INJURY AND VIOLENCE PREVENTION:
A LOCAL HEALTH DEPARTMENT PERSPECTIVE

Examination of Local Health Department Capacity and Infrastructure for Injury and Violence Prevention

NACCHO
National Association of County & City Health Officials

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Executive Summary

In 2011, the National Association of County and City Health Officials (NACCHO) surveyed local health departments (LHDs) to learn more about LHD infrastructure and capacity to prevent unintentional injury and violence. A sample of 489 LHDs was sent an online survey questionnaire; 165 responded, of which 146 were eligible to complete the survey. NACCHO also conducted eight key informant interviews to learn more about LHD infrastructure and capacity. The survey and key informant interviews revealed that LHDs lack specific divisions dedicated to injury and violence prevention activities due to lack of funding. Though many LHDs did not use surveillance data or conduct program evaluation, the needs of the community drove program strategies and approaches. LHDs expressed a need for technical support and assistance to complete evaluation, community assessment, strategic planning, evidence-based decision-making, and advocacy and policy change.

Based on the results of this infrastructure and capacity assessment, NACCHO recommends the following to improve local capacity for injury and violence prevention: (1) increase local, state, and federal funding to develop and maintain local prevention strategies and infrastructure at all LHDs; (2) support collaborative efforts among local, state, tribal, and federal public health agencies and community partners; (3) integrate an injury and violence prevention perspective into other public health efforts; (4) develop and implement evidence-based practices and innovative, promising, or model practices; and (5) ensure ongoing training and support to increase capacity of all LHDs to identify health disparities, address health inequities, monitor local data and trends, and assess impact of local prevention efforts.

Report Highlights

The following are key highlights from NACCHO's survey of LHD capacity to prevent injury and violence:

INFRASTRUCTURE — Almost 50 percent of injury and violence prevention activities occured in Health Promotion divisions, and 29 percent were located in Maternal and Child Health divisions.

STRATEGIES — Seventy-five percent of LHDs conducting injury prevention (IP) activities most often used educating or counseling in their prevention efforts. Sixty-nine percent of LHDs conducting violence prevention (VP) most often used raising community awareness in their prevention efforts.

FUNDING — The primary source of funding for IP activities at LHDs was state government (80%), whereas the primary source of funding for VP activities at LHDs was non-profits and foundations (66%).

COLLABORATIONS & PARTNERSHIPS — Eighty-two percent of LHDs conducting IP collaborated with other local government agencies, whereas 89 percent of LHDs conducting VP collaborated with local non-government agencies.

POLICY — Seventy-two percent of LHDs reported participating in local policy activities, most commonly increasing public awareness of existing policies (52%).

DATA COLLECTION & SURVEILLANCE — Seventy percent of LHDs that conducted IP activities and 57 percent of LHDs that conducted VP activities used surveillance data.

PROGRAM EVALUATION — Forty-four percent of LHDs that conducted IP activities and 36 percent of LHDs that conducted VP activities conducted some type of program evaluation.

TECHNICAL ASSISTANCE — Nearly half of IP staff and 38 percent of VP staff received technical assistance and training.

Introduction

Background

Injury and violence are significant public health problems and have many negative effects on the health of Americans, including premature death, disability, poor mental health, lost productivity, and increased healthcare costs. Injuries and violence are among the leading causes of mortality, disability, and morbidity in the United States. In 2010, injuries and violence combined were the third leading cause of death in the United States.[1] More than 170,000 deaths are attributed to injury and violence each year, most of which are due to poisoning (including prescription drug overdose), motor vehicle injury, firearms, and falls.[1] Injury is the leading cause of death for Americans ages one through 44 and the fifth leading cause of death among people of all ages.[1] Violence affects people of all ages, from infancy to adulthood. In 2010, over 16,000 Americans were victims of homicide and over 38,000 died by suicide.[2,3] Unintentional injury and violence are also among the leading causes of years of potential life lost.[1]

Nearly 30 million people receive treatment in emergency departments as a result of injury and violence each year.[4] In fact, injuries account for over 35 percent of emergency department visits annually. In a single year, injuries and violence cost the United States $406 billion, which includes over $80 billion in medical costs (6% of total health expenditures) and $326 billion in lost productivity.[5]

Despite the public health burden of injury and violence, according to the NACCHO's 2010 National Profile of Local Health Departments (Profile) study, the only comprehensive national survey of LHD infrastructure and activities, only 40 percent of LHDs reported IP activities and 24 percent reported VP activities.[6]

This report provides the following information:

- National data on the status of local injury and violence prevention programs and activities;
- Strengths and needs of LHDs conducting injury and violence prevention programs and activities; and
- Future priorities and recommendations for NACCHO and its partners to consider as they continue to support the work of LHDs.

Role of Local Health Departments in Injury and Violence Prevention

Given the public health burden of injury and violence, LHDs play a critical role in protecting and improving community safety in coordination and collaboration with local, state, and national partners. LHDs protect and improve community well-being by preventing disease, illness, and injury and affecting social, economic, and environmental factors fundamental to health. LHDs can work toward these ends through the 10 Essential Services:[7]

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of healthcare when otherwise available.
8. Assure competent public and personal healthcare workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Methods

Survey Design

In 2011, NACCHO surveyed LHDs to better understand their infrastructure and capacity to prevent injury and violence. NACCHO developed the survey instrument in conjunction with the National Center for Injury Prevention and Control, basing it on NACCHO's Profile survey and the Safe States Alliance State of the States Survey.[7,8] NACCHO adapted questions from both surveys; research and evaluation experts reviewed additional survey questions. The survey contained two identical sets of 36 questions, with one set about IP activities and the other about VP activities. The survey questions focused on LHD infrastructure, planning and implementation, data collection and evaluation, training and technical assistance, and policymaking in the prior year.

NACCHO's 2010 Profile indicated that 1,298 LHDs reported injury or violence prevention activities. NACCHO sent the online survey to a stratified sample of 489 LHDs that reported IP or VP activities. Approximately 100 LHDs were sampled from each jurisdictional stratum (<25,000; 25,000–49,999; 50,000–99,999; 100,000–249,999; 500,000+). A majority of the sample (79%) reported conducting IP and VP in the 2010

FIGURE 1: Survey Sample Distribution

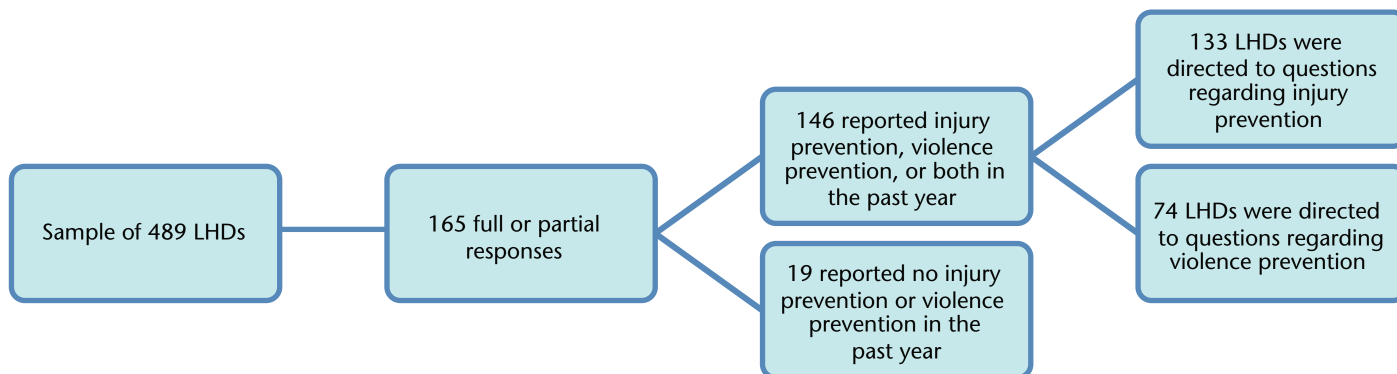


TABLE 1: Percentage Distribution of Local Health Departments Engaged in Injury Prevention and Violence Prevention, by Size of Population Served

Jurisdiction Population Size	United States	Sample
<25,000	42%	24%
25,000–49,999	21%	25%
50,000–99,999	15%	14%
100,000–499,999	18%	25%
500,000+	5%	12%

n=146

Profile. The remainder reported conducting IP only (10.5%) or VP only (10.5%).

