force. The establishment of a Prevention and Public Health Fund may increase funding for public health system activities as well as research. Other public health friendly actions include requirements that chain restaurants publish calories and nutrient information and imposition of taxes on indoor tanning salons.

The Affordable Health Care Act also provides for allocation of funds for a huge expansion of funding for Federally Qualified Health Centers (FQHC), which should provide for increased primary care capacity as well as covering those who remain uninsured. In Texas, estimates are that the health reform legislation will increase the Medicaid and CHIP eligible population by 2.1 million (those at 133% or less of the poverty level), potentially reducing the uninsured from 6.1 to about 1.7 million.4 While it is possible that this may have the effect of substantially reducing the safety net role of health departments, actual ramifications remain to be seen and there are serious concerns about unexpected outcomes and/or consequences, including who will chose coverage, access to care even when insured, capability of FQHCs to meet the increased demand for services, and ramifications when the enhanced reimbursement goes away after 2014 or 2016 (exact date is unclear).

On top of this, there is apprehension about potential reductions in government–supported public health care safety net capacity. Hospital districts, or their tax-paying constituents, may view the Affordable Care Act as license to reduce their capacity. This could have devastating effects as, for example, in Harris County, approximately 58% of the safety net demand is met by the hospital district.5 If there is sufficient political pressure to reduce taxes supporting hospital district services, other safety net providers, including local health departments will be required to cover the gap, thus increasing, not decreasing, the need for capacity.

Another concern is the distinctive prevention approach that public health providers assume when delivering services for certain diseases and conditions that have public health implications, an approach that is not typical in most busy primary care settings. Health Departments have a strategic role in providing prevention services, particularly in the areas of communicable diseases such as Tuberculosis, HIV, and syphilis and other sexually transmitted infections. Public health has...
a population-based, rather than individual, mindset, and this is apparent even when delivering primary care services such as family planning. Public health’s “client” is the community, not the individual, even though it may be the individual who is being treated. This is a different way of thinking from that seen in most primary care settings, where the client is the patient and larger ramifications to community health may be misplaced, to the detriment of the health of a community.

The bottom line of these uncertainties and unknowns is that the public health system, local health departments specifically, will continue to assume some level of safety net function for primary and preventive health services, at least in the short term. However, despite this vital function, the safety net provider role is not the primary role of health departments. Public health’s primary roles of assessment, policy development, and assurance will remain vital and will likely expand as a result of health care reform. Health departments play a unique role in assessment of a community through surveillance, including recognizing and responding to disease outbreaks (natural or man-made) and other public health issues in a timely manner, thus preventing further disease, monitoring and analyzing disease incidence and prevalence, and providing these data to ensure effective resource allocation. This role of protecting the community at the local level is the foundation of local public health and needs to be sustained.

Local health departments have seen deep cuts in both positions and funding. Between 26 and 50% of Texas local health departments have lost positions and/or had program cuts in the last two years, yet the need for public health services has only increased. Clearly, we must find a way to ameliorate the potential catastrophes waiting to happen with this loss of public health capacity.

As health care reform is implemented, the role of public health in assuring these activities must be redefined. The Texas Association of Local Health Officials (TALHO) Board and Membership have held a series of discussions on what the future of public health in Texas should look like. In this paper, we present our recommendations, a view of what a strong public health system should look like if we are going to be able to continue to address existing and emerging public health issues. These recommendations establish core requirements for what health departments should look like, ensure a minimum level of funding to support these activities, and provide creative solutions to structure each organization to fund public health in the most efficient, effective manner possible. The full version of this paper can be obtained by contacting the TALHO office at lee.lane@talho.org.

Recommendations
The first specific recommendation is to consider the question of what constitutes a local health department. We believe that all citizens of Texas should have access to a minimum level of the ten public health essential services and therefore, each local health department in Texas should offer these functions, although degree to implementation may vary. Currently there are some extremely small agencies functioning as local health departments. It is unlikely that they have all of the resources necessary to assure that all public health essential services are available to their constituents. Discussions need to be held on what constitutes a bona fide health department and whether there are situations where jurisdictions should be encouraged to combine. We believe that this approach may allow for more efficient and effective provision of all the essential public health services listed above.

Our second recommendation concerns the role of the Texas Department of State Health Services (DSHS) in local public health and consists of two parts. Firstly, we propose that DSHS’ role be redefined and suggest that the Centers for Disease Control and Prevention (CDC) model would be one worth emulating for public health in the State of Texas. The CDC, responsible for the health of the nation, operates at the national level by providing leadership and guidance and developing policy. Recognizing that the state health departments are, for the most part, in a better position to evaluate the needs of their community, CDC provides funds to help the states carry out these responsibilities. However, CDC allows state health departments to operate independently, within certain parameters. Experts at CDC are available to assist when local resources do not meet the immediate needs, e.g., epidemiological investigations.

In our vision, DSHS would continue to operate at the statewide level, providing leadership in the core public health functions of assessment, policy development, and assurance. It would set funding priorities, allocate resources, and provide guidance and technical assistance to local health departments, and facilitating discussions with federal agencies, statewide stakeholders, and international/border organizations. And, of course, the state health department has a role in securing funding from federal and state sources to support state level and local public health programs and health priorities. However, the actual provision of services should be left to the local health departments who represent the “boots on the ground” of public health in Texas, being operationally close to the needs of the community and ultimately responsible for population health in that area.

As part of this restructuring, the role of the Health Services Regions (HSRs) should be reexamined. Due to the absence of local public health departments in some jurisdictions across the state (approximately 190 of the 254 counties in Texas do not have a recognized local health department within the county, although 80% of the Texas population is served by a local health department), DSHS maintains eight HSR offices that provide a “safety net” of public health services and support local public health departments within their regional boundaries. While theoretically this may constitute an appropriate structure, in practice there can be overlap with local health departments in the area, resulting in duplication of effort. Therefore, consideration should be given to contracting services to existing local health departments, housing these HSRs within local health departments or providing support through direct assistance of temporarily or permanently assigning DSHS employees to local health departments. This
was done in the 1970s and is currently the practice with CDC employees. This will prevent duplication of administrative structure and give local health departments, who are the “boots on the ground”, the support they need to monitor and improve the public’s health.

We also propose that the State assume the role of offering surge capacity for local health departments when that need exists. This function already occurs in the case of laboratory services. It needs to be extended to other technical services, particularly epidemiologic and surveillance functions. Epidemiologic and surveillance services are vital for monitoring disease outbreaks and trends and yet these vitally important, specialized functions are not available in-house at all local health departments.

The final recommendations of this White Paper concern funding of public health activities. There is general agreement that public health is underfunded and its activities taken for granted, until contaminated spinach is distributed, unsafe air or water is detected, or pandemic influenza occurs. While some states such as Connecticut give each of its public health departments support at a per capita level in Texas there is no minimum level of funding for essential services. We propose that the State of Texas set a minimum level of funding that they will provide for this purpose to all localities. This would ensure a fair and equitable minimum funding level throughout the state rather than the disparate spending that can result when localities set their own level of support. Senator Nelson has introduced S.B. 969 (see end of article) to the 82nd Texas Legislative Session to provide for the establishment of the Public Health Funding and Policy Advisory Committee within DSHS to address some of these concerns.

However, there are other changes to funding methods that can enhance public health activities that do not involve increased resources. Of particular importance is the elimination of specialized funding streams. This will give health departments the latitude they need to redirect funding to meet the needs of their area. Increased efficiency and cost-effectiveness would result since many of diseases we combat often occur in the same populations. Cross training of personnel would lead to more efficient use of resources and enable dollars to go further. The CDC is moving towards elimination of specialized funding streams and Texas needs to follow their lead.

Community health would benefit from integration of services in the community. Local health departments need to take the lead on prevention activities in the community but they can serve as catalysts, not the implementers, inspiring the community to become involved in their own public health promotion efforts. Requests for prevention dollars should take this into account and require community-wide integrated programs. Community planning groups, in collaboration with the local health department, can develop an integrated community strategy with guidelines for prevention, taking into account the culture of that specific community while taking a systems approach to prevention.

SUMMARY
In this paper, we present the future of public health in Texas, a view of what it should look like if we are going to be able to continue to address existing and emerging public health issues. We discuss how health care reform will affect public health activities, leading into a vision of what a strong public health system should look like, including fiscal issues. Lastly we discuss how DSHS can support the provision of local public health services and provide recommendations for funding of these activities. It is our hope that policy makers will understand the importance of strengthening the public health capacity and will take the actions necessary to make this happen.

