IPRC

The University of North Carolina
Injury Prevention Research Center

NEWS

Focus on Terrorism and Emergency Response

Fall 2002

Vol. 11, No. 3

Inside

Injury Prevention Efforts Halted by War

Last fall, Janet Dal Santo, Wanda Hunter, and Carol Runyan of the UNC Injury Prevention Research Center (IPRC) were holding first discussions with health personnel in West Bank and Gaza to plan a new initiative to address the problem of childhood injuries in the two Palestinian regions. As of this fall, this initiative is on hold due to suicide bombings and military actions that have increased the magnitude and seriousness of injuries to children and adults alike.

The childhood injury prevention initiative was conceived as part of the Improved Village and Community Health Services Project for Gaza/West Bank, also called the MARAM Project, a collaborative effort planned by UNC IPRC and INTRAH, the international health improvement program based in the UNC School of Medicine. The project is being funded by a grant from the United States Agency for International Development (USAID) to PriceWaterhouseCoopers, the principal contractor, with a subcontract to INTRAH.

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Focus on Methodology:

The NC Emergency Department Database Project

US emergency departments (EDs) cared for 108 million patients in 2000 with 40 million of those visits resulting from injury (McCraig, 2002). Thus, the 4,800 hospital EDs in the US are potentially an excellent a source of injury surveillance data. However, variations in how data are collected and entered in different ED record systems impede the use of the data for injury research, prevention, and evaluation. The National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention (CDC) coordinated an initiative to foster more uniform emergency care data via a public-private partnership made up of six professional associations and three government agencies. From that partnership came a set of recommendations for the collection and recording of ED data that can be combined for analyses and comparison at local, state, and national levels. The partnership's recommendations have been released as *Data Elements for Emergency Department Systems Release 1.0 (DEEDS)*. The DEEDS document, available since 1997, is the basis of two demonstration projects funded by the CDC, one of them at the University of North Carolina at Chapel Hill, and the other at the Oregon

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From the Director

Beyond the "Bio" of Bioterrorism

UNC IPRC Director
Carol Runyan, MPH, PhD

Considerable attention and large sums of money have recently been targeted to addressing bioterrorism. A new Federal agency will address homeland security, consolidating other units with related expertise and authority. Needless to say, the nation and our leaders are concerned about the new threats that have surfaced in the past year. Intelligence sources point to the potential threat of terrorists unleashing biological and chemical agents with potentially grave impact, for example resulting from the introduction of smallpox in an urban area. As public health professionals, we are committed to prevention and therefore must be vigilant in understanding, anticipating, and preventing these potential risks by taking a range of precautionary steps.

An epidemiological examination of the problem suggests that the emphasis needs to be broader than bioterrorism. The terrorist attack on September 11, 2001 resulted in approximately 3000 fatalities –almost all from injury. Likewise, other more recent terrorist attacks in other parts of the world (e.g., Israel, Pakistan, India, Tunisia) have resulted in scores of deaths from traumatic injury. Repeatedly, we have seen on the evening news the trauma that can be wrought; yet injury control has received few invitations to the terrorism-prevention table. Federal and congressional attention to the injury aspect of terrorism has been very limited.

