

November 2006

Evaluating the Impact of ESB Surveillance Activities for the Division of Violence Prevention

Final Report

Prepared for

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*RTI International is a trade name of Research Triangle Institute.

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Executive Summary

Available data show that child maltreatment (CM) and intimate partner violence (IPV) are significant public health problems in the United States, resulting in an array of detrimental consequences for individuals, families, and society. In light of the dire need for valid IPV and CM surveillance data, the Etiology and Surveillance Branch (ESB) of the Division of Violence Prevention at the Centers for Disease Control and Prevention funded state-based IPV and CM surveillance activities in nine states (two with CM only, four with IPV only, and three with both CM and IPV) and assessed the impact of the funded activities with the current contract to RTI International.

Accordingly, the purpose of this project was to (a) define and assess the impacts (positive and negative) of the funded surveillance activities on several levels in terms of issues such as violence prevention, legislation, policy, and costs; (b) assess the impact of funding on surveillance infrastructure within states; (c) utilize information to support the development of IPV and CM surveillance plans for the future and enhance surveillance in other injury areas; and (d) inform initiatives to garner support for surveillance activities at national and state levels.

To accomplish the objectives of this project, RTI staff met with the Technical Monitor to clarify the project scope and goals and to obtain relevant documents from Center for Disease Control and Prevention (CDC) staff. We used the information gathered during this meeting and from a review of grantee meeting notes, interviews with CDC staff, and various documents submitted by grantees to describe the purpose, process, and operation of funded IPV and CM surveillance activities. This information was systematically organized using data abstraction forms enabling synthesis of information to determine the focus

of the evaluation design and the definition of *impact* in collaboration with CDC staff. This definition was revised as a result of CDC feedback and, with consensus on the definition of impact, a structured interview protocol was developed for a state stakeholder interview. This interview was used to gather credible evidence about the impact of IPV and CM surveillance initiatives from state project staff's perspectives (Section 4). We compiled the information and analyzed state interview data to develop this final report.

Program Descriptions. Some distinctions among programs were apparent from a cursory review of program descriptions. Even with a common funding source, programs vary substantially in goals, methods, and products. CM surveillance programs are clearly described at an earlier developmental stage than IPV surveillance programs, and the CM programs are more focused on development and less on sustainability and dissemination than are the IPV programs. It is also clear that program products and impacts are inconsistently reported, underlining the need for this assessment.

Defining Impact. From conversations with the project officer and other staff in ESB, it was decided that there are multiple levels of outcomes for these programs. Of these levels, the focus of our work was desired system and prevention outcomes. We focused on these types of outcomes because programs were charged with assessing system attributes, and linkage between surveillance program activities and long-term health outcomes is not feasible within this task. Focusing on the domains of system and prevention outcomes, the following working definitions of impact were proposed: (a) at the system level, desired outcomes include production of useful findings, using sustainable methods, and collaborative efforts; and (b) at the prevention level, desired outcomes include the use of surveillance data to increase awareness and support improved programs and policies.

CDC Interviews. Interviews were conducted with three CDC staff members with knowledge and expertise in various areas related to surveillance activities at CDC: Acting Director of NCIPC, Associate Director for Science in the Division of Violence Prevention, and Public Health Analyst in the Office of the Director of NCIPC. These staff members were asked a series of questions about their perspectives on CDC's focus on IPV and CM surveillance activities, and they were asked to give feedback on the operating definition of *impact* and related examples of outcomes developed by RTI staff. Given their feedback, it was determined that the definitions of *system*

impacts and *prevention impacts* were acceptable, and as recommended, only minor revisions were made to examples.

State Interviews. Interviews were conducted with representatives from all nine states. The majority of state stakeholders had served on the surveillance project for the duration of the project. Respondents included project managers, co-investigators, epidemiologists, and project directors. Responsibilities on the surveillance project for respondents included activities such as management of the entire project in terms of fiscal and programmatic oversight to specific epidemiological work.

Coded data were analyzed to develop themes across interviews. These themes fell into four described categories: prevention and system impacts, factors affecting implementation and sustainability of surveillance systems, efforts to ensure sustainability of systems, and guidance to other states attempting to implement systems.