The future of Public Health in Texas is an exciting one. Public health is credited with adding 25 years to the average lifespan during the twentieth century and TALHO is committed to continuing these achievements. Our recommendations for enhancing the infrastructure of public health are neither complicated nor expensive but will have significant implications for the delivery of the ten essential services to all residents of our great state.

REFERENCES

Texas State Assembly. Health and Safety Code. § 121.002 Definitions

82R7786 YDB-F
By: Nelson S.B. No. 969

A BILL TO BE ENTITLED
AN ACT
relating to the establishment of the Public Health Funding and Policy Advisory Committee within the Department of State Health Services.
BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
SECTION 1. Subtitle E, Title 2, Health and Safety Code, is amended by adding Chapter 117 to read as follows:
CHAPTER 117. PUBLIC HEALTH FUNDING AND POLICY ADVISORY COMMITTEE

SUBCHAPTER A. GENERAL PROVISIONS
Sec. 117.001. DEFINITIONS. In this chapter:
(1) “Commissioner” means the commissioner of state health services.
(2) “Committee” means the Public Health Funding and Policy Advisory Committee established under Section 117.051.
(3) “Department” means the Department of State Health Ser-
Sec. 117.052. APPOINTMENT OF MEMBERS. (a) The commissioner shall appoint seven members to the committee as follows:

(1) two regional health directors, each of whom is serving as a health authority in a municipality or county;  
(2) one local health department representative of a municipality or county with a population of 50,000 or less;  
(3) one local health department representative from a municipality or county with a population greater than 50,000 but less than 250,000;  
(4) one local health department representative from a municipality or county with a population of at least 250,000;  
(5) one local health department representative serving in a municipality or county as the health authority; and  
(6) one representative of a school of public health at an institution of higher education in this state.

(b) In making appointments, the commissioner shall select the members from nominations by associations representing local health departments, county governments, and municipal governments.

Sec. 117.053. TERMS; VACANCY. (a) Committee members serve staggered six-year terms, with the terms of two or three members, as applicable, expiring on February 1 of each odd-numbered year.

(b) If a vacancy occurs on the committee, a person shall be appointed to fill the vacancy for the unexpired term in the same manner as the original appointment.

Sec. 117.054. COMPENSATION AND REIMBURSEMENT. A committee member is not entitled to compensation for service on the committee and is not entitled to reimbursement for any travel expenses.

Sec. 117.055. PRESIDING OFFICER. The presiding officer is elected by a majority vote of all the committee members.

Sec. 117.056. MEETINGS. (a) The committee shall meet at least monthly or more frequently at the call of the presiding officer.

(b) To ensure appropriate representation from all areas of this state, the committee may meet by videoconference or telephone conference call. A meeting held by videoconference or telephone conference call under this subsection must comply with the requirements applicable to a telephone conference call under Sections 551.125(c), (d), (e), and (f), Government Code.

Sec. 117.057. APPLICABILITY OF OTHER LAW. Chapter 325, Government Code, does not apply to the committee.

Sec. 117.058. ADMINISTRATIVE COSTS. To the extent that a term or condition of a federal grant or federal law does not limit the use of federal grant money, the department or a local health entity may use federal grand money to pay the administrative costs incurred by the department or the local health entity in implementing and administering this chapter.

[Sections 117.051-117.100 reserved for expansion]  
SUBCHAPTER C. DUTIES OF COMMITTEE  
Sec. 117.101. GENERAL DUTIES OF COMMITTEE. The committee shall:

(1) define and make recommendations to the department on the core public health services a local health department should provide in a county or municipality;  
(2) evaluate public health in this state and identify initiatives for areas that need improvement;  
(3) identify all funding sources available for use by local health departments to perform core public health functions;  
(4) recommend policy priorities for the department to use in allocating money available for core public health services, in accordance with:
   (A) prevailing epidemiological evidence, variations in geographic and population needs, best practices, and evidence-based interventions related to the populations to be served;  
   (B) state and federal law; and  
   (C) federal funding requirements;  
(5) at least semiannually, make formal recommendations to the department on the use of funds available exclusively to local health departments to perform core public health functions and on the allocation of the available funds throughout this state;  
(6) make recommendations to the department on transitioning from a contractual relationship with the local health departments to a cooperative agreement relationship with the local health departments; and  
(7) make recommendations to the department on methods for fostering a continuous collaborative relationship with local health departments.

Sec. 117.102. PUBLIC TESTIMONY. (a) At least semiannually, the committee shall:

(1) invite public health stakeholders, including federal public health officials, county and municipal governments, schools of public health at institutions of higher education, and federally qualified health centers, to give oral or written testimony to the committee; and  
(2) provide opportunities for the general public to give oral or written testimony to the committee.

(b) The committee shall consult with key stakeholders to carry out the general duties of the committee.

Sec. 117.103. ANNUAL REPORT. Not later than November 30 of each year, the committee shall file a report on the implementation of this chapter with the governor, lieutenant
Sec. 117.104. SUPPORT STAFF. Using existing administrative, professional, clerical, and other personnel, local health departments or their designees may assist the committee in the performance of its duties under this chapter.

Sec. 117.105. OPEN MEETINGS ACT. The committee is subject to Chapter 551, Government Code.

SUBCHAPTER D. POWERS AND DUTIES OF DEPARTMENT

Sec. 117.151. FUNDING AND POLICY DECISIONS. The department shall consider the committee’s recommendations in making funding and policy decisions related to core public health services, provided the recommendations comply with prevailing epidemiological evidence, variations in geographic and population needs, best practices, and evidence-based interventions related to the populations to be served.

Sec. 117.152. ANNUAL REPORT. The department shall file an annual report with the governor, lieutenant governor, and speaker of the house of representatives on the implementation of the committee’s funding and policy recommendations and an explanation of the department’s reasons for not implementing any recommendation.

Sec. 117.153. COOPERATIVE AGREEMENT PLAN. Not later than June 30, 2012, the department shall develop a plan to transition from contractual agreements with the local health departments to cooperative agreements with the local health departments. The plan must include a mechanism to ensure the local health departments are accountable to the department for the funds allocated. This section expires June 30, 2013.

Sec. 117.154. COLLABORATIVE RELATIONSHIP WITH LOCAL HEALTH DEPARTMENTS. The department shall establish a continuous, collaborative relationship with local health departments.

SECTION 2. Subchapter B, Chapter 1001, Health and Safety Code, is amended by adding Section 1001.0305 to read as follows:

Sec. 1001.0305. LOCAL HEALTH DEPARTMENT POLICY. In developing policy related to funding local health departments as defined by Section 117.001, the department shall consult with the Public Health Funding and Policy Advisory Committee established under Chapter 117.

SECTION 3.(a) As soon as practicable after the effective date of this Act but not later than October 1, 2011, the commissioner of state health services shall appoint the members of the Public Health Funding and Policy Advisory Committee established by Section 117.051, Health and Safety Code, as added by this Act.

(b) Not later than the 30th day after the date all members are appointed to the Public Health Funding and Policy Advisory Committee as required by Subsection (a) of this section, the commissioner of state health services shall call the first meeting of the committee.

(c) At the first meeting of the initial members of the Public Health Funding and Policy Advisory Committee, the members shall draw lots to determine which two members will serve initial two-year terms expiring February 1, 2013, which two members will serve initial four-year terms expiring February 1, 2015, and which three members will serve initial six-year terms expiring February 1, 2017.

SECTION 4. This Act takes effect September 1, 2011.

An Offer Cash-Strapped Lawmakers Can’t Refuse: Save Money, Save Lives

The following news release, dated March 1, 2011 from the Texas Public Health Coalition is being reprinted for your information with permission from the Texas Medical Association.

As the state of Texas faces a huge budget crisis and the people of Texas face a huge health crisis, the Texas Public Health Coalition (TPHC) today offered solutions for both.

The public health advocates encouraged state senators and representatives to support public health initiatives now for the future health of Texans and the state budget. Solid science has shown that cutting budgets for tobacco-control and obesity-reduction programs has a negative impact on both the physical and the fiscal health of the state. The Public Health Coalition is a collection of more than 26 Texas health care organizations committed to advancing core public health principles in the state and local communities.

“We hope our legislators will make healthy choices now that can both help them balance the budget and help Texans live longer, healthier, more productive lives,” said Texas Medical Association (TMA) President Susan Rudd Bailey, MD. “For starters, Texas can no longer afford to indulge the smoking and eating habits of some at a huge cost to all Texas taxpayers.”