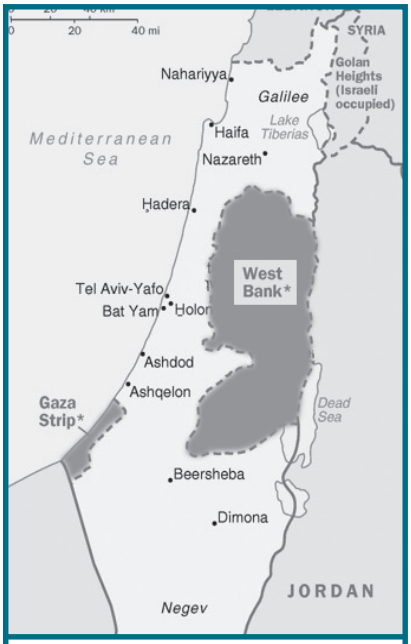
Development of sound surveillance methods, as demonstrated in the type of work Dr. Waller is pursuing in North Carolina (see page 1), is an important advance. This work, long overdue, builds on early work led by UNC IPRC in delineating approaches to emergency department surveillance. Likewise the development of new technologies now makes it possible for experts in one part of the world to assist their counterparts across the ocean in emergency response efforts, as demonstrated in the collaboration now taking place between UNC and professionals on the ground in West Bank and Gaza (also on page 1). Current efforts and experiences will enhance our preparedness to recognize and address any type of acute terrorist event – whether an anthrax infection, release of a toxic gas, or a bomb blast. However, surveillance and enhancement of acute care services form just part of the picture. We must also be working to prevent terrorist attacks, through collaboration on the social and political fronts, and we should be addressing ways to make potential terrorist targets less desirable as targets and safer if attacks do occur. As with any injury problem, there are roles for many types of professionals and organizations including those who design and construct buildings to be strong and provide good egress; those who train the public, and law enforcement, to recognize and apprehend potential terrorists; and those who work with victims to heal the physical and psychological scars that are the direct or indirect result of a terrorist event.

Not an "either/or" situation, attention must be devoted to preparing for a range of potential terrorist actions. In fact, the application of injury control principles to other topics would strengthen the public health response by pointing toward a range of interventions to prevent terrorist events (primary prevention), reduce the damage in an event (secondary prevention), and restore physical and psychological functioning of individuals and communities when an event occurs (tertiary prevention). The efforts made to address injury as an outcome of terrorism will have benefit for other forms of terrorism as well.

This Center is committed to working with colleagues addressing other aspects of preparedness so as to prevent and ensure readiness for whatever public disasters may ensue. I hope we will never have to apply these measures to terrorism. Yet we know that disasters, be they natural or man-made, are a part of human existence, so we need to work together, quickly and efficiently, so that we'll be better prepared to prevent or to face whatever comes our way.

From MARAM, page 1

MARAM, which means "ideal goal" in Arabic, was conceived in response to a Ministry of Health Report that indicated that West Bank and Gaza had the highest maternal mortality rates in the region and that injury is the leading cause of death among children in the area. The goal of the project is improved health for Palestinian families.



Map showing the locations of the West Bank and the Gaza Strip. Locations have been altered in color for emphasis.

(From: The CIA World Factbook: Web 2001 Edition).

While INTRAH developed plans to address reproductive health problems, Dal Santo, Hunter, and Runyan began developing plans to collect needs and assets data on childhood injuries in West Bank and Gaza in order to better understand both the problems and existing local infrastructure available to address the problems. The ultimate goal is to work with colleagues in the region to develop a national plan for childhood injury control in West Bank and Gaza and to recommend steps for improving the capabilities of the infrastructure to implement and evaluate the plan.

The team still hopes to conduct the needs assessment and work on the national plan but has had to defer their activities due to the conflict in the region. As a result, the immediate focus has shifted to helping local health providers organize trauma care services as hospitals have lost access to power and water and as military roadblocks have gone up around the region causing delays in getting injured persons to the hospitals for emergency treatment. Some patients, including women en route to the hospital for normal deliveries, have experienced complications, including death, due to road closures or long delays at checkpoints for ambulances. Doctors in West Bank and Gaza who are collaborating with MARAM have been forced to assist in some deliveries over the phone, coaching husbands and family members through the birthing process. Emergency obstetric care is being provided to address the lack of access to hospitals and medical equipment. Aid for civilians is being offered via a temporary office in Jerusalem opened by MARAM to provide this help.

Many more projects are being planned. A medical hotline is being set up for use by the public in the case of an emergency, permitting specialists to walk callers through first aid treatment for medical emergencies, including child birth, injury, or poison ingestion. Emergency medical protocols for use by these hotlines were shared with officials from the West Bank and Gaza Ministry of Health by the Department of Emergency Medicine at the UNC School of Medicine.