A total of 165 LHDs responded to the survey (response rate = 33.7%). Nineteen respondents did not complete the survey because they indicated that their LHD did not conduct injury or violence prevention activities within the year prior to the survey. These LHDs were excluded from the survey. Of the 146 respondents who indicated their LHD conducted injury or violence prevention in the past year, 133 were directed to the set of questions focused on IP and 74 were directed to the set of questions focused on VP (Figure 1). Not all LHDs responded to all survey questions, so the number of LHDs responding to each question varies, as noted in figures, tables, and the document text. Data for IP and VP activities are presented combined, except when notable differences in responses occurred. Moreover, some respondents completed both sets of questions, resulting in a total number of responses being greater than 146 when data are presented together on both IP and VP.

Key Informant Interview

In addition to an online survey, NACCHO conducted eight key informant interviews to gain further insight. Key informants were asked eight questions on LHD primary prevention activities, integration and collaboration, funding and resources, strategic planning, support, and general barriers. The participants were selected from survey respondents who indicated they were interested in participating in a discussion about injury and violence prevention capacity, based on jurisdiction size. Two respondents from each jurisdictional stratum were asked to participate in key informant interviews.

Survey Respondents

Compared to the general population of LHDs in the United States, the sample had a lower percentage of LHDs serving a jurisdiction size of less than 25,000, and a greater percentage of LHDs with jurisdiction sizes of 100,000–499,999 and 500,000+ (Table 1). The vast majority (70%) of LHDs surveyed represented county health departments (Figure 2).

FIGURE 2: Percentage Distribution of Local Health Departments Engaged in Injury Prevention and Violence Prevention, by Type of Geographic Jurisdiction

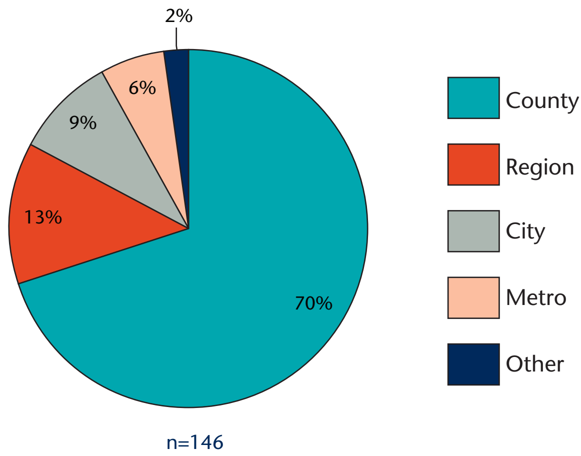
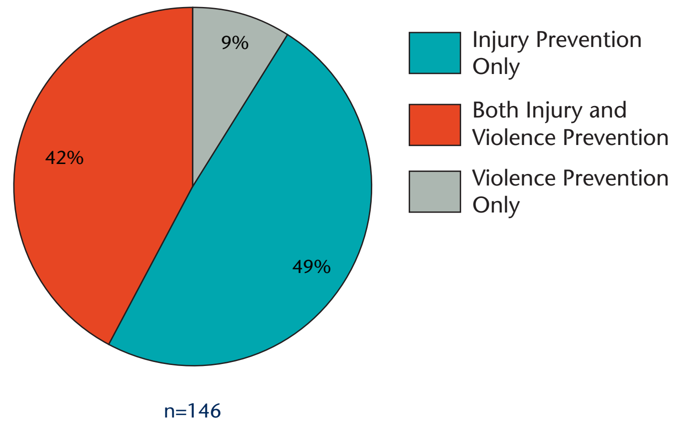


FIGURE 3: Percentage of Local Health Departments Providing Injury Prevention and Violence Prevention Services



Data Analysis

NACCHO used descriptive analysis of responses to each survey question to characterize injury and violence prevention infrastructure and capacity of respondents.

Injury and Violence Prevention Program Infrastructure

Engagement in IP and VP Activities

Of the 146 respondents who reported conducting any IP, VP, or both activities within the past year, 49 percent conduct only IP, nine percent conduct only VP, and 42 percent conduct both injury and violence prevention (Figure 3).

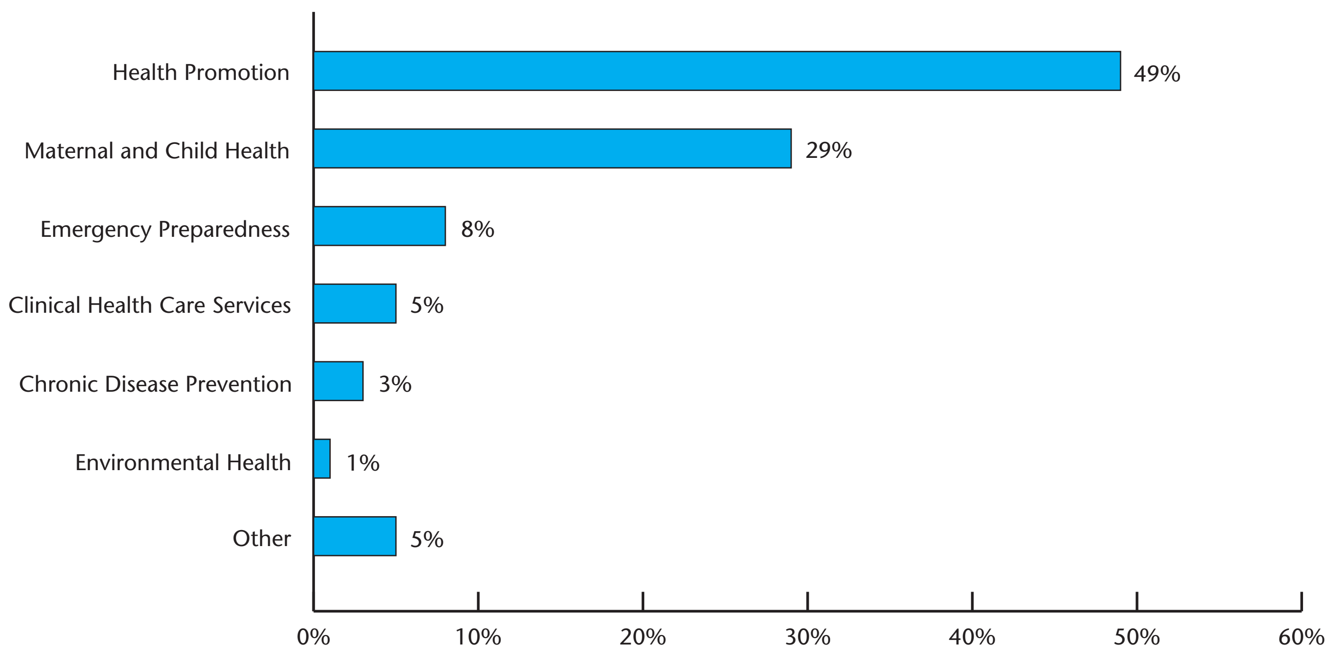
Most LHDs that conducted IP (76%) and VP (77%) did not have a separate, dedicated division. LHDs that reported no division primarily conducted IP, VP, or both activities through Health Promotion (49%) and Maternal and Child Health (29%) divisions (Figure 4).

In interviews, LHD staff explained that a separate division for IVP activities would be ideal but was not currently feasible due to lack of resources.

> *"It would be wonderful in every local health department if you had a team of injury and violence prevention people ... It's not a luxury that we have."*

FIGURE 4: **Percentage of Local Health Departments Providing IP and VP Activities, by Responsible Division**

n=155



Note: Some respondents completed both sets of questions, resulting in a total number of responses being greater than 146.

Prevention Efforts

LHDs engaged in a variety of activities related to the prevention of injuries and violence, primarily by providing community education and outreach and building partnerships (Table 2). Educating or counseling clients (75%) was among the top three efforts of LHDs conducting IP; raising community awareness of issues, programs, and services (69%) was among the top three efforts of LHDs conducting VP.

Funding

State government (42%) was the most frequently selected source for IP and VP efforts (Figure 5). Support from federal and state government most often came in the form of monetary support, while support from local government, businesses, and non-profits most often came in the form of in-kind support. Budget cuts resulted in the reduction, restructuring, or elimination of injury and violence prevention efforts in some LHDs.