The most commonly reported themes from each of these categories are presented below.

Prevention and system impacts

- **Heightened awareness of violence:** The existence and dissemination of data increases both the government's and the public's awareness of problems.
- **Demonstrated need for resources:** Data have been used to justify funding for continued or expanded surveillance activities.
- **Improvement of prevention programs:** Within state government, use of surveillance data has led to examination of the relationship of IPV and CM with other injury areas and related issues, such as substance abuse.
- **Informed policy and legislation:** Surveillance data have been used to support changes in law enforcement and prevention policy. Legislative changes supported by surveillance data include the domestic violence fatality bill and legislation for preventing shaken baby syndrome.
- **Collaboration:** All systems reported building new collaborations or enhancing old ones. Most frequently mentioned were state and local Violence against Women coalitions, hospital associations, and law enforcement.
- **Improved quality of surveillance data input and output:** Validity of data used by surveillance has been improved by collection of more detailed survey data and better data coding. Data produced by surveillance are an

improvement either because no data were available previously or because surveillance systems have improved data quality.

- **Dissemination of data:** Data have been distributed for use by others, including legislators, state ways & means committees, university researchers, state and local domestic violence coalitions, health care providers, state councils on CM, the National Child Abuse Reporting System (NCANDS), and local child welfare agencies.
- **Reports:** All programs provided some type of reports for dissemination of data. These included reports to CDC, state agencies, and other local, regional, and state stakeholders.
- **Web sites:** Eight programs reported posting data or reports on Web sites, with as many as 3,000 page views recorded.
- **Presentations:** Seven programs reported specific data on presentations, including 24 presentations at national or international conferences, 15 presentations at regional or state conferences, and 17 at local conferences.

Factors affecting implementation and sustainability

- **Data Access:** Six programs noted that data access issues were primarily focused on internal/external capacity and confidentiality/human subjects issues.
- **Data Quality:** Five respondents noted issues regarding the accuracy of some surveillance information (i.e., incomplete capture because of issues with coding, variations in how cases are identified, and a general lack of capacity within agencies to capture the data).
- **Relationship/conflicts:** Five respondents indicated that conflicts related to turf issues (e.g., the domestic violence community, Advisory Board members), issues related to funding streams (particularly with the domestic violence community, noted by 2 IPV respondents), and approaches to identifying cases often proved challenging to system implementation and sustainability.
- **Organizational support:** Five respondents noted organizational support as a key factor in system implementation and sustainability. This was described in terms of both external agencies' capacity and the respondent's internal agency's capacity.

Efforts to Ensure Sustainability

- **Link to other surveillance and violence prevention efforts/ continuation of current surveillance activities:** For the majority of IPV respondents, the Behavioral Risk Factor Surveillance System (BRFSS) and the National Violent Death Reporting System (NVDRS) were the surveillance activities that respondents most commonly anticipated using in future surveillance efforts. CM respondents more frequently noted child death review teams as a source for data and one that will be continued for CM surveillance.
- **Produce data that demonstrates value of system:** Six respondents noted the importance of analyzing existing survey data, developing manuscripts, and finding unique methods of disseminating findings and demonstrating the utility of data.
- **Linked to/secured other funding sources:** Five respondents noted the importance of tying the larger CM/IPV surveillance efforts into these types of previously established data sources. The preexisting mechanisms have organizational support and enable the newer surveillance efforts to have greater sustainability.

Guidance for other surveillance systems

- **Develop effective partnerships:** Collaborate with service providers and those who control needed data by building understanding of the benefits of surveillance to partners.
- **Disseminate data to demonstrate its usefulness:** Work with reporting partners and advocates to make sure that data are in a useful format and will be understood.
- **Expand types of data used:** Multiple data sources are essential to identify cases.
- **Educate data providers to maintain data access and quality:** Personnel providing data need training on coding of CM/IPV-associated injuries and deaths, and it is important to communicate with data providers about how HIPAA and Institutional Review Board issues can facilitate data access.
- **Recognize cost of systems/build appropriate funding base:** If additional Federal funding should become available, State representatives noted that the funding should be prioritized to states that have created systems to ensure sustainability, rather than fund new systems.