Officials from the Ministry of Health from West Bank and Gaza are planning for a visit to UNC in October. While in Chapel Hill, these officials will meet with Injury Prevention Team members of the MARAM project, including staff from IPRC, to make necessary modifications in plans in hopes that the conflicts will subside and injury prevention planning will resume.

Because travel to the region still may be difficult, the IPRC team is planning distance learning initiatives to train officials in the West Bank and Gaza in injury prevention strategies, walking them step by step through an injury prevention model, that can be applied by local professionals.

For more information about the MARAM projects, see http://www.intrah.org/MARAM.html.

Do you have a question on an injury topic?

UNC IPRC provides technical assistance at no charge on many injury prevention topics, including requests for data and data sources. If we don't have the answer, we will try to forward your questions to those who do.

Just visit our website: http://www.sph.unc.edu/iprc/aboutinjury/request.html. Once there you can send an email detailing your request.

IPRC NEWS

IPRC News is a free publication of the University of North Carolina Injury Prevention Research Center. The mission of the Center is to build the field of injury prevention and control through a combination of interdisciplinary scholarly approaches to research, intervention, and evaluation as well as through the training of the next generation of researchers and practitioners.

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From NCEDD, page 1

Health Sciences University through the Oregon Health Department. The principal investigator for the North Carolina Emergency Department Database (NCEDD) Project is Dr. Anna Waller, long time faculty member with IPRC and Research Assistant Professor in the Department of Emergency Medicine at the UNC School of Medicine. Three North Carolina hospitals have been involved in the NC demonstration project: UNC Hospitals, New Hanover Regional Medical Center, and Cape Fear Hospital. The latter two are in the New Hanover Health Network.

The NCEDD Project was initiated to pilot the DEEDS system, and to make recommendations for changes, if any, for the next implementation of DEEDS. The objectives of the NCEDD pilot project are:

1. To adopt ED data standards (DEEDS) in North Carolina,

2. To demonstrate that ED data can be captured electronically at the local hospital level, securely transmitted to a central data repository, translated to a standard format (DEEDS) for aggregation, and securely accessed via the Internet,

3. To explore the potential for data linkage between NCEDD and other state data repositories (e.g., prehospital databases, Regional Advisory Committees, trauma registries), and

4. To assess the potential for near-real-time electronic collection of ED data.

Though EDs have the potential to provide data useful for injury surveillance, there are three challenges that exist in the current methods of collection, management, and dissemination of ED data that limit its use. First, not all of the information that ED physicians enter into the patient record is captured electronically. As a result, clinical information critical to understanding the injury is often not included and therefore not disseminated. Second, the data are not collected in a standard format. Typically, each hospital has its own codes for variables, making it impossible to aggregate the data without translation. For example, while one ED records male as "0" and female as "1," another records male as "M" and female as "F." The third challenge is that often the data that are collected and disseminated are billing data. These data are usually collected and made available only on an annual basis; thus there is a time delay of one to two years before the data can be used for research or intervention. In addition, most ED billing data contain information limited to a few elements that describe the diagnosis and patient characteristics. The NCEDD Project has provided a useful technical solution to these problems.

How does the solution work? First, an electronic ED data file is automatically created by the hospital information system, including the NCEDD data elements. The types of information collected include patient identifiers/ demographics, facility and practitioner information, arrival information, disposition information, and ICD-9-CM codes for diagnoses, procedures and external cause of injury. These data are more comprehensive than billing data. Following an automated schedule, the hospital's ED data file is put in a specific location on a hospital computer where it is then transferred by

secure ftp-transmission to the NCEDD central server at the State Center for Health Statistics (SCHS). Hospital data are then automatically translated to the NCEDD/DEEDS standard and loaded into the NCEDD central database via data integration software. The translation programming is derived from a detailed data dictionary developed by the hospital's IT staff and the NCEDD project team. This secure transmission can be done on a monthly, weekly, daily or even an hourly basis. NCEDD has demonstrated that the DEEDS format can be applied to data from distinctly different hospital databases and can provide aggregate data in a timely and efficient manner.