TABLE 2: Percentage of Local Health Departments Engaged in Injury Prevention and Violence Prevention Efforts

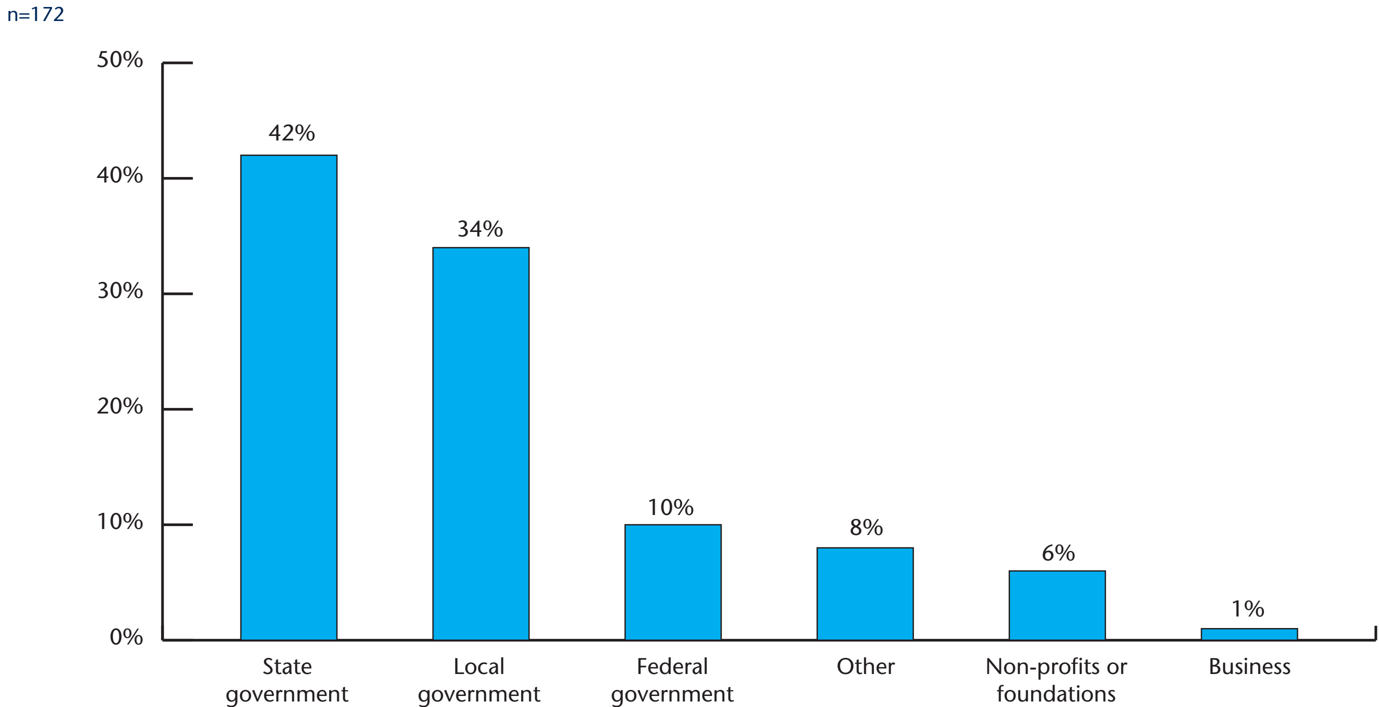
Injury Prevention Efforts		Violence Prevention Efforts	
Activities	%	Activities	%
Provided community education and outreach	83	Provided community education and outreach	77
Built partnerships	82	Built partnerships	75
Educated or counseled clients	75	Raised community awareness of issues, programs, and services	69
Administered or implemented programs	73	Educated or counseled clients	64
Disseminated information	71	Disseminated information	63

n=103 n=64

Note: Respondents were able to select more than one response.

FIGURE 5: Percentage of Local Health Departments Receiving In-Kind and Monetary Support for Injury Prevention and Violence Prevention, by Source

n=172



Note: Some respondents completed both sets of questions, resulting in a total number of responses being greater than 146.

"Sustainable funding is by far the largest barrier for all of our injury prevention work. We've not been able to identify very many sources of multiyear funding."

"Budget cuts have directly affected our ability to address injury prevention."

Partnerships

LHDs engaged in IP most frequently reported collaborating with other local government agencies (82%), whereas LHDs engaged in VP most frequently reported collaborating with local non-government agencies (89%) (Figure 6). LHDs reported engaging with other divisions for IP more frequently than for VP. LHDs reported engaging with other internal divisions for IP more frequently than for VP.

In interviews, frequently mentioned local partners included schools, colleges/universities, local law enforcement and highway patrol, hospitals and healthcare providers, daycares, and local non-government organizations.

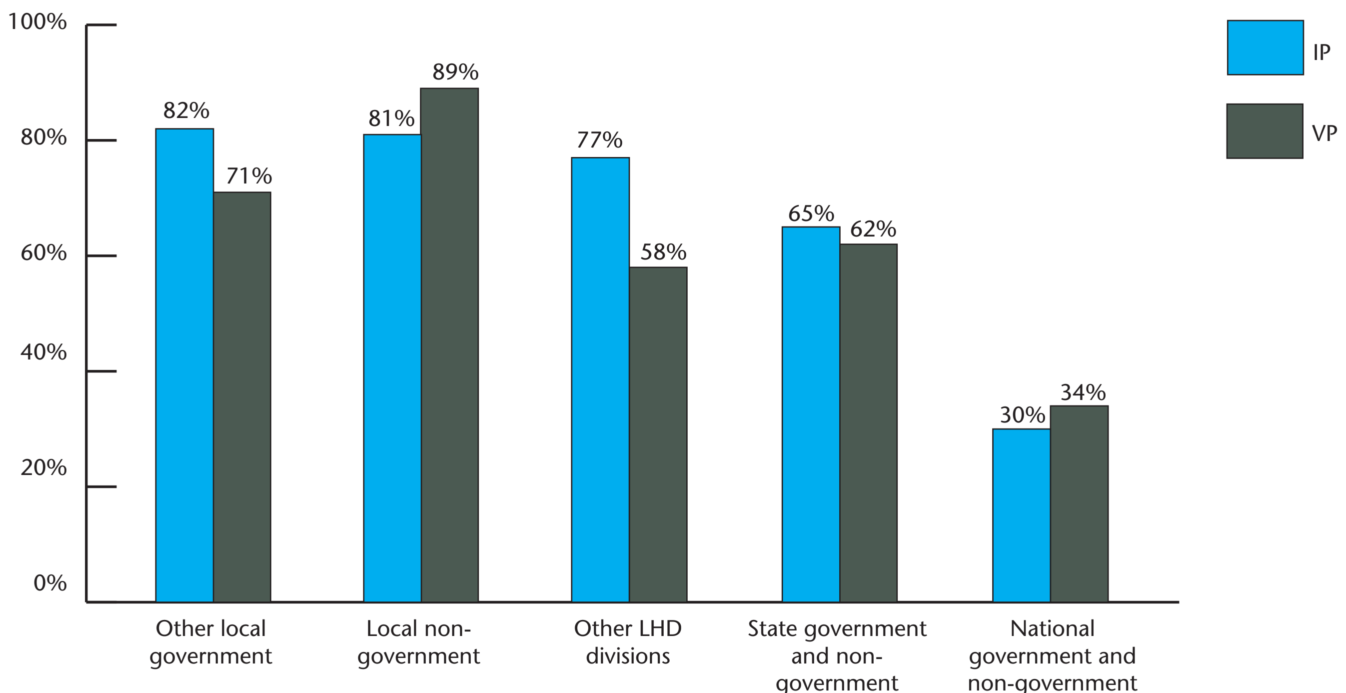
Collaboration enabled LHDs to better implement strategies and ensure that community members received the services and support they needed. Interviews revealed that established, consistent relationships and strong leadership facilitated effective partnerships, while lack of facilitation, limited time, limited funding, and changing priorities were barriers to collaboration. LHDs emphasized the importance of finding common goals among competing priorities and the need for LHD staff to have effective community organizing and facilitation skills.

"Everyone comes to the table with their own objectives and their own set of goals. And so we have to make sure that they know that we appreciate and respect their goals, but also that we need a goal as a coalition, and that's probably the hardest thing."