Tobacco prevention and control: Tobacco is the leading cause of preventable death in Texas, Dr. Bailey pointed out. Nearly 25,000 deaths each year in Texas are linked to tobacco, she said. The direct and indirect cost of smoking in Texas is $20 billion per year.

Dr. Bailey and her TPHC colleagues said the draft state budgets in the House and Senate cut about $23 million in state and federal funds from tobacco-control programs. “This cut amounts to four-fifths of our meager tobacco-control budget. We oppose this cut as it’s penny-wise but very pound-foolish,” she said.

Recent national research shows smoking cessation programs return up to $2.61 for every dollar spent.

TPHC endorsed statewide smoking ban legislation:

• House Bill 670 by Rep. Myra Crownover (R-Denton) and Senate Bill 355 by Sen. Rodney Ellis (D-Houston), which would prohibit smoking in public places and workplaces; and
• Senate Bill 268 by Sen. Carlos Uresti (D-San Antonio), which raises the legal age to buy tobacco products from 18 to 19.

“The cost to the state of Texas for this indoor smoking ban is zero. But the savings are immense,” said Texas Nurses Association (TNA) President Susan Sportsman, RN, PhD, dean of the College of Health Sciences & Human Services at Midwestern State University in Wichita Falls.

Dean Sportsman noted that a report released last week found that passing this legislation would save Texas — Texas businesses, Texas government, and individual Texans — more than $400 million a year.

Savings to Texas Medicaid: Prohibiting indoor smoking would reduce chronic disease and help the ailing state budget — saving $31 million for Medicaid over the next two years. And that includes about $13 million in state dollars invested in the program.

Dean Sportsman named one group of people many might not consider as vulnerable to secondhand smoke. “Nowhere can you see more tragic evidence of the cost of smoking than in our neonatal intensive care units, where infants born prematurely due to exposure to secondhand smoke are struggling to live.” She said many newborns begin life in neonatal intensive care units hooked up to IVs and breathing machines instead of being able to rest in their mother’s arms.

The cost of caring for a low birth-weight baby born prematurely is about $50,000. “Since Medicaid pays for about half of all births in Texas, we estimated that every premature birth we can avoid because of the indoor smoking ban will save Texas Medicaid $25,000,” Dean Sportsman added.

Obesity prevention: TPHC members also are hopeful that legislators will continue to help Texas fight its obesity epidemic. Obesity causes suffering, poor health, and poor schooling, and it costs Texas businesses almost $10 billion a year. Obesity is responsible for a 27-percent growth in health care spending. More than 5 million Texans are obese; this is expected to double over the next 20 years.

Despite these facts, the draft state budgets would cut ALL funding for state obesity-prevention programs — $4.8 million. They also would cut public school health programs by more than two-thirds, or $65 million. TPHC strongly opposes those proposed cuts because they will cost Texas so much more in the not-too-distant future.

“TTP members endorsed several fat-fighting bills. They include:

• Senate Bill 186 by Sen. Jane Nelson (R-Lewisville) and House bills 280 and 281 by Rep. Carol Alvarado (D-Houston), which would require Texas high school students to complete an additional one-half credit of physical education and one-half credit of health for graduation;

• House Bill 127 by Representative Alvarado, which bans the sale of unhealthy drinks to students in schools; and

• Senate Bill 224 by Senator Nelson, which requires schools to report students’ fitness and academic scores to the Texas Education Agency.

In addition to TMA and TNA, the members of the Texas Public Health Coalition are American Cancer Society; American Diabetes Association; American Heart Association; American Lung Association of Texas; Bexar County Medical Society; Blue Cross and Blue Shield of Texas; Children’s Hospital Association of Texas; Coalition for Nurses in Advance Practice; LIVESTRONG; Sustainable Food Center; Texas Academy of Family Physicians; Texas Association of Local Health Officials; Texas Association of Community Health Centers; Texas Dental Association; Texas Dietetic Association; Texas Health Institute; Texas Nurse Practitioners; Texas Pediatric Society; Texas PTA; Texas Public Health Association; Texas Renal Coalition; The Immunization Partnership; Travis County Medical Society; and United Ways of Texas.

TMA is the largest state medical society in the nation, representing more than 45,000 physician and medical student members. It is located in Austin and has 120 component county medical societies around the state. TMA’s key objective since 1853 is to improve the health of all Texans. For more information please contact: Pam Udall (512) 370-1382; cell: (512) 413-6807; e-mail: pam.udall@texmed.org or Brent Annear (512) 370-1381; cell: (512) 656-7320; e-mail: brent.annear@texmed.org.
The following “OpEd” pieces were written by students at the UT School of Public Health for a course, Introduction to Management and Policy Sciences. The assignment is meant to give students the opportunity to demonstrate skills in communicating public health information to a general newspaper audience and inspiring action in response. Topics are chosen by the students representing their individual interests. The pieces selected for inclusion here illustrate the many facets of public health. Themes range from the health impacts of specific foods, to next steps in reducing the effects of nicotine on the population, to mandatory flu vaccinations for health care workers, and even considerations about legalizing drugs.

As with all opinion/editorial comments we publish, the sentiments expressed do not necessarily reflect those of the Texas Public Health Journal or Association.

Ban Trans Fat and Fight for Healthy Texans

Noor Alzarka

We’ve all heard about trans fats in the news. And with chronic diseases and obesity spreading throughout the United States at an epidemic rate, it is time that we take action to change unhealthy diets. But what is a trans fat? Many have been told that “trans fats are bad for you,” but the average person has a hard time actually defining what they are. The technical explanation is that trans fats are created by a food processing technique called hydrogenation, which turns liquid oils into solid fats. Although some trans fats do occur naturally in meat and dairy products, most of our consumed trans fats are artificial and used in fast foods and packaged foods because they have a longer shelf life.¹

And why should the average person care about trans fats? They were originally used as a substitute for saturated fats which were known to raise LDL “bad” cholesterol levels, and which were also linked to health problems. But trans fats are now known to also raise LDL “bad” cholesterol levels, just like saturated fats do, and to decrease HDL “good” cholesterol levels, making them an even greater health risk than are saturated fat.³

According to the Center for Disease Control and Prevention (CDC), trans fats are linked to an increased risk for heart disease, diabetes, and stroke. Heart disease is ranked as the nationwide number one cause of death by the CDC⁷, and chronic diseases cause 7 out of every 10 deaths each year.⁸ In 2006, heart disease accounted for over 10,000 deaths in Texas alone.⁹ Banning trans fats in Texas is one step we can take toward healthier choices and toward combating costly chronic diseases, and even the American Medical Association (AMA) endorsed a ban on artificial trans fats beginning in 2008.⁷ Trans fats are also associated with high-caloric foods which can indirectly promote obesity. The population of Texas adults is over 25% obese, meaning at least one in every four adults is considered obese. One national study of adolescents found that 70% of obese children were at risk for cardiovascular disease⁶, and consumption of trans fats only serves to compound this widespread problem.

But if trans fats are really such a health risk, why haven’t Texans already taken action to ban them? The answer is, they have. El Paso’s Democratic Senator, Eliot Shapleigh, proposed a bill (SB 204) to prohibit foods containing trans fats from being sold by restaurants, and it passed through both the Texas Senate Committee for Health and Human Services and the Texas House Committee for Public Health. But no further action was taken on this bill since May of 2009 when it was placed on the general state calendar¹⁰. Even less headway was made on a similar bill to ban trans fats from meals served in Texas public schools (SB 352), which was filed in the Texas Senate and was referred to the Texas Senate Committee on Education in 2009, but has not yet passed this committee review¹¹. As responsible Texans, we need to show our support for such legislation that promotes public health in the best interests of our community.

As knowledge of the health risks posed by trans fats has increased in acceptance, some groups have already begun phasing out the use of trans fats. Some fast food restaurants, such as McDonalds and KFC, have stopped using trans fats in their cooking oil, although it has not been eliminated from all products.¹ And Texas school lunch plans state that they will try to reduce trans fat content in school meals.

What else can consumers do to oppose trans fats?

• Make sure lawmakers are aware of our concerns about trans fats.
  • Support restaurants that have already stopped using trans fats.
  • Take an active role in your community and local school committees to support eliminating trans fats instead of just reducing them in our school cafeterias.
  • Support restaurants that have already stopped using trans fats.
  • Make sure lawmakers are aware of our concerns about trans fats.

What can lawmakers do?