Dr. Anna Waller, Principal Investigator for NCEDD.

When fully implemented, this system will successfully circumvent the three challenges described earlier; however, there are also policy and procedural limitations that are related to concerns for the protection of patient privacy. Because of these concerns, the data currently collected have no identifiers. Though record identifiers can be used that will not identify the patient, and there are no legal prohibitions to sharing the data, hospital legal counsel, privacy and security officers and IRB members are concerned that patient identity might be inferred from other information given. Yet with no way to identify the record, data that are not clearly understandable or that seem inconsistent cannot be clarified. Further, the accuracy of the data transmitted cannot be checked by referring back to the original record. Another limitation is that multiple visits by the same patient are indistinguishable from visits by other patients. These factors restrict our ability to use the records for a completely accurate depiction of the events surrounding an injury and its treatment. It is anticipated, however, that legislation under consideration in NC will soon allow the collection of patient identifying data under the direction of the State Health Director. Access to identified ED data will continue to be extremely limited.

Throughout the pilot project, which is now winding up, Dr. Waller and colleagues have been submitting recommendations for improving the DEEDS document to the CDC on an on-going basis. Just as NCEDD has been a collaborative effort, the development of *DEEDS, Release 1.0*, was also a group effort. Dr. Waller participated in the development of the original DEEDS document, as did Dr. Herbert Garrison, IPRC Core Faculty member and professor of emergency medicine at East Carolina University.

Dr. Garrison played a major role as one of the twenty-two members of the DEEDS writing committee, drawing on ideas generated in a UNC IPRC-sponsored symposium that resulted in a frequently-cited paper dealing with the development and use of ED data for injury (Garrison et al., 1994). This paper proposed a national strategy for using such data that has been used in the development of practices to generate more uniform ED data in North Carolina.

The demonstration phase of the project is almost completed and the NCEDD is poised for rapid expansion in the coming year. The technical solution that has been developed will be implemented at 15 – 20 EDs in NC, based on their size and location. Funding to support this expansion is pending from the Office of Public Health Preparedness and Response in the Bioterrorism Branch of the Epidemiology Section of the Division of Public Health in the Department of Health and Human Services. According to Waller, when NCEDD becomes a statewide ED database, it will allow more complete population-based surveillance than the existing trauma registry or motor vehicle crash files because it will include information on all ED visits, not a subset based on cause of injury or diagnosis. Additionally, linking ED data to EMS and trauma registry data will allow monitoring of injury outcomes from the pre-hospital phase, through the ED stay, up to hospital discharge. The ultimate goal is the utilization of the North Carolina Emergency Department Database by all of North Carolina's approximately 120 hospital-based EDs. Implementing this system statewide will be a challenge, but one worth the effort in the potential benefits gained.

See NCEDD, page 9 for references

The IPRC Spotlight On… **Richard J. Smith, III**

Richard J. Smith, III

Bringing people together to solve problems important to injury control and public health has been the mission of UNC IPRC's External Advisory Committee member, Richard J. Smith, for more than thirty years. As chief of the Injury and Emergency Medical Services (IEMS) Branch of the Maternal and Child Health Bureau (MCHB), he believes that his role, and that of other persons and agencies in the federal government, is to bring multiple partners together to improve systems of health care. This branch of the MCHB is a little more than two years old and Smith is its first chief. He describes taking this position as a means of getting "back into injury control" after briefly working as Deputy Director of the Office of Public Health for the Indian Health Service. As Deputy Director, his responsibilities were related to general public health concerns, and he preferred to maintain a focus on injury control. He surmises that it was his broad-based experience in the injury field that made him a perfect choice for his current position. He has worked in injury control at the community, regional, state, and national levels and has, in his own words, "grown with the field."