While most LHDs reported receiving support from state government agencies, key informant interviews revealed varying levels of satisfaction with the relationship between the LHD and state government.

FIGURE 6: **Percentage of Local Health Departments Engaged in Collaboration for Injury Prevention and Violence Prevention, by Partner Type**

n (IP)=104; n (VP)=65



“Our state does have an injury and violence program, and we have a great contact at the state level [who] is wearing 25 hats, which makes it challenging to really aggressively attack any particular injury mechanism. But we have a great resource at the state level, so that’s always really exciting.”

“We have a good relationship [with the state], albeit sometimes a confusing relationship. I don’t have a lot of contact at all. I mean, I turn in my reports. I don’t really hear much back, and I go about my business. I figure if there’s a problem, somebody will tell me.”

TABLE 3: **Factors Influencing Selection of Injury and Violence Prevention Priorities**

Factors Influencing Priorities	Mean
Funding	4.53
Community demand	4.43
Availability of evidence-based strategies or programs	4.31
Needs assessment or surveillance data	4.30
Opportunity to collaborate with other stakeholders	4.25
National, state, or local mandates	4.13
Staff expertise/interests	4.03
Availability of innovative approaches	3.90
Political pressure	3.49

n=160
Note: Scale ranged from 1 (Very Unimportant) to 5 (Very Important).
Note: Some respondents completed both sets of questions, resulting in a total number of responses being greater than 146.

TABLE 4: **Factors Influencing Selection of Injury and Violence Prevention Strategies and Interventions**

Factors Influencing Strategies	Mean
The strategy meets the needs of the community and LHD.	4.64
The resource needs of the strategy fit the LHD’s capacity.	4.57
There is evidence for the strategy’s effectiveness.	4.47
There is community interest in and support for the strategy.	4.43
There is administrative interest in and support for the strategy.	4.27
The strategy is better than what it will replace.	4.23
The strategy is sustainable beyond the original funding period.	4.23
The impact of the strategy is observable and easy to measure.	4.10
Other stakeholders recommend the strategy.	3.99
The strategy is easy to implement.	3.98
The strategy can be tried out before it is fully adopted.	3.57

n=159
Note: Scale ranged from 1 (Very Unimportant) to 5 (Very Important).
Note: Some respondents completed both sets of questions, resulting in a total number of responses being greater than 146.

Strategic Planning for Injury and Violence Prevention Programs

Twenty-five percent of LHDs engaging in IP and 34 percent of LHDs engaging in VP had an up-to-date plan for IP and for VP, respectively. LHDs identified funding, community demand, and availability of evidence-based strategies as the most important factors in determining priority areas for all respondents (Table 3).

Key informant interviews indicated that funding and resource availability greatly influenced LHDs' ability to address injury and violence. National and local data were also driving forces in determining injury and violence prevention priorities.

> *"We have a directive from the state on what focus areas they're looking at and we write a grant in relationship to those focus areas and that's how our grants have traditionally been awarded."*
>
> *"A lot of [priorities are] going to be driven by the funding."*

LHDs primarily determined what strategies and interventions to use based on the needs of the community and the LHD, the resource needs of the strategy, and evidence for the strategy's effectiveness (Table 4).

Policy Activities

Most respondents (72%) reported participating in local policy activities (Figure 7). One-fifth of respondents indicated they did not engage in any policy work in the past year. Reasons for not engaging in policy activities included limited resources, the time-consuming political process, and concern about how policy change would be received by the community. The most common types of policy activities of all respondents were increasing public awareness of existing policies (52%), conducting or participating in community organizing (50%), and meeting with policy- and decision-makers (44%) (Figure 8).

> *"Our county commissioners are not open to infringing policy change. Our community is [very] opposed to changing laws, any laws that restrict the way they do business or any personal freedoms."*

FIGURE 7: **Percentage of Local Health Departments Engaged in Policy Activity for Injury Prevention and Violence Prevention, by Jurisdiction Level**

n=137

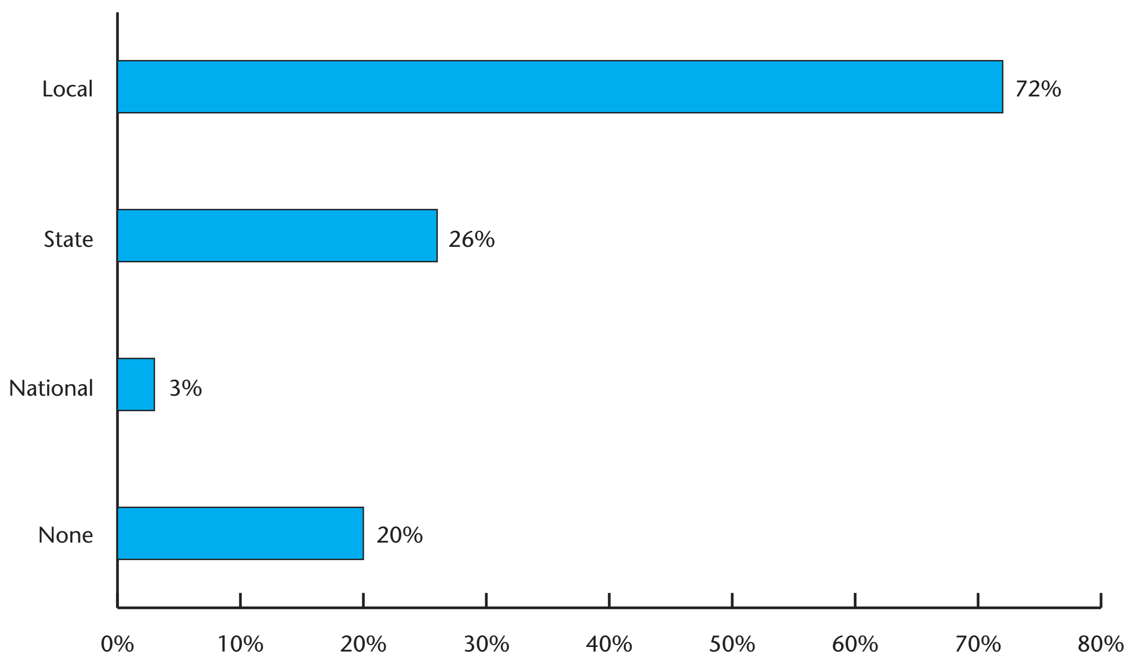
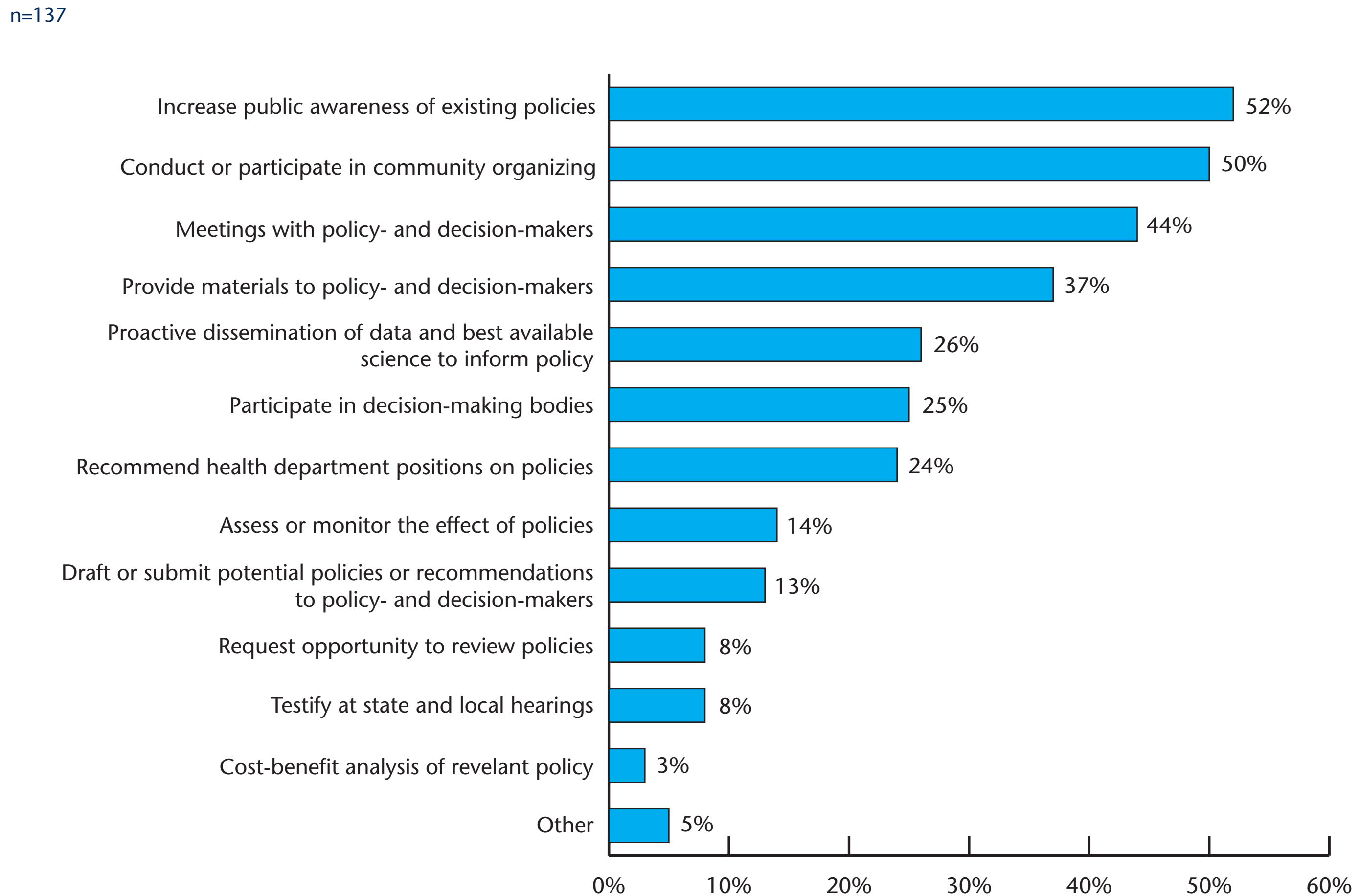