• Direct more political attention toward the stalled Senate Bills 204 and 352 during the next legislative session beginning this January 2011, and hopefully push these bills vital steps closer to becoming laws.
  • Follow El Paso Democrat Eliot Shapleigh’s lead³ by supporting more legislation to ban public and private use of trans fats in food products and food preparation, and include...
appropriate repercussions for violations in the new legislation.

• Expand the effort to ban trans fats to our Texas public schools, and help fight childhood risks of chronic diseases and obesity.

• Address this health risk on the local Texas front by following the state examples of New York and California, which have already implemented bans on trans fats in restaurant foods.4

With ours and our children’s health at stake, banning trans fats is just one of many steps that Texans can take toward improving our well-being, decreasing our risk for deadly chronic diseases such as heart disease, and living healthier lives.

REFERENCES

Smoke Free Workplaces for All Texas
Jon Law

Next year, El Paso will celebrate the ten year anniversary of its Clean Indoor Air Ordinance. For a decade now, residents of my hometown have enjoyed smoke free bars and restaurants. The cities of Austin, Dallas, Fort Worth, Houston, and San Antonio likewise protect their workers with smoking bans. Including these cities, almost 6.3 million Texans, 36% of all Texans, are now protected from secondhand smoke exposure in public and indoor workplaces.1 It’s time to safeguard the health of all workers across the Lone Star State from the hazards of secondhand smoke.

Much more than an inconvenience, secondhand smoke (SHS) is a carcinogen, causing disease and premature death, even among individuals who do not smoke.9,5 It has been shown that exposure of adults to SHS has adverse effects on the cardiovascular and pulmonary systems, causing coronary heart disease and lung cancer.7 Children exposed to SHS are at increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma.9

In the United States today, it is expected that employers will maintain a work environment that does not pose risk of serious harm for their employees. For example, inhalation of asbestos fibers can cause serious illness, including lung cancer. As such, the use of asbestos is highly regulated across the U.S.6 SHS is similarly dangerous, yet unevenly regulated. The principle of justice asserts that all workers who are similarly situated should work in a correspondingly safe environment, and most Texans agree. In a 2009 survey, 72% of respondents across Texas indicated that employees of restaurants and bars have a right to clean air. Sixty-eight percent of respondents in the same survey favor a statewide law that would prohibit smoking in all indoor workplaces and public facilities.2

Critics of clean indoor air ordinances frequently assert that smoking bans will negatively affect the economy in these areas, claiming that restaurants and bars will lose customers. Research over the last decade has shown the inaccuracy of this argument. Since El Paso has implemented its smoking ban, researchers analyzed sales tax reports and monthly mixed-beverage tax receipts provided to the Texas Comptroller of Public Accounts. Their analyses show no change in sales after the smoking ban was implemented.8 A study in California found that bar and restaurant revenues actually increased after smoke free ordinances were in place.7 The implementation of smoking bans may encourage more people to frequent restaurants and bars, where smoking was formerly allowed. There is no empirical evidence indicating that smoking bans negatively affect business.

Making Texas smoke free requires effort from constituencies across the state. There are two actions that you can do to help. First, call your state senator and state representative and let them know that “you support a comprehensive statewide smoke-free work place law that will eliminate smoking in indoor public places including restaurants, bars, and other workplaces.” If you do not know who your representative is, go to the website www.fyi.legis.state.tx.us/ and enter your address. The website will generate a list of all elected officials for your residence.

You can also help by signing on to the Smoke Free Texas petition. Go to the www.smokefreetexas.org and click on the “Take Action” button. This link will take you to the electronic petition to support a comprehensive statewide smoke-free work place law. Thank you in advance. Your support will help Texas ensure that all of its citizens have a safe working environment.

REFERENCES
6. Occupational Safety and Health Administration. (2010). Asbestos. Re-
the onset of other illicit drug use and classification concluded that the use of marijuana is associated with a study published in the Journal of Drug and Alcohol Dependence. Hopefully reducing the violence in Mexico and the threat of spillover to America’s border. Good public health policy on one side of the border has profound potential to influence the public safety on the other side.

REFERENCES

If the intent of legalizing marijuana is to deplete the demand for it we should use public health to our advantage in accomplishing this rather than harming it and overhauling our drug policy through legalization. Public policy should be used to influence and fund prevention measures and lower risk factors associated with marijuana use. There has been a lot of success with programs like DARE, which is currently in use in 75% of the nation’s school districts and we should strive to increase that number. There is a need for a surge in national campaigns to raise awareness on the dangers of marijuana use, and more funding for evidence based research to aid in our decisions. If we truly want to have an impact on reducing demand then these programs need to be applied in Mexico as well and efforts need to be taken to reduce crime and poverty through education.

The people of Mexico and the United States deserve better than taking the easy way out and turning corrupt violent cartels into corrupt violent corporations. Through the use of good policy and public health there can be change and the demand for marijuana and other drugs can be successfully reduced hopefully reducing the violence in Mexico and the threat of spillover to America’s border. Good public health policy on one side of the border has profound potential to influence the public safety on the other side.

Supply and Demand
Noah Strohacker
A stoned throw away from El Paso, Texas is Ciudad Juarez, Mexico also known as the murder capital of the world. According to a State Department travel warning, two thousand six hundred people were killed in Juarez during 2009 and the number for 2010 is expected to exceed three thousand. The violence in Ciudad Juarez is attributed to two major drug cartels, the Sinoloa, and the Juarez cartel. These cartels are at war with one another and Mexican authorities over control of cities and drug smuggling routes into the US. Although El Paso is listed as the nation’s second safest city of its size, it is not immune to spillover from the violence. On June 29, 2010 six bullets from an AK47 assault rifle hit the El Paso City Hall during a shootout less than a quarter of a mile away in Juarez, and on the evening of August 21, 2010 a stray bullet from another shootout penetrated a building at the University of Texas at El Paso and closed a highway.

As one can imagine these incidents have raised serious concern among El Pasans and have prompted a call for local, state, and federal intervention before the situation escalates even more. However, since these incidents are occurring in Mexico there are limited ways to have a positive effect from this side of the border.

One proposal aimed at ending the violence in Juarez comes from El Paso City council representatives Steve Ortega, Beto O’Rourke and Susie Byrd. O’Rourke sees this as a problem of supply and demand and has suggested that legalizing marijuana in El Paso will reduce some of the demand and therefore reduce the violence while also generating tax dollars. The council members have not provided any details of how exactly they would implement this policy change, but have tried to gain the attention of President Obama regarding this idea.

Although there is some evidence that suggests legalizing marijuana can reduce demand and even violence, this option fails to consider the public health risks at stake. The Centers for Disease Control and Prevention states that marijuana carries a broad range of psychological and biological effects, many of which are dangerous and harmful to health. While a study published in the Journal of Drug and Alcohol Dependence concluded that the use of marijuana is associated with the onset of other illicit drug use and classifies marijuana as a “gateway drug”. Logic would conclude that even though legalizing marijuana could curb its demand, we could potentially raise the demand for other drugs like heroine or cocaine. This would in turn have no effect on the violent Mexican cartels and would lead to other health concerns such as an increase in HIV/AIDS transmission, domestic violence, and more crime. Research has also shown that legalizing marijuana could put adolescents at greater risk. The two most abused drugs by adolescents are those that are legal for adults, alcohol and tobacco. We have seen considerable problems regulating the advertisement of alcohol and tobacco to adolescents and the same could prove true for the advertisement of marijuana if it was legalized.
A Rose by Any Other Name: High Fructose Corn Syrup Rebranded
Sam Stubbsfield

The Corn Refiners Association has recently requested FDA approval to re-label high fructose corn syrup as “corn sugar” replacing a technical- and chemical-sounding name with two simple, non-threatening words everybody knows. The stated goal of this re-labeling is to “eliminate consumer confusion,” but it's unclear what confusion they want to eliminate, and why”.

Recently, high fructose corn syrup (or HFCS for short) has come under increasing attack both in the scientific and popular press. Historically, high fructose corn syrup is a relative newcomer. It began widespread introduction in the US market in the early 1970s and eventually was being used in equal amounts to cane and beet sugar. This rise in use has accompanied a tripling in obesity and diabetes among the US population. Even though the amount of HFCS consumed increased along with diabetes and obesity, it does not mean necessarily that one caused the other. It is very hard to prove that HFCS caused the increase in obesity and diabetes because so many other things changed in the US during this time. Scientists have done detailed studies of HFCS and have shown it can cause many of the same health effects observed in the US population during this rise in HFCS consumption. Admittedly, other studies have shown no significant effects of HFCS. As a result of these studies, we have learned a possible way that HFCS could lead to these health problems.