Smith's recent move back into injury control has led him to new challenges. After serving as the IEMS branch chief for two years, he was designated to lead the development of the Bioterrorism Hospital Preparedness Program (BHPP). Smith thinks that this program, initiated because of the events of 9/11, became part of the IEMS Branch because IEMS has programs that operate in all 50 states and associated territories and these programs have connections with key partners involved with health departments, hospitals and EMS organizations, at both the state and local levels, connections necessary for the rapid response desired to prepare agencies in each state. Smith and his new BHPP team have utilized this infrastructure to distribute the $125 million appropriated. Twenty percent of the funds were distributed in February to states that had developed preliminary plans for preparedness. The other 80% of the funds were distributed beginning in May for assessments and implementation, a notably rapid response for distribution, especially when one considers the program was nonexistent before the end of September, 2001.

Though this program is focused on bioterrorism, Smith sees an opportunity and a need for the injury control field to be involved in this effort. At the state level, injury professionals need to make state officials aware of their particular knowledge, skills, abilities, and strengths that they can bring to the issue of preparedness. For example, some states may be proposing to initiate surveillance systems to collect information about injuries related to bioterrorist attack, including chemical, radiological, and nuclear. In many states injury epidemiologists have already developed surveillance systems that capture major trauma events that could be adapted to collect additional information and used to assess bioterrorism preparedness. Collaboration between injury control and bioterrorism professionals could prevent creation of duplicative systems and result in a more efficient use of resources. Though the challenge Smith faces in building the bioterrorism program is somewhat different from his responsibilities and experiences in his earlier work, he is guided by a clear identification of the role of public health to improve systems of health care, in this case, the preparedness of hospitals and related entities, including EMS, to respond to a bioterrorist attack. This work draws well on his prior experiences in leading the Indian Health Service's injury control efforts for twenty years.

In 1970, he began to work with the Indian Health Service (IHS) and remained for the next 30 years. Smith began his work on injury prevention in a small Eskimo village just north of the Arctic Circle. There he worked on problems typical of the community: sled dog bites, frostbite injuries, and drownings. Originally set for two years, he stayed three, and then moved to another village about 500 miles west of Anchorage. Finding the work rewarding, and the career opportunities good, he continued his work in the U.S. Public Health Service Commissioned Corps. Among other accomplishments at the IHS, Smith designed and developed a community-based injury prevention training program – the first and still the most comprehensive program of its kind in the country. Smith considers this to be the most notable of his achievements. To him, the key to effective training is being able to "recognize the process by which we can train people to both understand the magnitude of injury and to improve their ability to effect change." He urges that injury prevention education not be just an exercise, or theory, but a practical and effective tool for developing a cadre of professionals who take action to reduce

injury. In this sense, his training program is one of the most effective ways he has "convened partners" to improve the health and lives of American Indians and Alaska Natives.

Development of the program has been methodical and patient. In 1987, the first course, "Introduction to Injury as a Public Health Problem" was taught. Evaluation for the course consisted of one question posed to the students. The question was, "What should the next course be?" Based on the collective evaluations a surveillance course was developed and offered, and the evaluation focus was again, "What should the next course be?" The third course to be developed went beyond introductory material and beyond the development of individual skill to the process of creating effective partnerships. The course was related to the question: "How do you engage partners to effect change?" Through this method of collaborative learning, the basics for developing leaders, increasing skills, creating partnerships, developing leaders, and finding funding have all become foundations for course development.

Today, this injury program has expanded to include five different types of courses ranging from mini-courses, which last three hours to a fellowship which lasts a year. Though the audience is varied, the intent of the program as a whole is to train individuals who will put their knowledge into immediate use in their communities (Smith, et al., 2000). Smith stresses the importance of asking (and answering) critical evaluation questions. Transferring education to practice is the only way to answer those questions and to test the training program. Successful injury control programs and activities that have been undertaken by program graduates provide the evidence that this training program has been successful. Smith states that his legacy, if he were to have one, would be the "cohort of dedicated folks [it took] to build an injury prevention training program – the best [program] there is."