Discussion and Conclusion

Overall, states were able to demonstrate impacts at both prevention and system levels. States showed productivity in disseminating data through a variety of mechanisms, as well as in increasing awareness of violence, advocating for funding, improving prevention programming, and informing policy and legislation. A few states made strides in setting up surveillance structures that are on track for some level of institutionalization within their state. Critical components of this ability included building and enhancing collaboration, making improvements to the quality of data entered and produced by the system, and—perhaps most important—widely disseminating data with utility for various stakeholders.

Some states clearly indicated that their surveillance efforts would be discontinued at the end of CDC funding. Respondents for these states noted that a lack of organizational support and various leadership changes prevented stability of system resources. These two factors were mentioned by most states as important determinants of surveillance system impacts and sustainability.

We gleaned general recommendations from state feedback regarding surveillance activities:

- There is need and desire from states for guidance on criteria for successful surveillance systems.
- Several states noted that they are at the cusp of ensuring sustainability of their systems. It is important that states are able to secure internal fiscal buy-in and continue to leverage outside resources for continued surveillance sustainability.
- It appears critical for those working with surveillance systems to be fully aware of and in a position to build collaborations with IPV/CM stakeholders in their states and to utilize existing surveillance data sources.
- It is important to ensure that there are venues for states to learn from one another. States are in the most appropriate position to provide feedback on best practices in surveillance efforts and to ensure that recommendations made regarding surveillance efforts are feasible and practical.

As a part of deliverables for this study, the findings have been disseminated through presentations at two national conferences. A manuscript has also been developed and will be

submitted to a peer reviewed journal upon receipt of CDC Clearances. These deliverables have and will allow for continued dissemination of the important information gathered through this impact evaluation.

1

Introduction

Available data show that child maltreatment (CM) and intimate partner violence (IPV) are significant public health problems in the United States, resulting in an array of consequences and detrimental effects to individuals, families, and society. Approximately 2.6 million referrals for CM (including physical, sexual, and emotional abuse, and child neglect) concerning almost 4.5 million children were made to state and local child protective services (CPS) agencies in 2002. An estimated 4.8 million rapes and physical assaults are perpetrated against women by an intimate partner, and 2.9 million intimate partner physical assaults are perpetrated against men each year.

Although IPV and CM affect millions of women and children annually, surveillance systems are fragmented, and data for these injuries are often lacking. To address this need, the Etiology and Surveillance Branch (ESB) of the Division of Violence Prevention at the Centers for Disease Control and Prevention (CDC) funded state-based surveillance activities for IPV (1994–1999, 2000–2005) and CM (2001–2004) in the states listed below. The nine states with ESB-funded surveillance activities operated five CM surveillance programs and seven IPV surveillance programs, as shown in Table 1-1.

In a unique effort to look beyond the primary objectives and products of CDC surveillance projects, CDC funded RTI to assess the related program and policy impacts of these surveillance efforts. Accordingly, the purpose of this project was to (a) define and assess the impacts (positive and negative) of the funded surveillance activities on several levels in terms of issues such as violence prevention, legislation, policy, and costs; (b) assess the impact of funding on surveillance infrastructure within states; (c) utilize information to support the development of IPV and CM surveillance plans for the future

Table 1-1. Summary of ESB-Funded Surveillance Programs

State	Intimate Partner Violence Surveillance	Child Maltreatment Surveillance
California		•
Kentucky	•	
Massachusetts	•	
Michigan	•	•
Minnesota	•	•
Missouri		•
Oklahoma	•	
Oregon	•	
Rhode Island	•	•

and enhance surveillance in other injury areas; and (d) inform initiatives to garner support for surveillance activities at national and state levels.