The reason for concern is that the way the body absorbs and processes HFCS and regular sugar is fundamentally different, but understanding this requires a bit of chemistry. Regular sugar is really two molecules stuck together. Our body breaks the pair into two separate molecules, and then absorbs the individual molecules. HFCS, on the other hand, already has the two molecules separate. This means that the body loses the ability to regulate separating the molecules before absorption. Scientists have found that this lack of regulation can throw off a lot of important processes in your body. This is an extremely important distinction, because even though the overall amount of fructose in high fructose corn syrup is not that much more than in regular sugar, the way your body sees it is very different. This can lead to you not feeling full after eating HFCS, storing extra fat, and it can actually drain your body’s energy stores. This distinction is lost on the Corn Refiners Association, which talks only of the number of calories in HFCS, not the way the body absorbs them.

The epidemic of obesity, diabetes, and high blood pressure continues to stress our health care system. As health care costs climb ever higher and we are faced with more people living sicker longer, we cannot afford to ignore this potential hazard to our county. Rising costs of Medicaid, Medicare, not to mention private spending on health insurance threaten to cripple our country’s economy and put us at a competitive disadvantage to our international competitors. Not only at stake is the health of our population, but also the fate of our economy and status as an international superpower. Given the potentially large role HFCS has played in these epidemics, we cannot ignore it.

High fructose corn syrup has made its way into every corner of the American diet: spaghetti sauce, bread, salad dressing, yogurt, frozen fruit, and juice concentrate, for example. The processed food industry uses HFCS as more than just a sweetener, since it also helps food maintain moisture, improve creaminess, and enhance other flavors. The major culprit, however, is sweetened soda, which accounts for 70% of HFCS consumption. An important reason that HFCS finds its way into everything is that it is flat-out cheaper than sugar. The Federal government ensures this through a combination of tariffs on imported sugar and subsidies to corn farmers. In fact, from 1996 through 2005 the only profits made by corn farmers were Federal subsidies. Since 2006, corn prices have risen due to increased food prices and a demand for corn-based ethanol, averaging 80% more expensive than in the previous 10 years. This made HFCS production more expensive, and for the first time since their introduction, we have seen a drop in HFCS and a rise in regular sugar consumption.

This hopeful news points us in several directions for action. First, act locally, very locally. Look at the labels for the food and beverages you consume and see how much HFCS you take in. An easy step is to decrease your soda consumption, or to switch to diet sodas or boutique brands that use cane sugar as a sweetener. Some major soda makers now offer some flavors sweetened with cane sugar, such as Pepsi Throwback or Dublin Dr Pepper.

• Educate yourself and those around you. The “confusion” mentioned by the Corn Refiners Association cites a survey that 58% of respondents incorrectly believed that HFCS had more fructose than table sugar. HFCS has 55% fructose compared to 50% fructose in table sugar. The 58% of respondents actually answered this question correctly and were not confused at all. The Corn Refiners Association is manufacturing this consumer confusion as an excuse to rebrand their maligned product.

• Talk with your Federal representatives. We know that if the price of HFCS is raised, less of it will be used. Encourage them to revisit corn subsidies and the protectionist policies on sugar imports. Small changes in the price of HFCS could have large effects on the health of America.

REFERENCES
Mandatory Flu Vaccination for Healthcare Workers

Stephanie Younts

Influenza is a contagious respiratory illness caused by a flu virus. Up to 20% of the population gets the flu every year. Signs and symptoms of the flu can include fever, chills, cough, runny nose, stuffy nose, headaches, muscle aches, tiredness, vomiting, and diarrhea. The flu can cause mild to severe illness, and in the worst cases, can lead to death. According to the Centers for Disease Control and Prevention (CDC), influenza kills 36,000 people in the United States each year. 1

The flu can be transmitted to others up to 6 feet away by droplets typically from a cough or sneeze. Less commonly, a person can get the flu by touching a surface that has the flu virus on it. Since the flu can be spread up to 24 hours before a person shows any signs or symptoms of having the illness, they may spread the flu before they even know they are sick. The flu can also be spread for up to 7 days after becoming sick. 1

Complications from influenza are the cause of 200,000 hospitalizations each year. Those who are at highest risk of severe complications from the flu include children under 5 years old, adults 65 years and older, pregnant women, and those with chronic medical conditions such as asthma or other chronic lung disease, heart disease, weakened immune systems, diabetes, etc. 1

In addition to the acute illness caused by influenza, this disease places a huge burden on society in terms of lost days of school and work. If people come to work when they are sick, they are likely to be less productive and, even worse, can spread the virus to their patients, co-workers, or other students.

Influenza is a vaccine preventable illness. Each year the flu vaccine contains three different strains of influenza virus that have been predicted to be the most common in that particular year. The main two types of vaccinations available are the traditional flu shot which contains inactivated virus and the inhaled nasal spray flu vaccine. The risks from vaccination are very low and last only a day or two. They can include pain and soreness to injection site, hoarseness, fever, aches, cough, and allergic reaction. 1

The CDC recommends that all health care workers and students in training to become a health care worker should be vaccinated annually. This recommendation extends to all workers who may come in contact with patients or residents in nursing homes or other long-term care facilities. 2 Just this year, the American Academy of Pediatrics has also released a policy statement calling for the mandatory vaccination of all healthcare professionals. The reason that it is so vital that health care workers get vaccinated for the flu is that they can easily transmit the disease to those populations that are most vulnerable for having severe complications from getting the flu. The goal of influenza vaccination of health care workers is to achieve a 100% vaccination rate at each institution. 2 Despite the CDC recommendation for annual flu vaccination of healthcare workers that has been in effect since 1984, it is estimated that less than 40% of health care workers get the flu vaccine each year. 3 This low level of coverage is unacceptable.

The following are my proposed actions to address this issue:

• Health systems should include mandatory influenza vaccinations for health care workers as part of a comprehensive patient safety quality program that includes other infection control measures such as hand washing and good respiratory hygiene.

• Health care facilities should ensure that they have an adequate supply of influenza vaccine each year to offer at no cost to their employees and that they have an adequate distribution system in place to administer the vaccine to each health care worker.

• Health care administrators take the lead by being the first in their facilities to get the flu shot and by leading system-wide educational campaigns about flu prevention every year.

• Health care workers who refuse the flu vaccination for reasons other than approved medical or religious reasons should be required to fill out a signed declination every year. If a dire pandemic situation arises and state and/or local health department recommends it, health care workers should not be able to decline the influenza vaccine except for approved medical or religious.

• Those who refuse the flu vaccination should be required to wear a surgical mask to work during flu season to protect their patients.

• Health care workers should take the initiative in their workplace to get their own flu shot and then encourage their co-workers to do the same. If your workplace doesn’t have a flu vaccination campaign in place, speak to your supervisor or administrator about starting one.

Several health care institutions have already successfully implemented mandatory influenza vaccination programs for their health care workers. One example is Virginia Mason Medical Center in Seattle. They achieved a 96% influenza immunization rate implementing a new hospital policy in 2005. Exemptions were only allowed for 1% of the employees for medical or religious reasons. Joyce Lammert, MD, the Chief
As with any new initiative, challenges and barriers will need to be addressed and overcome. For example, some health-care workers still believe that they can transmit the virus to their patients after getting the flu shot. This is false. Others may worry that they don’t have enough time to get the vaccine or that it will only be offered at inconvenient hours. Health care facilities should alleviate these concerns by offering the vaccine during all shifts at convenient locations and at no charge to the employee. Probably the most important step in rolling out a widespread vaccination campaign is ensuring adequate ongoing education for everyone involved.

Take the initiative to reduce burden of this disease. Help protect our most vulnerable populations from the flu. Support mandatory influenza vaccination for health care workers.

REFERENCES

Oleander: A Poisonous Plant That Does Not Live Up to Its Urban Legend
Mathias B. Forrester
Texas Department of State Health Services, Austin, Texas

A number of plants are poisonous, resulting in injury or even death. One plant with a poisonous reputation is oleander. There are two species of the plant. The common pink oleander (Nerium oleander) is an evergreen shrub or small tree with long, narrow leaves and red, pink, or white flowers. The entire plant is toxic, containing the cardiac glycosides neroside, oleandroside, oleandrin, and nerine - steroids that resemble digitalis. The yellow oleander (Thevetia peruviana) is a close relative of N. oleander. It also is an evergreen shrub or small tree with leaves like N. oleander. However, its flowers are yellow or yellow-orange. The whole plant also is poisonous, containing cardiac glycosides including thevetin A and B, thevetoxin, and peruvoside.