Originally from Mobile, Alabama, Smith attended graduate school at West Virginia University. He has an MS degree in Environmental Engineering and has lived and worked in Alaska, Nevada, Arizona, and finally, Rockville, Maryland. Smith joined the UNC IPRC External Advisory Committee in 1998 building on his prior collaboration with the Center. He plays a special role in helping to advise the Center on its activities that are directed at translating research into practice.

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The Injury and Emergency Medical Services Branch

The Injury and Emergency Medical Services Branch is part of the Division of Child, Adolescent, and Family Health. The branch has six programs that promote injury control through training, technical assistance, and financial support.

The **Injury and Violence Prevention Program** supports child and adolescent injury prevention. This program supports the Children's Safety Network (CSN). For more information about CSN, visit: http://www.childrenssafetynetwork.org/

The **Poison Control Centers Program** has the goal of creating a high quality national system of poison control centers.

The **Emergency Medical Services for Children** was created to reduce child disability and death due to injuries. Funding for programs and services is nationwide. Each state has the responsibility for developing its own program. For more information about EMSC, visit their website at http://www.ems-c.org/

The **Traumatic Brain Injury (TBI) State Demonstration Grant Program.** This program was created to improve services to persons with traumatic brain injury.

The **Trauma/EMS Systems Program** was created to facilitate the development of comprehensive trauma care delivery systems in all states and territories.

The **Bioterrorism and Hospital Preparedness Program** was developed in 2001 to make sure hospital emergency departments are prepared to respond to bioterrorist attack.

For additional information about the IEHS branch, visit: http://ftp.hrsa.gov//mchb/factsheets/dcafh.pdf

World Trade Center Injuries: Reflections of a Burn Specialist

Everyone knows about the disaster that occurred on September 11, 2001 at the World Trade Center (WTC) and of the subsequent recovery efforts. Mr. Ernest Grant, Nursing Education Clinician for Burn Outreach from the North Carolina Jaycee Burn Center, was there. The call for help came from the American Burn Association through their regional offices to burn centers and to their staffs. The Association's efforts were to recruit burn nurses throughout the country to serve two-week shifts, 15 nurses per shift. After the announcement of the need by Dr. Michael Peck, burn center director and IPRC advisory committee member, Grant and two other colleagues accepted the call.

Just four weeks after the blast, Grant arrived in New York and initiated preparation for work. This included a crash course on how to work in the environment of the Cornell Presbyterian Hospital Burn Center where all burn victims from the WTC were treated. Just before his first shift, he took part in what had become a ritual for clinicians: a trip to Ground Zero, just five miles away. As he arrived at the site, he noticed that dust covered everything and fires were still burning. The din created by the huge machines moving wreckage was incredibly distracting. Suddenly, a body was uncovered and another ritual began. Everyone ceased what they were doing and the machinery stopped while, in silence, the body was removed from the area. The complete silence was "eerie," as Grant put it, as was the entire scene. Surrounding buildings were draped in red and orange netting showing different levels of salvageability. Some buildings were completely demolished and others appeared untouched, yet were condemned.

Was he prepared for this situation? With clinical expertise, yes. Emotionally, no. The clinical needs and response were both adequate and familiar, but the emotional response that Grant encountered was unlike anything he had ever experienced. He explained, "In hurricanes, floods, and other natural disasters, people experience injury, death, and other kinds of loss. There is certainly a response of grief and stress, but they more or less know what to expect in the aftermath, because others have experienced these things before." The events of September 11th left people –especially New Yorkers— with intense feelings of grief and loss, but in addition they felt frightened and vulnerable because they did not know if the attacks were over or if they would continue to witness and experience more horror. To compound that feeling, the anthrax letters began to appear during his stay. The arrival of letters containing anthrax at CBS and NBC had a significant effect, as he had traveled to that part of town the evening before the letters arrived. The threat of contamination and infection added to the uncertainty and the tension of the situation. One of the bigger battles, it would seem, was to combat the emotional response to the emergency.

