GETAC IP Committee Workgroup Meeting January 17, 2014

Members Present: Shelli Stephens-Stidham, Scott Christopher, Jessica Laplant, Colin Crocker, Susan Burchfield, MaryAnn Contreras, Courtney Edwards, Wayne Dennis, Stewart Williams, Chaps Tucker (Empirical Care Group), Vickey Thompson (Baylor Health Care System)

1. The meeting was called to order by Shelli Stephens-Stidham at 0900. Introductions around the room. Thanks to Shelli for providing the meeting location
2. Discussion from the committee about developing recommendations for Texas hospital based injury prevention programs. These would be *recommendations* for Level 1-4 trauma centers as to what a hospital based IP program should look like.
    a. Stewart noted that most IP programs are based outside the hospital- not internal. The same is true for Safe States.
    b. What does an Injury Prevention job/program look like when based out of a hospital? The definition in the Green book is vague for what a program should look like. The program should address mechanisms of injury based on the hospital trauma registry according to the ACS. Levels 1-3 are required to have a coordinator. It is essential criteria for Levels one and two.
    c. The value of an IP program that is hospital based relies on the perception of the person evaluating the program
    d. Jessica noted that many hospitals have requirements for community outreach hours for their nursing staff. This can be a resource to the IP coordinator.
    e. The Spectrum of Prevention papers that the committee worked on last year were reviewed. There was discussion on the layer of "Organizational Changes" in the Spectrum were considered as an opportunity for internal IP optimization within the hospital setting
    f. The group agreed that an internal hospital IP program should be expanded and researched
    g. The Safe States Alliance core components of state public health and injury and violence prevention programs were reviewed
3. **Recommendations from the committee** for components in professional IP development:
    a. **Data-** Use data from the hospital trauma registry, CDC, state trauma registry, regional trauma registry or other valid source. Use data to determine priorities and focus areas. Provide a menu of locations of valid data sources and collaborate with partners to gather data—example: work with police department for violent crime data. How do we analyze data? Professional relationships and networking are tools to find and use data. This can include collaborating with partners such as engineering, city officials, etc… Trauma registrars could use specific training on data analysis. Also Schools of Public Health are good resources for analysis. Courtney Edwards will further define and outline this recommendation.
    b. **Collaboration-** Engaging partners for collaboration and IP development are vital for healthy IP efforts. What are tools to form and maintain successful partnerships? These partnerships also are an opportunity to access data. What are examples of data, social, organizational and legislative policy partners? How are these efforts nurtured and expanded? Susan Burchfield will further define and outline this recommendation.
    c. **Professional structure-** Development of formal channels for IP training will define the foundation of the injury prevention field. Growing proficient and specialized education for the study of injury prevention is essential to the often misunderstood profession.

Consideration by organized trauma groups such as Trauma Regional Advisory Councils, DSHS, universities and other institutions of higher education should be given to provide quality training and education for the IP professional. IP should be a part of overall wellness. Mary Ann Contreras will further define and outline this recommendation.

d. **Strategies for IP- should** be reviewed annually with specific quantifiable activities. The Spectrum of Prevention should be utilized with each strategy. Shelli Stephens-Stidham will further define and outline this recommendation.
e. **Evaluation-** A measurement tool of impact and value for IP efforts validates efforts. The evaluation process should be weaved through out each phase of any IP strategy. It can define needs and delineate specific targeted areas for injury prevention. Stewart Williams will further define and outline this recommendation.

4. Appendix- The committee agreed to develop an appendix that includes:
   a. A position statement defining an IP professional
   b. Core competencies
   c. Budget
   d. Definitions
   e. Suggestive timelines for focus groups
   f. Measuring progress
5. The next scheduled workgroup meeting will be May 2 in Corpus Christi
6. The meeting was adjourned at 12:00 noon