FIGURE 8: Percentage of Local Health Departments Engaged in Informing Policy for Injury Prevention and Violence Prevention, by Activity Type



> *"I think for us, [the barrier to policy change is] having the time to commit to [policymaking] and not knowing what steps to take to get to that point."*

Data Collection and Use in Local Communities

Data Collection and Use Capacity

LHDs reported higher capacity for all data-related tasks for IP than for VP (Figure 9). LHDs that conducted IP and VP most often rated their capacity to share data with community members as "very high" or "high" (64% and 57%, respectively). LHDs that conducted IP least often rated their capacity to analyze data as "very high" or "high" (33%), whereas LHDs that conducted VP least often rated their capacity to collect original data as "very high" or "high" (22%).

Seventy percent of LHDs that conducted IP activities and 57 percent of LHDs that conducted VP activities reported using surveillance data in the year prior to the survey. Among LHDs that conducted IP activities and used surveillance data, the most common uses for surveillance data were program planning (71%) and awareness building (71%); for LHDs that engaged in VP and used surveillance data, the most common uses for surveillance data were awareness building (76%) and community assessment (66%) (Figure 10).

FIGURE 9: Percentage of Local Health Departments Reporting Very High or High Capacity for Injury Prevention and Violence Prevention Surveillance and Evaluation, by Activity

n (IP)=100; n (VP)=60

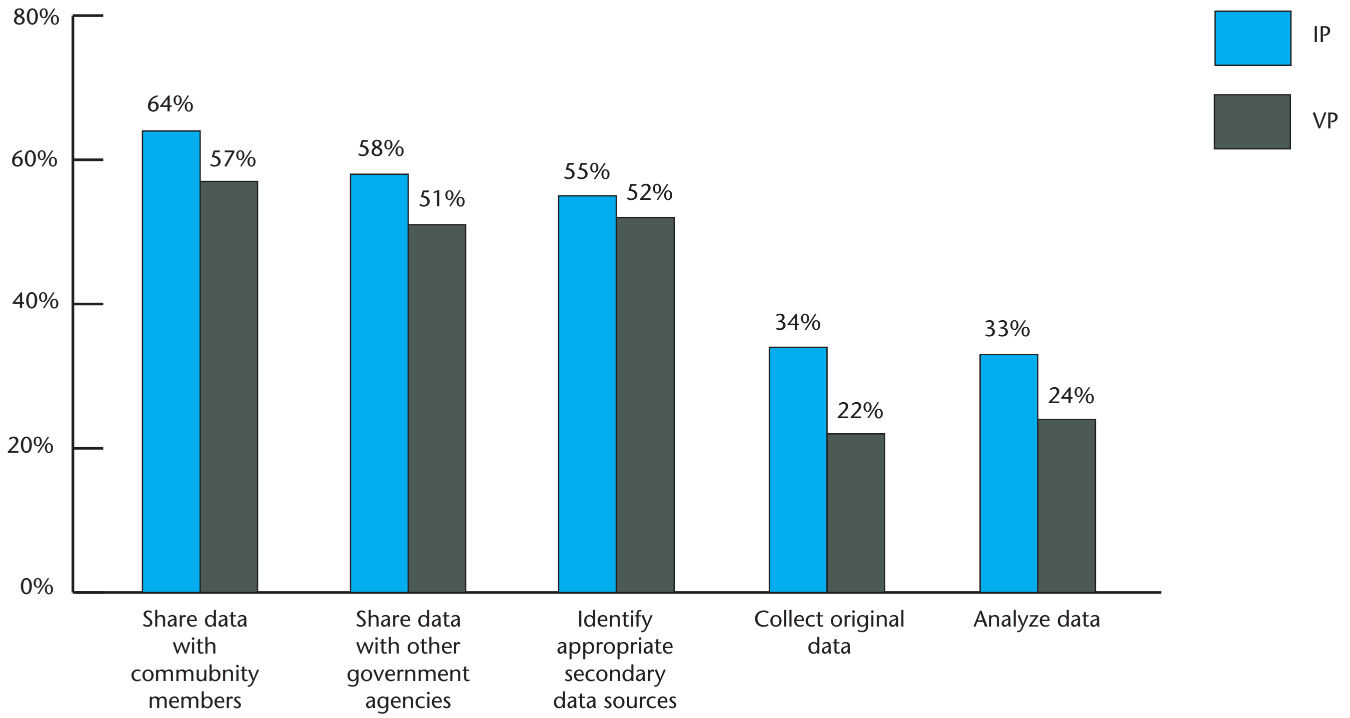
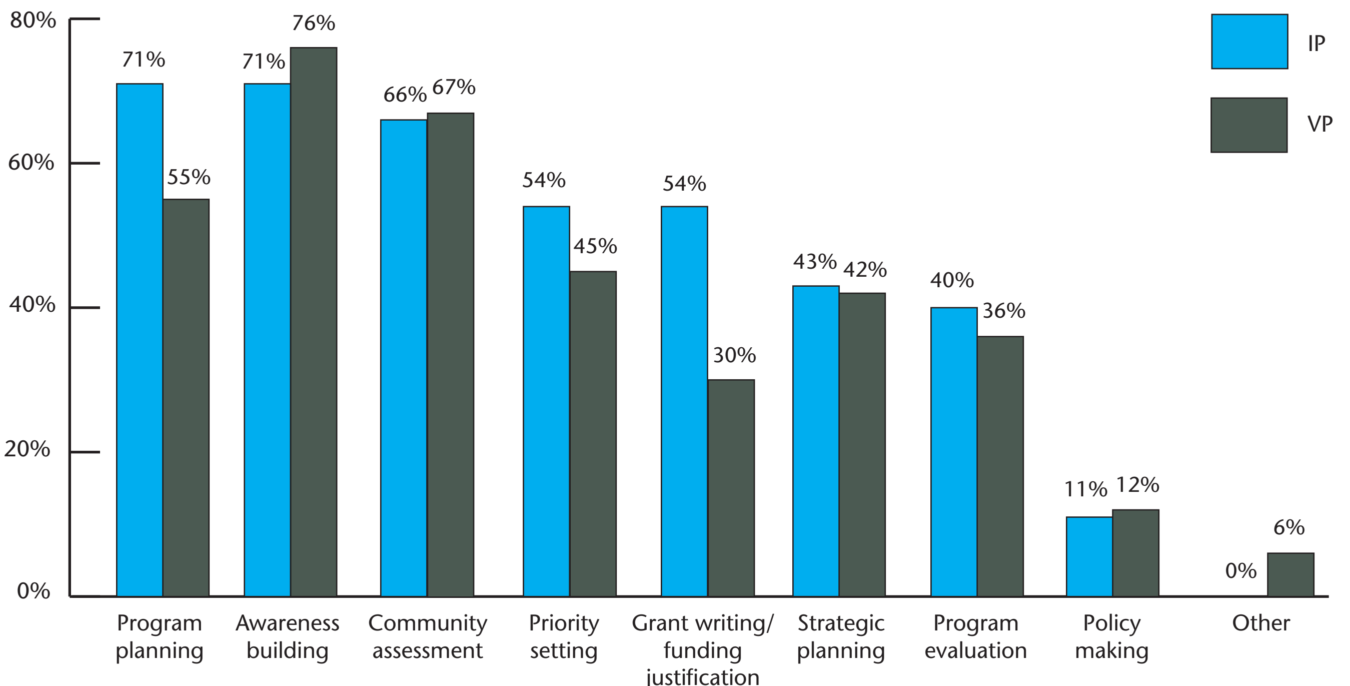