The symptoms of oleander poisoning include nausea, vomiting, abdominal pain, dizziness, slow pulse, irregular heartbeat, dilation of the pupils, diarrhea, drowsiness, and coma. Deaths have been reported with oleander ingestion. The plant has even been used to commit attempted murder. There is a persistent urban legend of poisonings and deaths occurring when oleander branches have been used as skewers for cooking food, particularly hot dogs. However, an extensive literature search found no credible reports of such events in modern medical literature.

In spite of its toxicity, oleander is widely cultivated and often used in landscaping around homes in the United States, including Texas. Thus, one might expect a number of serious poisonings resulting from oleander ingestions.

During 2000-2009, 718 oleander ingestions were reported to Texas poison centers. The number increased from 296 in 2000-2004 to 422 in 2005-2009. There was a seasonal pattern to the ingestions with 413 (57.5%) reported during April-July. May had the highest number of ingestions (162 or 22.6%).

The distribution of patients by gender was 380 (52.9%) male, 334 (46.5%) female, and 4 (0.6%) unknown gender. Children 5 years or younger accounted for the majority of ingestions (416 or 57.9%). Most (636 or 88.6%) of the ingestions occurred at the patient’s own residence. The distribution of ingestions by the circumstances of or reason for the ingestion were 656 (91.4%) unintentional, 56 (7.8%) intentional, 5 (0.7%) tampering or malicious intent, and 1 (0.1%) unknown.

The majority (548 or 76.3%) were managed on site (at home) while 78 (10.9%) were already at or en route to a healthcare facility when the poison center was contacted, 87 (12.1%) were referred to a healthcare facility by the poison center, and 5 (0.7%) were managed at an unknown location. Most (384 or 53.5%) of the ingestions resulted in no effects, 258 (35.9%)
had minimal effects, 46 (6.4%) had moderate or major effects, and 30 (4.2%) had effects considered unrelated to the oleander. No deaths were reported.

The most commonly reported specific symptoms of oleander ingestion were similar to those found in the literature: vomiting (48), nausea (16), oral irritation (13), drowsiness (12), bradycardia (9), abdominal pain (9), diarrhea (8), and fever (6). The most frequently reported treatments were dilution with a drink (392), administration of activated charcoal (75), eating food or a snack (52), administration of a cathartic (26), and administration of IV fluids (20). These were consistent with the recommended treatment of decontamination and supportive care.

The data from Texas poison centers indicate that, in spite of oleander’s extreme toxicity and widespread use, it appears to result in relatively few adverse ingestions. Most ingestions can be managed at home. However, in the event of an oleander ingestion, it might be advisable to consult a poison center or other healthcare provider to be safe.

REFERENCES

The Long and Winding Road to Automobile Safety
Carolyn Medina, MA, MLIS
Librarian, Texas Department of State Health Services*, Austin, Texas

Are automobile accidents a public health problem? Many people would reflexively answer that accidents are not a public health problem. They automatically think of public health as combating infectious diseases or perhaps providing health care to poor people. But if you look at the top ten causes of mortality in 2007, unintentional injuries (of all types) ranked fifth nationally and THIRD in Texas. The majority of deaths (31.6 percent) in 2007 to residents ages 1 through 44 were due to accidents. Although the category of accidents includes more than just traffic accidents, the rate of motor vehicle accidents in 2007 was estimated to be 39.7 per 100,000 people in Texas. Worldwide, injuries represent 12% of the global burden of disease, ranking third, and again the main cause of death among 1-40 year olds. Twenty-five percent of deaths from injury are from road traffic injuries according to the World Health Organization (WHO) data. Maybe public health solutions can and should be found for automobile accidents after all.

What would a public health approach look like? According to the WHO’s report on road safety, public health involves injury surveillance (collecting data), research into the real causes of accidents, exploring ways to prevent or reduce injuries, implementing interventions and evaluating them, persuading policy makers and people in positions of power to improve safety, and advocating for ways to protect passengers, pedestrians, and cyclists, as well as drivers. Population-based solutions, rather than solely blaming individual drivers, and taking a systems approach to the whole problem of accidents are needed in order to find solutions to the unnecessary loss of life due to traffic accidents throughout the world, as well as here in Texas.

Mortality from automobile accidents has been around since the beginning of horseless carriages. Arguments about the solution to these accidents have existed almost as long. Let’s think back to how it was when these horseless carriages first drove down a muddy lane. Shortly thereafter, we would find the first automobile accident. According to JAMA, the first accident in the United States took place in New York City on Sept. 1, 1899 when a real estate broker stepped off a streetcar, was hit by a car, and died soon after. The World Health Organization discussed the epidemiology of road traffic accidents as early as 1962 and declared these accidents a major public health issue in 1974.

Over the years, there have been different popular explanations for why there were so many traffic accidents and what approach to take to fix the problem. Some proposed that technology is at fault. If manufacturers would build safer cars and put more safety devices in them, there would be less loss of life. For instance, the well-known book, Unsafe at Any Speed: The Designed-in Dangers of the American Automobile by Ralph Nader, was published in 1965. Legislation forcing manufacturers to include certain safety features was passed the next year (The National Traffic and Motor Vehicle Safety Act).

Long before Ralph Nader, however, a physician pushed the automobile manufacturers to build safer cars. Dr. Claire Straith, a plastic surgeon in Detroit, spent his days trying to repair the results of car crashes to human faces. He became a crusader for better engineering inside the automobile. He met personally with Walter Chrysler and the 1937 Dodge had some safety features built into its interior.

Other reformers have focused on the driving environment, pushing for safer roads to be built, for better signs to be installed, for ways to separate pedestrians and bicycle traffic, and encouraging slower speed limits at night. Although there was a Traffic Safety Council established in 1957, most highway safety laws in Texas are a direct result of the 1966 national legislation. The Texas Traffic Safety Act of 1967, Chapter 723, Texas Transportation Code, declares it to be a vi-
tal government purpose and function of the state and its legal and political subdivisions to establish, develop, and maintain a program of traffic safety in Texas.10

But most efforts have focused on the individual driver, blaming accidents on clumsy driving. Solutions include pushing for more drivers’ education, requiring a license to drive, and creating laws that deal with perceived driver impairments, i.e., restricting people with epilepsy or the very young or the very old from driving.

The campaign against drunk driving has been going on for at least fifty years. In August, 1957, Scientific American reported, “Automobile accidents in the U.S. are now the subject of a large-scale investigation as if they were an epidemic—as they are. The Department of the Army, the American Medical Association and other major groups are studying many phases of the matter, from the design of tollbooths to the personality of truck drivers. Among other significant findings are that sedatives and tranquilizing drugs dull a driver’s skill, and that the dangerous effects of an evening of drinking may last as long as 18 hours, regardless of coffee therapy.”11

The most well-known campaign against drunk drivers comes from the nonprofit organization, Mothers Against Drunk Driving (MADD).12 It was created in 1980 by one mother whose 13 year old daughter was killed by a drunk driver. Other mothers joined the cause and a movement was born. MADD has been extremely effective in publicizing the results of drunk driving and in getting legislation passed. Here in Texas these changes are especially noted - in 30 years, Texas law has gone from allowing open cans of beer in the car to “no refusal” nights when police may take blood to test blood alcohol levels of suspected drunk drivers.

We know that mixing alcohol with driving kills. So does excessive speed. One of the side effects of the oil embargo in the 1970’s was lowering the national speed limit to 55. Afterwards a significant drop in traffic fatalities was noted.13 However, as soon as the oil emergency was over, people pushed very hard to return to higher speed limits.

Over the years, many efforts have been made to reduce the amount of tragedy caused by automobile accidents. But there have also been major impediments to the safety movement. American culture is one – we love our cars. We love speed and the open road. People do not want to be told what to do by their legislators or their health officials, such as having to wear seat belts or to use helmets on motorcycles.14 We will have to change our culture and the political environment to truly decrease the amount of traffic accidents. “Should the government protect us from ourselves” continues to be debated. Maybe a start would be if we could finally get Texas drivers to use their turn signal.