Asked how his experiences might inform future injury control efforts, Grant's response focused on ameliorating the effects following injury. He emphasized that following 9/11 people should understand that something like this can happen at any time and that we as a nation need a better system of disaster preparedness. For example, during the time he was at Ground Zero, he observed many clinicians at the scene, many of them just waiting. By this time, a month after the tragedy, there were few survivors to be rescued. In retrospect, he feels resources might have been better utilized if those clinicians had been relocated to work in the hospitals during this time. In addition, there was some concern that local hospitals would not be able to maintain sufficient supplies of special items. Luckily, companies anticipated the increased need for supplies and automatically shipped them in. One manufacturer shipped two truckloads of a special skin covering that is used on burn patients in preparation for the surgical application of skin grafts. Another reason that the demand for materials did not overcome the supply was that the actual number of burned patients was relatively small. Only 25 persons required hospitalization for burns.

Ernest Grant, RN, MSN

Due to the small number of burned patients, the outpouring of support, and the anticipation of needs that characterized the aftermath of 9/11 in NYC, the Cornell Burn Center was able to adequately meet the needs of these patients. Yet it caused Grant to reflect on what "might have been." He feels strongly that hospitals need to develop special contingency plans in preparation for potential future disasters that involve large numbers of injured patients.

Grant's comments on injury prevention

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measures come from experience. Deeply committed to injury prevention, Grant has worked on several IPRC-sponsored projects, including "Remembering When," a program to prevent falls and injuries from fire in older adults; "Learn Not to Burn;" and a fireworks injury prevention project. Currently he is working with Dr. Mike Bowling, IPRC investigator, on "Get Alarmed," a state-based house fire prevention program. As Burn Outreach coordinator, Grant travels across the state and the nation providing training to firefighters, emergency medical staff, nurses, and other health care providers. In recognition of his efforts and dedication to burn care and prevention, he was given two national awards: Nursing Spectrum's 2002 Nurse of the Year Award and the American Nursing Association Honorary Nursing Practice Award.

Injury Seminar Series

IPRC's Fall Injury Seminar Series began with Dr. Kevin Guskiewicz's presentation entitled: "T*he NFL: A Life of Hard Knocks? A Look at the General Health of Retired Football Players*" on September 25. Dr. Guskiewicz's presentation was related to his studies involving the injury histories of retired NFL players. A summary of this presentation is available on the IPRC Website at http://www.sph.unc.edu/iprc/resources/resources.html.

The series will continue through the academic year, with one injury seminar each month. The public is invited to all seminars. Please continue to monitor the IPRC website for details about the time and location of future seminars.

Donaghue Awarded Paper Prize

Suzanne Donoghue, MPH

This year's recipient of the Susan P. Baker Student Research Paper Award is Suzanne E. Donoghue for her submission, "Domestic Violence in North Carolina: Ecological Factors Associated with Domestic Violence Protective Order Filing and Case Decisions." In recognition of this achievement, the UNC Injury Prevention Research Center (IPRC) will present Ms. Donoghue with a plaque and a monetary prize during the second of the fall injury seminar series, on October 29.

The award, named in honor of Professor Susan P. Baker, a pioneer in the field of injury control and founding director of the Johns Hopkins Center for Injury Research and Policy, recognizes outstanding injury research by any undergraduate, graduate, or professional student enrolled during the past academic year in a degree-granting program in the state of NC. Papers submitted for the award competition are distributed to a panel of injury experts who rate each submission on clarity of purpose, scientific merit, and significance to the field. This year, six papers were submitted addressing topics related to occupational injury, sports injury, and intimate partner violence.

Ms. Donoghue's paper — her thesis for the Master of Public Health degree in Health Behavior and Health Education — described county-specific rates of domestic violence protective order (DVPO) filing, in NC; rates of DVPO denial, including involuntary dismissal, in NC; and how rates of DVPO filing and denial vary by county characteristics including the presence of a domestic violence agency in the county. Her findings suggested that battered women who have access to a domestic violence provider are more likely to file for a DVPO, and to have the order granted. Much of her data was obtained from the "North Carolina Domestic Violence Needs Assessment Survey," created by the Violence Working Group of IPRC.