FIGURE 10: Percentage of Local Health Departments Reporting Use of Surveillance Data for Injury Prevention and Violence Prevention, by Activity

n (IP)=65; n (VP)=33



The most common surveillance data source for LHDs that engaged in IP was fatality data (85%), whereas the most common source of surveillance data for LHDs that conducted VP was behavioral data (88%) (Figure 11). LHDs that engaged in IP more often used emergency department data (35%) than LHDs that engaged in VP (24%). LHDs that engaged in VP reported more use of law enforcement reports (45%) than LHDs that engaged in IP (34%).

Evaluation

Forty-four percent of LHDs that engaged in IP and 36 percent of LHDs that engaged in VP conducted some type of program evaluation in the year prior to the survey. Of the LHDs that engaged in program evaluation, most (67%) collected anecdotes, measured behavior change (58%), and measured knowledge gain and retention (56%) (Figure 12).

Technical Support and Continuing Education

Technical Support and Assistance

Nearly half (49%) of IP staff and 38 percent of VP staff received technical support and assistance in the year prior to the survey. Of the LHDs that received technical support and assistance, all (100%) LHDs that engaged in IP received technical support or assistance from state government agencies, compared to 61% of LHDs that engaged in VP (Figure 13). LHDs participating in IP activities also received technical support and assistance from other local government agencies (59%) and foundations or associations (28%). LHDs conducting VP activities also indicated other local government agencies (61%) and academic institutions (22%) provided technical support and assistance.

The top three technical assistance needs of LHDs engaging in IP were evaluation (54%), community assessment (46%), and strategic planning (40%) (Table 5). The top three technical assistance needs of LHDs engaging in VP were strategic planning (40%), evidence-based decision-making (36%), and advocacy and policy change (34%).

Fifty-six percent of LHDs that conducted IP activities and 43 percent of LHDs that conducted VP activities provided IP and VP continuing education, training, or technical assistance opportunities to individuals or organizations outside of the LHD, respectively.

Continuing Education

Eighty percent of LHDs that conducted IP activities and 77 percent of LHDs that conducted VP activities reported that their staff participated in continuing education or training

FIGURE 11: Percentage of Local Health Departments Reporting Use of Surveillance Data for Injury Prevention and Violence Prevention, by Source

n (IP)=65; n (VP)=33

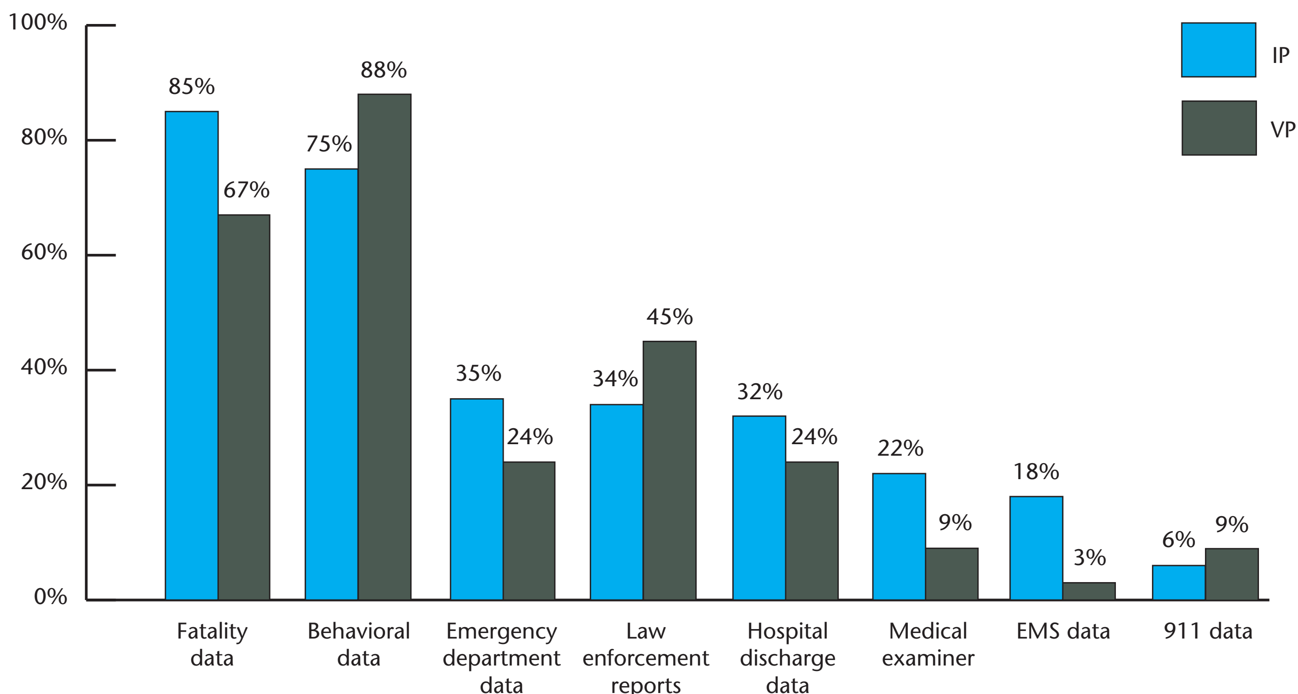


FIGURE 12: Percentage of Local Health Departments Reporting Evaluation of Injury Prevention and Violence Prevention Efforts, by Activity