For a list of key highway safety laws currently in effect in Texas see: http://www.ghsa.org/html/stateinfo/hystate/tx.html

REFERENCES


Around Texas

“Friends of the School of Rural Public Health” Kicks Off, “This is Public Health” With First Lady of Texas, Anita Perry

The “Friends of the School of Rural Public Health” initiative was launched with First Lady of Texas, Anita Perry, serving as the first honorary chair. The intention was to increase the public’s awareness of the school’s faculty, students and programs and is an extension of the national “This is Public Health” program initiated by the Association of Schools of Public Health. On Friday, February 25, Texas A&M University System Chancellor and Mrs. Mike McKinney hosted a luncheon at their home with a program kicking off the public health awareness campaign for the Texas A&M Health Science Center School of Rural Public Health (SRPH). The Friends of SRPH will serve as ambassadors of the school.

“I have a deep appreciation for public health and where we are as a country, state, and community – especially compared to so much of the world. Most of us have the luxury of taking things like clean water for granted, but we should always challenge the status quo and seek out creative, practical, cost-effective solutions to everyday health issues that affect our world,” states Mrs. Perry. “Yes, A&M is known for some legendary programs, but its School of Rural Public Health – in my opinion – is one of the state’s best-kept secrets!”

For more information on the campaign, contact Rae Lynn Mitchell, school communications director, at (979) 458-0773 or rlmitchell@srph.tamhsc.edu

Texas Public Health Training Center – March 2011

Nancy Crider

TPHTC Governmental Public Health Practice Award

TPHTC recently released a call for applicants for the TPHTC Governmental Public Health Practice Award. This competitive award seeks to build capacity and further the mission of the TPHTC by giving students the opportunity to have applied experience in the governmental public health system. The TPHTC Governmental Public Health Practice Award is the first internship program of its kind. This 200 hour, paid internship is funded through the HRSA, Public Health Training Center Grant. The award will provide students enrolled in Texas’s three schools of public health: The University of Texas Health Science Center at Houston School of Public Health, The University of North Texas Health Science Center School of Public Health and Texas A&M University Health Science Center School of Rural Public Health with the experience necessary to excel in Texas public health departments following graduation. The goals of this program are:

- To prepare students to take advantage of career opportunities in health departments through applied opportunities
- To expose students to career opportunities in governmental public health
- To orient interns to the practice, policies and skills necessary to thrive in the public sector
- To assist governmental public health in recruiting qualified candidates

All applicants must be a currently matriculated graduate student at a school of public health in Texas and must use this internship to satisfy a practicum requirement. Awardees will acquire direct experience in various divisions of local, county and regional health departments across Texas including Houston, Dallas, El Paso, Brownsville, College Station, Amarillo, Tarrant and Brazoria County. Each intern will be supervised and mentored by an experienced public health professional. Students will also have the opportunity to interact with other professionals in the field. Since the internship satisfies the practicum requirement of all three schools of public health, each intern will complete a final project that has been approved by their supervisor and the TPHTC. Interns will be selected for an interview following a blind review of applications. TPHTC anticipates ten ($2,400) awards for summer 2011. Awards will be announced in early April 2011.

For more information, contact Natarsha D. Horton at tphtc@uth.tmc.edu or (713)500-9389.

TPHA Preconference – “Human Trafficking”, Wednesday, April 13, 2011, 9:00 – 11:30 AM.

The mission of the TPHTC is to improve the state’s public health system by strengthening the technical, scientific, managerial and leadership competencies and capabilities of the current and future public health workforce. TPHTC provides face to face and online training that reach audiences across Texas. Monthly Grand Rounds hosted by local health departments keep public health practitioners engaged, challenged and up-to-date.

For further information or to schedule onsite training for your organization contact Nancy Crider at nancy.m.crider@uth.tmc.edu; Cara Pennell at clpennel@srph.tamhsc.edu; or Jeffrey Moon at jmoon@hsc.unt.edu Texas Public Health Training Center website www.txphtrainingcenter.org

Annual Education Conference-“Public Health is the Ticket”-April 13-15, 2011
The TPHA Annual Education Conference is just around the corner. If you’ve not already registered please do so before the early bird deadline of April 1st to take advantage of the reduced registration rates. The continuing education committee is pleased to announce the program has been approved for continuing education credits by the Texas Department of State Health Services Continuing Education Service as follows: Continuing Medical Education: The Texas Department of State Health Services (DSHS) Continuing Education Service (TMA provider #4006803) designates this live activity for a maximum of 12.25 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This course has been designated by the Texas Department of State Health Services for 1.5 contact hours of education in medical ethics and/or professional responsibility.

Continuing Nursing Education: The Texas Department of State Health Services (DSHS), Continuing Education Service is an accredited provider (P0180) of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation. Texas Department of State Health Services Continuing Education Service has awarded 12.25 contact hours of Continuing Nursing Education.

Social Workers: The Texas Department of State Health Services (DSHS), Continuing Education Service under sponsor number (CS3065), has been approved by the Texas State Board of Social Work Examiners to offer continuing education contact hours to social workers. Texas Department of State Health Services Continuing Education Service has 12.25 awarded contact hours of Continuing Social Work Education. This course has been designated by the Texas Department of State Health Services for 1.5 contact hours of education in professional ethics and social work values.

Registered Sanitarians: The Texas Department of State Health Services (DSHS), Continuing Education Service is considered a sponsor of continuing education for Registered Sanitarians according to the Texas Administrative Code, Title 25, Part 1, Chapter 140, Subchapter C, Rule §140.113 Texas Department of State Health Services Continuing Education Service has awarded 12.25 contact hours of Continuing Education.

Certified Health Education Specialists: The Texas Department of State Health Services (DSHS), Continuing Education Service has been designated as an approved provider (#TX0038) of continuing education contact hours by the National Commission for Health Education Credentialing, Inc. Texas Department of State Health Services Continuing Education Service has awarded 12.25 contact hours of Continuing Certified Health Education Specialist Education.

Certificate of Attendance: The Texas Department of State Health Services (DSHS), Continuing Education Service cer-
ties that this attendee participated in the educational activity listed above. Texas Department of State Health Services Continuing Education Service has awarded 12.25 hours for attendance.

Approving a total of 24.75 contact hours for three days. 12.25 contact hours is the maximum CE's an individual can receive for attending this conference.

Certified Public Health (CPH) professionals may claim any learning activity that addresses one of the domains tested by the CPH exam. At this point, reporting CPHCE is on the honor system. Keep any registration, attendance, or completion records, certificates of attendance or achievement, confirmations of registration, or post-event evaluation invitations or follow-ups. For multi-session events, keep the agenda/schedule of events and circle and initial the sessions that you attend. For more information about the CPHCE go to www.Publichealthexam.org.

TPHA Governing Council
The TPHA Governing Council voted to approve the following resolutions for member consideration and approval. Additionally, these resolutions will be drafted into Gov. Co. position statements, reviewed and sent to our legislature upon approval. Please watch your email inbox and/or mail box for your opportunity to vote on these resolutions:

Standard Resolution A Proposed Standard Resolution A:
Since the 2010 Annual Meeting of the Texas Public Health Association, the deaths of several of our members have occurred. In respect to the memory of these departed associates, the membership of the Association herein stands in silent tribute to the deceased members, and their deaths will be noted in the official records of the Association.

John Murphy-Vital Statistics Section
Reid Martin-Environmental and Consumer Health Section

As the office is notified of deaths of our members we will add those names to the list of deceased members.

Proposed Standard Resolution B
The membership of the Texas Public Health Association, highly aware of the time and effort to plan and arrange for the 2011 Annual Educational Conference, wishes to express its gratitude to the Program Planning Committee, chaired by Adriana Babiak-Vazquez, MA, MPH, Stephen L. Williams, Director, City of Houston Health & Human Services Department and Staff of the City of Houston Health & Human Services Department

The Texas Public Health Association wishes to express its thanks to all our Exhibitors and Sponsors for their most generous and gracious support and contributions to the annual meeting.

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WHEREAS, disasters and pandemics can occur any time and start the spread of a communicable disease; and
WHEREAS, about 71 percent of Texas children 19-35 months are fully immunized; and
WHEREAS, adolescents also need to be immunized; and
WHEREAS, more costly and new vaccines increase the cost of immunizing children and adolescents; and
WHEREAS, in 2009, Texas experienced almost 8,500 cases of vaccine-preventable infectious diseases, and
WHEREAS, some of the earliest cases of H1N1 in the United States were diagnosed in Texas in spring 2009; and
WHEREAS, recent disasters requiring the mobilization of workers throughout Texas and in other states highlight the importance of immunizing and tracking child and adult immunizations; now, therefore be it
RESOLVED, that the Texas Public Health Association supports the 2011 Immunization Priorities to change ImmTrac, the state’s immunization registry, to an opt-out system; establish a statewide disease prevention and health quality initiative to improve vaccination rates among health care workers, early-childhood care providers, and others working within the patient care infrastructure; lengthen the amount of time allowed to secure required consent for a patient record to stay in the registry; and expand data-sharing capabilities among states to extend beyond disaster purposes.