Challenges to assessing the impact of these surveillance systems include, most notably, developing a comprehensive definition of *impact* that obtains suitable input and buy-in from stakeholders, and collecting and synthesizing different types of data from various sources to identify the purpose, process, and operation of funded surveillance activities in a uniform and feasible manner without undue burden. To accomplish the objectives of this project, we initially met with the Technical Monitor to clarify the project scope and goals and to obtain relevant documents from CDC staff. The information gathered during this meeting was used in describing the purpose, process, and operation of funded IPV and CM surveillance activities (Section 2). In addition, RTI staff conducted a review of grantee meeting notes, interviews with CDC staff, and various documents submitted by grantees. This information was systematically organized using a document review data abstraction form enabling synthesis of information to determine the focus of the evaluation design and the definition of *impact* in collaboration with CDC staff (Section 3). This definition was revised as a result of CDC feedback and, with consensus on the definition of impact, a structured interview protocol was developed for a state stakeholder interview. This interview was

used to gather credible evidence about the impact of IPV and CM surveillance initiatives from state project staff's perspectives (Section 4). RTI staff compiled and analyzed this information to develop this final report. We conclude this report with general recommendations regarding future surveillance and related activities (Section 5).

2 Program Descriptions

2.1 IPV SURVEILLANCE PROGRAMS

This section provides an overview of ESB-funded programs in IPV and CM, with the goal of describing the background for assessing the impacts of these surveillance projects on programs and other related systems. For each program type (IPV and CM), we describe and compare program structure, goals, case definitions and types of data used, and products reported by states.

This summary is based on a review of program documents, which were selected by the CDC Project Officer for RTI's review. They include applications for continued funding, semiannual reports, and final reports. Although the project team has worked to present information accurately and consistently, and states were asked to review these documents and provide feedback on their contents, discrepancies may exist in some data reported—such as funding amounts of full-time equivalent (FTE) staff—as a result of variations in program year or differences between requested and funded amounts.

2.1.1 IPV Program Structure

Identified budget figures were similar across all programs, most likely determined by the amounts allowable under the funding mechanism (Table 2-1). Five of the seven programs reported contracting out program operations, with between 15 and 100 percent of funds subcontracted out. For four of these states, one or more universities served as subcontractors. FTE staff positions ranged from 1.2 to 4.15, though it was not clear from the documents reviewed whether staff positions reflected staff at the funded agency only, or all funded staff. Three states

reported contributing in-kind funding, in addition to time that may have been contributed for the program director.

Only one program (Massachusetts) was housed in an epidemiology unit; all others were housed in injury or violence prevention units.

Table 2-1. IPV Surveillance Program Structure

	KY	MA	MI	MN	OK	OR	RI
Annual budget (latest) ^a	\$290,224	—	\$296,220	\$294,659	\$292,919	\$293,188	\$260,000
Percent contracted out	100	—	66	10	36	0	49
In-kind funding ^b			✓ ^c			✓	✓
Full-time equivalent staff	4.1	—	1.2	3.15	3.15	4.15	3.1
Sponsoring program							
Epidemiology unit		✓					
Violence/injury prevention unit	✓		✓	✓	✓	✓	✓

^aDoes not include any carry-over funds from previous fiscal year budget.

^bOther than PI salary.

^cThe in-kind funding was \$200,000 from Michigan State's federal bioterrorism funding and was used in the 02–03 budget (Year 08), not in the latest budget.

2.1.2 IPV Program Goals and Objectives

Two types of goals were described: those relating to building and sustaining the surveillance system, and those describing the impacts of surveillance activities on prevention programs (Table 2-2). The most commonly reported goals and objectives related to standardizing system operations and building system sustainability. Objectives in this area included institutionalizing the surveillance system, establishing partnerships for ongoing data provision, and building public support for surveillance. Five of the seven states explicitly stated system development and maintenance as goals in themselves.

Four states (Kentucky, Massachusetts, Michigan, and Oklahoma) identified goals related to the data collection methods. Specific aims in this area include pilot testing recommended data elements, developing methods for emergency room surveillance, and revising and testing uniform definitions.

Four states (Kentucky, Massachusetts, Oklahoma, and Rhode Island) specified goals related to assessing population needs. Specific aims included tracking IPV incidence and prevalence, providing statewide data, monitoring trends over time, and understanding causes of injuries. Five states (Michigan, Minnesota, Oklahoma, Oregon, and Rhode Island) identified goals related to prevention and advocacy, including dissemination of data, supporting policies, programs and research, and developing collaborations for prevention.