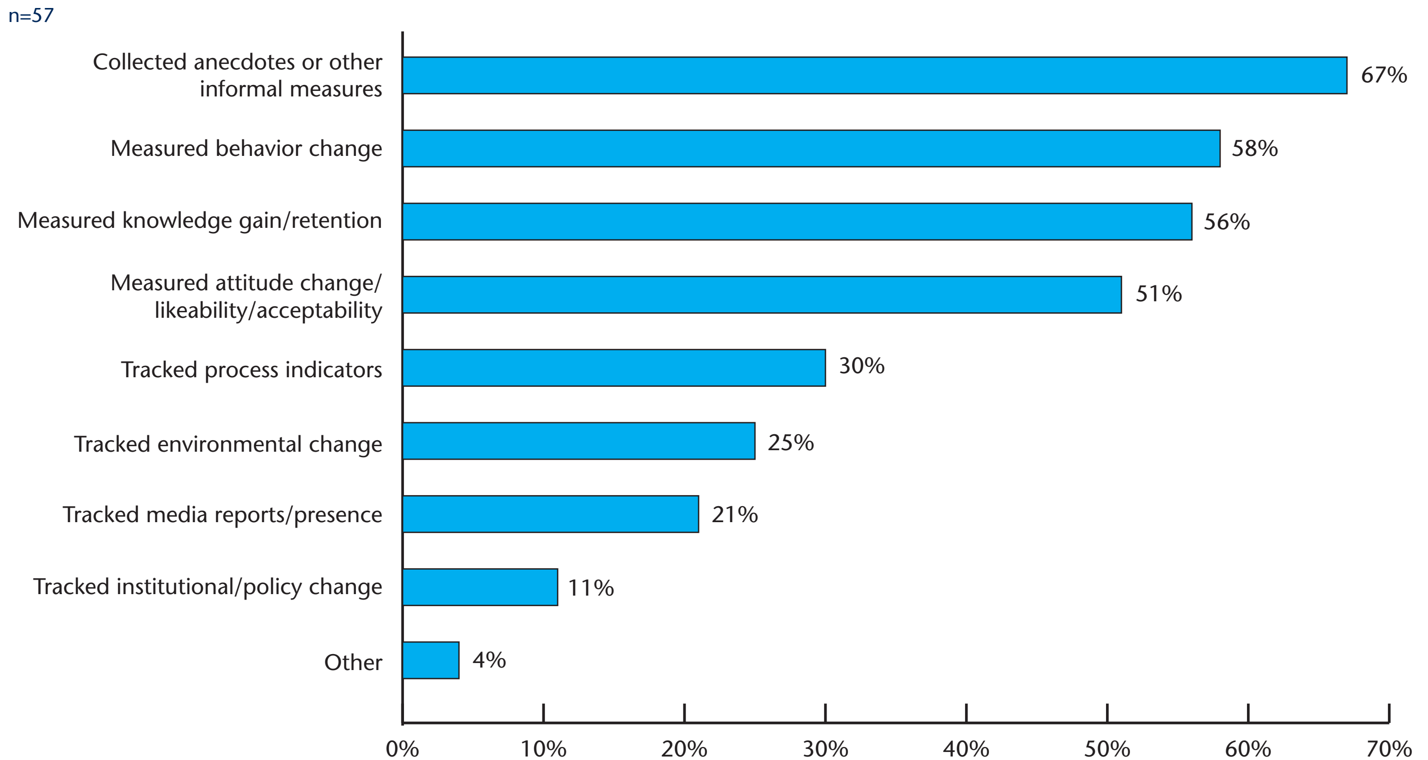


FIGURE 13: Percentage of Local Health Departments Receiving Technical Support and Assistance, by Source

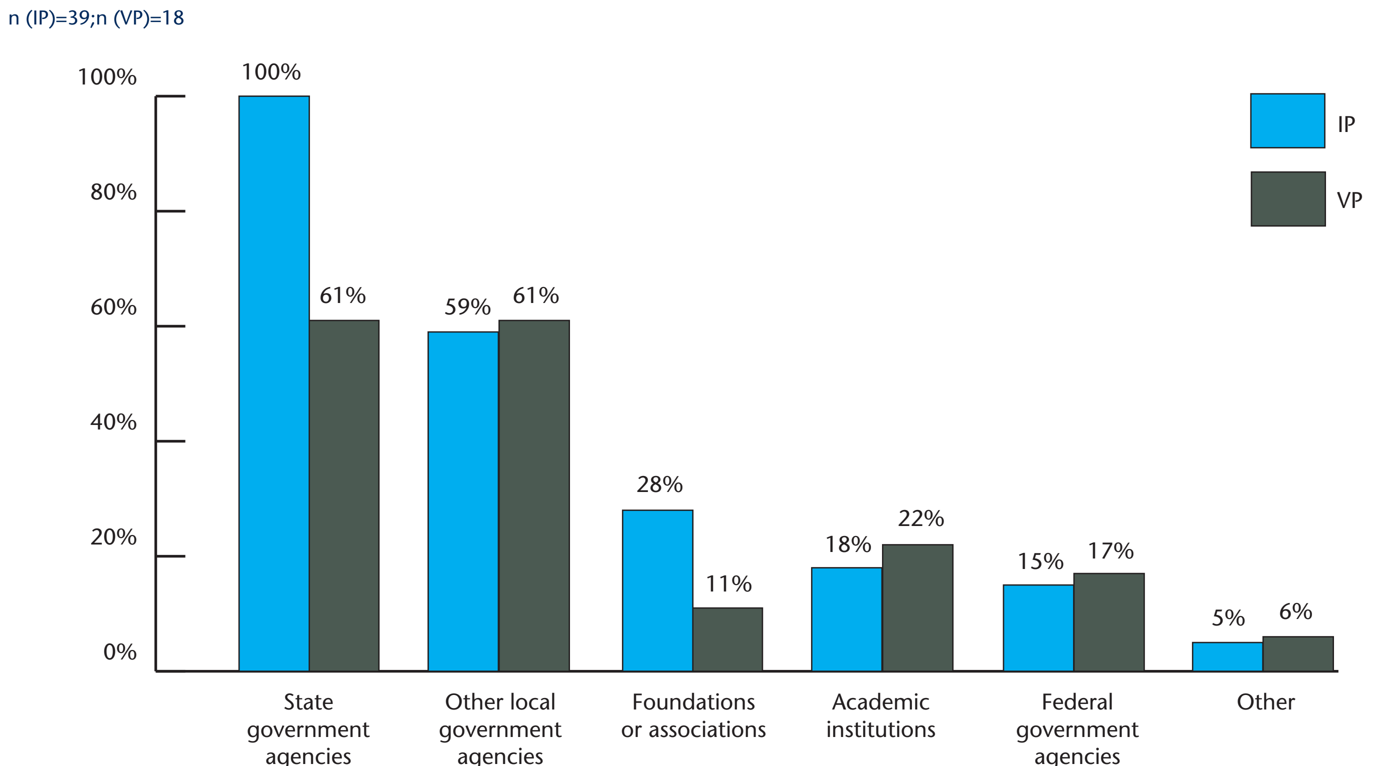
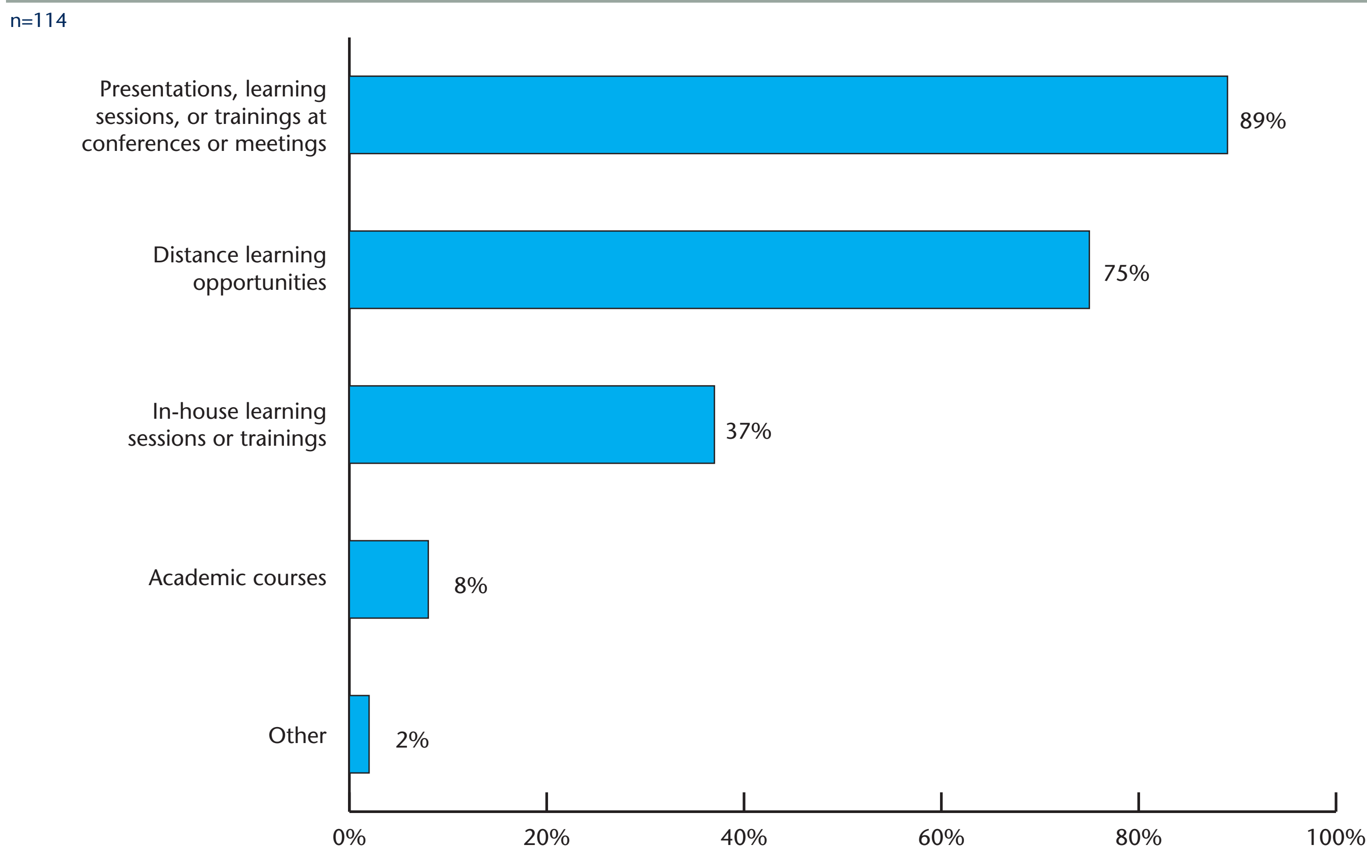