Proposed Resolution 4 – Texas Should Be Smoke-Free
WHEREAS, Texans have a right to be second-hand smoke-free; and
WHEREAS, more than 30 states now require that workplaces be smoke-free; and
WHEREAS, almost 80 percent of the country’s population is protected by smoke-free laws in workplaces, restaurants and bars; and
WHEREAS, more than half of Texans do not have this same protection; and
WHEREAS, every year the direct medical expenses of smoking, loss of workplace productivity and premature death cost Texas more than $20 billion; and
WHEREAS, tobacco is the leading cause of preventable death in Texas; and
WHEREAS, secondhand smoke is associated with an increased risk for sudden infant death syndrome, asthma, bronchitis, and pneumonia in young children, and
WHEREAS, while 33 Texas municipalities have passed local smoke-free ordinances, less than half of the Texas population living in incorporated municipalities is protected by smoke-free; now, therefore be it
RESOLVED, that the Texas Public Health Association supports comprehensive statewide smoke-free legislation that eliminates exposure to secondhand smoke in all indoor workplaces throughout Texas; funding for evidence-based interventions to reduce tobacco use, provision of full smoking cessation benefit coverage for state employees and enforcement of tobacco laws to prevent access to minors.

APHA News
The American Public Health Association is sponsoring two TPHA members to attend the APHA Midyear meeting on Implementing Health Reform. Incoming TPHA President, Bobby Schmidt as well as our Affiliate Representative to the APHA Governing Council, Dr. Catherine Cooksley will be attending on behalf of TPHA. Affiliate Members who are not members of APHA can register for the midyear meeting at the discounted partner rate. APHA members are eligible for additional discounts. For information about how you can attend the conference see below or go to www.apha.org and click on Midyear Meeting.

APHA Midyear Meeting
2011 Midyear Meeting
Chicago, Illinois • June 23-25, 2011

The Affordable Care Act is transforming our nation’s health system with clear implications for the delivery of public health programs and services and a renewed emphasis on prevention and wellness. At the same time, dramatic shifts among policymakers at all levels make it clear that now, more than ever, the public health community needs to understand the law, be able to anticipate obstacles that lie ahead and be nimble in our response to unforeseen challenges.

Join the American Public Health Association and our partners for “Implementing Health Reform - A Public Health Approach”, to be held June 23-25, 2011, in Chicago. This APHA Midyear Meeting will offer the opportunity to learn in an interactive environment what the Affordable Care Act means for public health, wellness and prevention. It will equip attendees from federal, state, local and tribal agencies and organizations with the tools needed for implementing the provisions of the Affordable Care Act and improving health outcomes in communities across the country.

This meeting will not be a place to sit back and listen; rather it will provide a forum to articulate a call to action for all of those interested in moving from a medical care delivery system to a system that assures health and wellness. The public health community and current and new partners will come together to give distinct voice to our cause.

These are historic times, yet there is still much to be done. We look forward to seeing you in June at the APHA Midyear Meeting, Implementing Health Reform: A Public Health Approach.
TPHA has made registration for this meeting even easier, just go to the TPHA website www.texaspha.org click on the APHA news page and you can make all of your arrangements right there.

**APHA Presidents-Elect Meeting**
This year, Kaye Reynolds, incoming president-elect will attend the APHA Presidents-elect meeting June 8-9 in Washington, DC. During this meeting, Kaye, along with other state affiliates’ presidents-elect will learn about APHA’s mission, priorities, and governance model; become acquainted with APHA benefits to our affiliate in terms of resources and services available to TPHA. She will also have an opportunity to visit her congressional representatives.

**Call for Scholarship Applications**

**SCHOLARSHIPS**
Awarded to students for the purpose of providing financial aid and encouragement to attend the college of their choice for the purpose of pursuing a degree in the field of public health. The dollar amount of scholarship monies available will be announced after the Association’s Spring Quarterly Meeting each year (April/May), as well as the dollar amount and number of grants to be awarded. The dollar amount granted will not exceed the amount of interest earned on the Scholarship Account in the previous year.

**REQUIREMENTS**
1. Applicant or immediate family member of applicant must be a TPHA member in good standing for at least one year at the time of application.
2. Scholastic record of not less than a 2.5 average on a 4.0 system. Transcript of last completed semester or high school transcript must accompany application.
3. Applicant’s course of study must be applicable to public health employment. Degree plan or course outline must accompany application.

**JUDGING**
Decision of the Scholarship Committee will be based on the following: Financial need, academic record and character. Only one scholarship will be awarded per individual. Unsuccessful applicants are encouraged to re-apply, providing they meet the criteria.

**ENDORSEMENTS**
The applicant must be sponsored by a member of TPHA, other than the family member. A letter from the TPHA sponsoring member is required. Letters of endorsement from at least two teachers or professors and/or school administrators in support of the application are required. Also, letters from employers, past and present should be included, as well as letters from anyone who is cognizant of the applicant’s qualifications.

**APPLICATION DEADLINE**
Applications with ALL SUPPORTING DOCUMENTS must be received by July 10th. The recommendation of the Scholarship Committee will be made at the August Quarterly Meeting and announced after the decision of the August Governing Council.

**THE FOLLOWING MUST ACCOMPANY EACH APPLICATION**
1. Complete Scholarship Application
2. Official transcript of grades, including the last grading period.
3. Letter from TPHA member.
4. Letters of endorsement.
5. Resume and/or curriculum vitae.

All applications are considered confidential and will become the property of TPHA. For a copy of the application please contact Terri Pali at (512)336-2520 or e-mail at txpha@aol.com or go to our website at www.texaspha.org to access a fill-in form.
### TPHA HONORARY LIFE MEMBERS

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<tr>
<th>Year</th>
<th>Name</th>
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<tr>
<td>1948</td>
<td>V. M. Ehlers*</td>
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<td>1949</td>
<td>George W. Cox, MD*</td>
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<td>1950</td>
<td>W. Bohls, MD*</td>
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<td>1952</td>
<td>Hubert Shull, DVM*</td>
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<td>J. W. Bass, MD*</td>
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<td>Earle Sudderth*</td>
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<td>1956</td>
<td>Austin E. Hill, MD*</td>
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<td>J. V. Irons, ScD*</td>
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<td>Lewis Dodson*</td>
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<td>L. P. Walter, MD*</td>
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<td>Nell Faulkner*</td>
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<td>1965</td>
<td>James M. Pickard, MD*</td>
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<td>Roy G. Reed, MD*</td>
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<td>W. Howard Bryant*</td>
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<td>Albert Randall, MD*</td>
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<td>Maxine Geeslin, RN</td>
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<td>Sue Barfoot, RN</td>
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<td>Jo Dimock, RN, BSN, ME</td>
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<td>Marietta Crowder, MD</td>
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<td>Wm. F. Jackson, REHS*</td>
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<td>Charlie Norris*</td>
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<td>T. L. Edmonson, Jr.</td>
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<td>David M. Cochran, PE</td>
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<td>JoAnn Brewer, MPH, RN*</td>
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<td>Dan T. Dennison, RS, MT, MBA</td>
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<td>Mary McSwain, RN, BSN</td>
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<td>Robert L. Drummond</td>
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<td>Nina M. Sisley, MD, MPH</td>
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<td>Tom Hatfield, MPA</td>
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<td>Janet Greenwood, RS</td>
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<td>2005</td>
<td>Charla Edwards, MPH, RN</td>
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<td>2006</td>
<td>Janice Hartman, RS</td>
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<td>2007</td>
<td>Jennifer Smith, MSHP</td>
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<td>2008</td>
<td>Catherine D. Cooksley, DrPH</td>
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<td>2009</td>
<td>Hardy Loe, M.D.</td>
</tr>
<tr>
<td>2010</td>
<td>John R. Herbold, DVM, PhD</td>
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*deceased

### TPHA Life Members

- **Ron Anderson, MD**
- **Minnie Bailey, PhD**
- **Ned V. Brookes, PE**
- **Oran S. Buckner, Jr., PE, RS**
- **Burl Cockrell, RS**
- **Exa Fay Hooten**
- **Robert MacLean, MD**
- **Sam Marino**
- **Annie Lue Mitchell**
- **Laurnance N. Nickey, MD**
- **David R. Smith, MD**
- **Kerfoot P. Walker, Jr., MD**