Table 2-2. IPV Surveillance Program Goals and Objectives

	KY	MA	MI	MN	OK	OR	RI
System development and maintenance	✓	✓	✓			✓	✓
System standardization and sustainability	✓	✓	✓	✓	✓	✓	✓
Development and evaluation of data collection methods	✓	✓	✓		✓		
Assessment of population needs	✓	✓			✓		✓
Prevention and advocacy			✓	✓	✓	✓	✓

2.1.3 IPV Case Definition and Data Sources

The specified the populations of interest for states' IPV surveillance systems appear to reflect the sources of surveillance data used in each system (Table 2-3). Two programs include men: those in adult protective service cases (Kentucky) and those treated for IPV injuries (Oklahoma). All states collected information on nonfatal IPV injuries, and five collected information on fatal IPV injuries.

The most common data sources for IPV surveillance were surveys. Each state reported using survey data; some specified using the Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavior Survey (YRBS), the Pregnancy Risk Assessment Monitoring System (PRAMS), or state-specific surveys of women.

The next most common data sources were emergency room reports, police reports and court data (six states each) and death records, including both medical records and death certificates (five states each). Other data sources reported include media reports, social service data on adult protective service cases, and data collected with rape kits.

Table 2-3. IPV Surveillance Case Definition and Data Sources

	KY	MA	MI	MN	OK	OR	RI
Target population	Women in intimate relationships; men and women in APS	Women over age 12	Women over age 16	Women over age 12	Men and women	Males or Females over age 12	Women over age 12
Type of injury							
Fatal	✓		✓	✓	✓	✓	
Nonfatal	✓	✓	✓	✓	✓	✓	✓
Data source							
Emergency room	✓	✓	✓	✓	✓	✓	
Police	✓		✓	✓	✓	✓	✓
Social services	✓						
Death records	✓		✓	✓	✓	✓	
Court	✓		✓	✓	✓	✓	✓
Media			✓	✓	✓		
Survey	✓	✓	✓	✓	✓	✓	✓
Other							✓

2.1.4 IPV Program Products

Products of the IPV surveillance program were described primarily in terms of dissemination (Table 2-4). The important role that dissemination plays in awareness raising was often unstated. Presentation settings included the American Public Health Association (APHA), state epidemiology conferences, state conferences on domestic violence, national conferences on sexual violence and domestic violence, and other, unspecified conferences. Six states listed reports, including documentation of surveillance findings, replication guidelines, and data briefs. Four states reported submission or publication of a total of five journal articles. Four states reported training activities for physicians, residents, hospital information system personnel, and epidemiology students. Other products included development of working relationships, provision of data for legislative hearings, and factsheets.

Table 2-4. IPV Surveillance Program Products

	KY	MA	MI	MN	OK	OR	RI
Presentations	✓	✓	✓	✓	✓	✓	✓
Reports ^a	*	✓	✓	✓	✓	✓	✓
Journal articles	✓	*	✓			✓	✓
Course/trainings		✓	✓	✓	✓		

^aExcluding required project reports.

*Reported by Centers for Disease Control and Prevention staff; not identified in program documents.

2.2 CHILD MALTREATMENT SURVEILLANCE PROGRAMS

2.2.1 Child Maltreatment Program Structure

Budget figures for CM surveillance programs, unlike those for IPV programs, varied because fatal and nonfatal surveillance programs were funded separately (Table 2-5). Three programs focused on fatal CM and four on nonfatal CM. All programs except one reported contracting out between 5 and 99 percent of the program budget. Three programs reported in-kind funding. Reported staff were 1 or less, suggesting that these figures may not include subcontracted staff.

Program locations vary. Both California programs are housed in the Epidemiology and Surveillance Section of a larger Injury Control Branch. The Minnesota program is housed in a violence prevention unit. Other sponsoring units include a public health institute (Michigan), a center for health information (Missouri), and department of family health (both Rhode Island programs).

2.2.2 Child Maltreatment Program Goals and Objectives

Five programs in four states described goals in terms of surveillance system development and maintenance (Table 2-6). Objectives in this area include identifying cases from multiple data sources, linking data sources, and unduplicating records. All programs identified goals related to the development and evaluation of data collection methods. Specific aims in this area include assessing the utility of multiple data sources and alternate approaches of linking sources, and evaluating methods to identify unrecognized cases.