TABLE 5: Percentage of Local Health Departments Reporting Technical Support and Assistance Needs, by Topic

Topic	IP	VP
Evaluation	54%	32%
Community assessment	46%	32%
Strategic planning	40%	40%
Advocacy and policy change	39%	34%
Data analysis	39%	26%
Data collection	38%	24%
Evidence-based decision-making	37%	36%
Grant writing	36%	32%
Quality improvement	31%	18%
Needs assessment	27%	20%
	n=84	n=50

FIGURE 14: Percentage of Local Health Departments Receiving Continuing Education and Training for Injury Prevention and Violence Prevention, by Type



opportunities. The most common types of continuing education LHD staff received included presentations, learning sessions, or trainings at conferences or meetings (89%) and distance learning opportunities (75%) (Figure 14).

Participants in the interviews emphasized the benefits of continuing education.

> ***"We benefit a lot from [conferences] and the educational training. It's phenomenal."***
>
> ***"Well, the webinars are really helpful. They're very accessible and easy to do. You can schedule those and get a lot of good information on those, so for me, that's probably been the most beneficial... to be able to get access to these experts, and then to listen to the Q&A afterwards, you know on your phone or computer, that's been one of the big breakthroughs in training communication I think."***

Discussion

Summary of Main Findings

Most LHDs that conducted IP and VP activities did not have a division dedicated solely to those activities. IP and VP activities were primarily conducted through Health Promotion and Maternal and Child Health divisions. Injury and violence prevention efforts were largely in the form of providing community education and outreach, building partnerships, educating or counseling clients, and raising community awareness of issues, programs, and services.

Funding was a driving force of IP and VP activities. LHDs that engaged in IP and VP indicated that funding affected their ability to have dedicated divisions or departments for these activities. State government primarily provided financial support and was a major source of support for IP. Non-profits primarily provided in-kind support and were a major source of support for VP. LHDs often collaborated with other local government agencies and local non-government agencies. LHDs identified local partnerships with schools, colleges and universities, local law enforcement and highway patrol, hospitals and healthcare providers, and daycares as key to program success.

Strategies for IP and VP were primarily determined by the needs of the community and LHD, the resource needs of the strategy, and evidence of the strategy's effectiveness. Funding, resource availability, and national and local data were also driving forces in determining injury and violence prevention priorities.

Policy efforts primarily occurred at the local level. Top policy activities included increasing public awareness of existing policies, conducting or participating in community organizing, and meeting with policy- and decision-makers.

Many LHDs surveyed did not use surveillance data, did not conduct program evaluation, and reported less capability to collect original data and to analyze data. When LHDs used surveillance data, they did so for program planning, awareness building, and community assessment. Common evaluation activities included collecting anecdotes and other informal measures, measuring behavior change, knowledge gain, and attitude change/likeability/acceptability.

LHDs received more technical assistance and support for IP than VP, and that support was provided primarily by state government agencies and other local governmental agencies. Top technical assistance needs for LHDs were evaluation, community assessment, strategic planning, evidence-based decision-making, and advocacy and policy change. Most LHD IP and VP staff take part in continuing education opportunities.

Implications

This report enhances understanding of injury and violence prevention capacity at the local level. This survey reveals that LHDs need more support from federal, state, and local governments in order to adapt, implement, and sustain IP and VP efforts in their communities.

Given the public health burden of injuries and violence, LHDs play a critical role in protecting and improving community safety in coordination and collaboration with local, state, and national partners. To ensure successful injury and violence prevention efforts, decision-makers must recognize both injury and violence as public health issues and value the public health approach to injury and violence prevention. It is important that community-, state-, and national-level partners continue to support LHDs by providing funding, technical assistance, and resources for coordinated, collaborative approaches to addressing the causes of injury and violence at the local level.

Limitations

The findings in this report provide important perspectives from LHDs but may not be applicable to all 2,800 LHDs in the United States. Given the low response rate, the sample included in the analysis may not represent all the LHDs that indicated their organization conducted IP, VP, or both activities. All data were self-reported and were not independently verified.

Recommendations

Based on the results from this infrastructure and capacity assessment of LHD injury and violence prevention, NACCHO issues the following recommendations for federal, state, and local government:

- **Recommendation 1:** Increase local, state, and federal funding to develop and maintain local prevention strategies and infrastructure, including leadership, coalitions/partnerships, surveillance, communication, and evaluation, at all LHDs.
  - Increase funding and support to ensure all LHDs have a separate, designated injury and violence prevention division with dedicated staff; and
  - Provide additional federal funding for injury and violence prevention activities at the LHD.
- **Recommendation 2:** Support collaborative efforts among local, state, tribal, and federal public health agencies and community partners.
  - Increase multi-sectorial collaboration and partnerships between injury and violence prevention programs within local, state, and national governments and non-government organizations;
  - Increase collaborations between injury and violence prevention staff and decision-makers to ensure LHDs are able to contribute to new and existing policies and recommendations; and
  - Strengthen partnerships with local governmental and non-governmental agencies.
- **Recommendation 3:** Integrate the public health approach to injury and violence prevention perspective in other public health efforts.
  - Encourage collaboration with other public health efforts (e.g., maternal and child health, chronic disease prevention, infectious disease prevention, and health promotion); and
  - Increase awareness of the public health approach to injury and violence prevention among LHD programs and partners.
- **Recommendation 4:** Develop and implement evidence-based practices and innovative, promising, or model practices.
  - Improve capacity to conduct program evaluation;
  - Increase access to evaluation professionals; and
  - Increase use of best practices for implementation,

including fidelity monitoring, outcome evaluation, facilitative administration, and system change.

- **Recommendation 5:** Ensure ongoing training and support to increase capacity of all LHDs to identify health disparities, address health inequities, monitor local data and trends, and assess impact of local prevention efforts.
    - Increase LHD injury and violence prevention staff access to and receipt of technical support and assistance to implement programs, evaluate program success, conduct community assessments, develop strategic plans using evidence-based decision-making, and inform advocacy efforts and policy changes;
    - Identify new resources to support technical assistance and training, such as foundations or associations, academic institutions, and federal government;
    - Increase federal and state technical assistance and training to all injury and violence prevention staff;
    - Support LHD efforts to analyze current data, collect new data, and identify appropriate secondary data sources in order to implement programs and evaluate outcomes; and
    - Increase the use of surveillance data, especially for policymaking, program evaluation, strategic planning, grant writing, and priority setting.

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Related Resources from NACCHO

2010 National Profile of Local Health Departments
http://www.naccho.org/topics/infrastructure/profile/resources/2010report/

Injury and Violence Prevention at NACCHO
http://www.naccho.org/topics/hpdp/injuryprevention/

Injury and Violence Prevention Policy Statements
http://naccho.org/topics/hpdp/injuryprevention/policy/

Local Injury and Violence Prevention Capacity Assessment Tool
http://www.naccho.org/toolbox/tool.cfm?id=3031

Local Health Department Budget Cuts and Job Losses Research
http://www.naccho.org/topics/infrastructure/lhdbudget/

Local Health Department Injury and Violence Prevention Infrastructure and Activities
http://eweb.naccho.org/prd/?na221pdf

Standards and Indicators for Local Health Department Injury and Violence Prevention Programs
http://naccho.org/topics/hpdp/injuryprevention/resources/standards.cfm

Making the Case for Local Injury and Violence Prevention
http://eweb.naccho.org/prd/?na505PDF

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