Having completed her Master's program at UNC, Ms. Donoghue is currently working at the Research Triangle Institute in the Tobacco Use Research Program.

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About the UNC Injury Prevention Research Center…

Founded in 1987, the University of North Carolina Injury Prevention Research Center is one of 11 "Centers of Excellence" funded by the National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Our mission is to build the field of injury prevention and control through a combination of interdisciplincary scholarly approaches to research, intervention, and evaluation as well as through the training of the next generation of researchers and practitioners. IPRC operates as a "center without walls" facilitating injury collaboration and research on our own campus as well as with researchers and practioners throughout the US, and increasingly throughout the world.

IPRC Biostatistics Core Hires First Manager

Dave Perkis, MA

Dave Perkis, manager for the Biostatistics Core Unit, comes to IPRC to guide the development of that Unit by organizing and marketing its services, and managing the expertise of students and faculty in the delivery of those services. He is responsible for managing data collected by the Center faculty and students. Another part of his work is to guide IPRC-affiliated faculty and students in the use of secondary data, thus maximizing the use of such data to fulfill the Center's research agenda. Perkis will also provide leadership in identifying needs and organizing opportunities to train students and faculty in new methods of research and analysis pertinent to the mission of the Center.

Perkis is well prepared for this challenge. He has a BSE (bachelor of science in engineering) from the University of Pennsylvania and a master of arts in economics from the University of Cincinnati. He has worked as a chemical engineer within research and development at Procter & Gamble in Cincinnati, Ohio, and as a data analyst at the Institute for Health Policy and Health Services Research at the University of Cincinnati. During his career in research, he has produced a US Patent, as well as published several academic publications. This combined managerial and scientific experience enables him to assist biostatisticians and programmers in the delivery of methodological, statistical and computer support services as well as to provide valuable expertise in shepherding the research of the Center.

Previous accomplishments by Perkis:

US Patent No. 5648328. Process for producing a particulate laundry additive composition for perfume delivery.

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Upcoming Events

October 9-11
STIPDA 2002 Annual Meeting
Madison Hotel, Washington, DC
(770)-690-9000
email: STIPDA@mindspring.com
www.STIPDA.org

November 6-8
18th Western Regional Symposium on Child Abuse & Sexual Assault
SCAR/Jasper Mountain, Eugene, OR
(541)-747-1235
email: susiej@scar-jaspermtn.org
www.scar-jaspermtn.org

November 8-9
5th Annual National Survivors of Violence Conference: "From Pain to Power and Anger to Action: A United Voice for Prevention"
The Harvard School of Public Health
Boston, MA
(617)-495-7777
www.hsph.harvard.edu/php/

November 9-13
APHA's 130th Annual Meeting
American Public Health Association
Philadelphia, PA
(202)-777-2479
email: lynn.schoen@apha.org
www.apha.org/meetings

November 14-15
Emergency Response and Preparedness Symposium
Marriott Shadows Resort and Golf Club, Scottsdale, AZ
(847)-699-2929
www.asse.org/sem_emergency02.htm

November 14-15
50th Annual Detroit Trauma Symposium
Detroit Marriott Renaissance Center
Detroit, MI
(313)-745-3138
email: tcrowe@dmc.org

November 16-17
23rd Annual Neurorehabilitation Conference on Traumatic Brain Injury and Stroke
Boston Marriott Cambridge, Boston, MA
(781)-348-2113
www.braintreehospital.org

November 21-22
Traveling Together: Navigating the System to Achieve Success after Brain Injury
Toronto Hilton, Toronto, Canada
(416)-597-3422 ext. 3961
email: conference@abinetwork.ca
www.abinetwork.ca/conference

December 9-11
5th Annual National Conference on Changing Roles of Law Enforcement in Ending Violence Against Women
National Training Center on Domestic & Sexual Violence, Austin, Texas
(512)-407-9020
www.ntcdsv.org

IPRC NEWS

Vol. 11, No. 3

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