Table 2-5. Child Maltreatment Surveillance Program Structure

	CA Part I	CA Part II	MI	MN	MO	RI Part I	RI Part II
Annual budget (latest) ^a	\$97,144	\$293,706	\$278,709	\$278,709	\$287,987	\$47,277 ^b	\$223,977
Percent contracted out	39	27	2	0	79	99	100
In-kind funding			✓			✓	✓
FTE staff	1.0	2.0	1.0		0.65		0.2
Sponsoring program							
Epidemiology section within injury prevention unit	✓	✓					
Violence/injury prevention unit				✓			
Other			✓		✓	✓	✓

Note: FTE = full-time equivalent.

^aIncludes 2-month carryover.

^bSmaller budget due to a low number of child deaths relative to other states.

All programs except those in Rhode Island specified goals related to assessment of population needs. These include describing incidence and prevalence of CM, overall and by population subgroup, as well as describing the characteristics of maltreated children. Both of the California programs, as well as the Minnesota program, identified goals related to prevention and advocacy, specifically the dissemination of surveillance information.

Table 2-6. Child Maltreatment Surveillance Program Goals and Objectives

	CA Part I	CA Part II	MI	MN	MO	RI Part I	RI Part II
System development and maintenance	✓	✓	✓	✓	✓		
Development and evaluation of data collection methods	✓	✓	✓	✓	✓	✓	✓
Population-level epidemiology (incidence and risk factors)	✓	✓	✓	✓	✓		

2.2.3 CHILD MALTREATMENT Case Definition and Data Sources

Programs varied somewhat in the age range for CM surveillance, with some populations defined as children less than 10 years of age (California, Michigan, Minnesota, Missouri) and others as children less than 18 (Rhode Island) (Table 2-7).

All programs utilized data from child protective services (CPS). Five programs used records of inpatient hospitalizations, and three used records of emergency room visits. The three programs focused on fatal CM used data from CPS, law enforcement, and death records.

Table 2-7. Child Maltreatment Surveillance Case Definition and Data Sources

	CA Part I	CA Part II	MI	MN	MO	RI Part I	RI Part II
Target population	0–9 years	0–9 years	0–9 years	0–9 years	0–9 years	0–17 years	0–9 years
Type of injury							
Fatal	✓		✓			✓	
Nonfatal		✓		✓	✓		✓
Data source							
Emergency room				✓	✓		✓
Law enforcement	✓		✓			✓	
Child protective services	✓	✓	✓	✓	✓	✓	✓
Hospital discharges		✓	✓	✓	✓		✓
Death records	✓		✓			✓	

2.2.4 CHILD MALTREATMENT Program Products

Relatively few products were described in the documents reviewed for CM surveillance programs, apart from products developed for ongoing program operations. Missouri had two peer-reviewed publications. Two programs (Minnesota and Missouri) described presentations given or planned. Both California programs, as well as the Michigan program, reported journal articles either in progress or complete. The California Part I program reported creation of a prevention committee within the child fatality review council and policy changes related to data collection in justice and social service agencies. Other products mentioned include newsletter articles and data provided for a Grand Rounds presentation.

Table 2-8. Child Maltreatment Surveillance Program Products

	CA Part I	CA Part II	MI	MN	MO	RI Part I	RI Part II
Presentations	*	*	*	✓	✓	*	*
Journal articles	✓	✓	✓		*		

* Reported by CDC staff; not identified in program documents.

2.3 DISCUSSION

From this programmatic review there were apparent distinctions among programs. Even with a common funding source, programs vary substantially in goals, methods, and products. CM surveillance programs are clearly described at an earlier developmental stage than IPV surveillance programs, and the CM programs are more focused on development and less on sustainability and dissemination than the IPV programs. It is also clear that program products and impacts are inconsistently reported, underlining the need for this assessment.

This section provides an overview and general description of the similarities and differences among programs and serves as a starting point for more thorough data collection. Subsequent chapters will provide more details on the process for defining impacts and information from states on impacts of their surveillance systems.

3

Defining Impact

3.1 PROPOSED DEFINITION

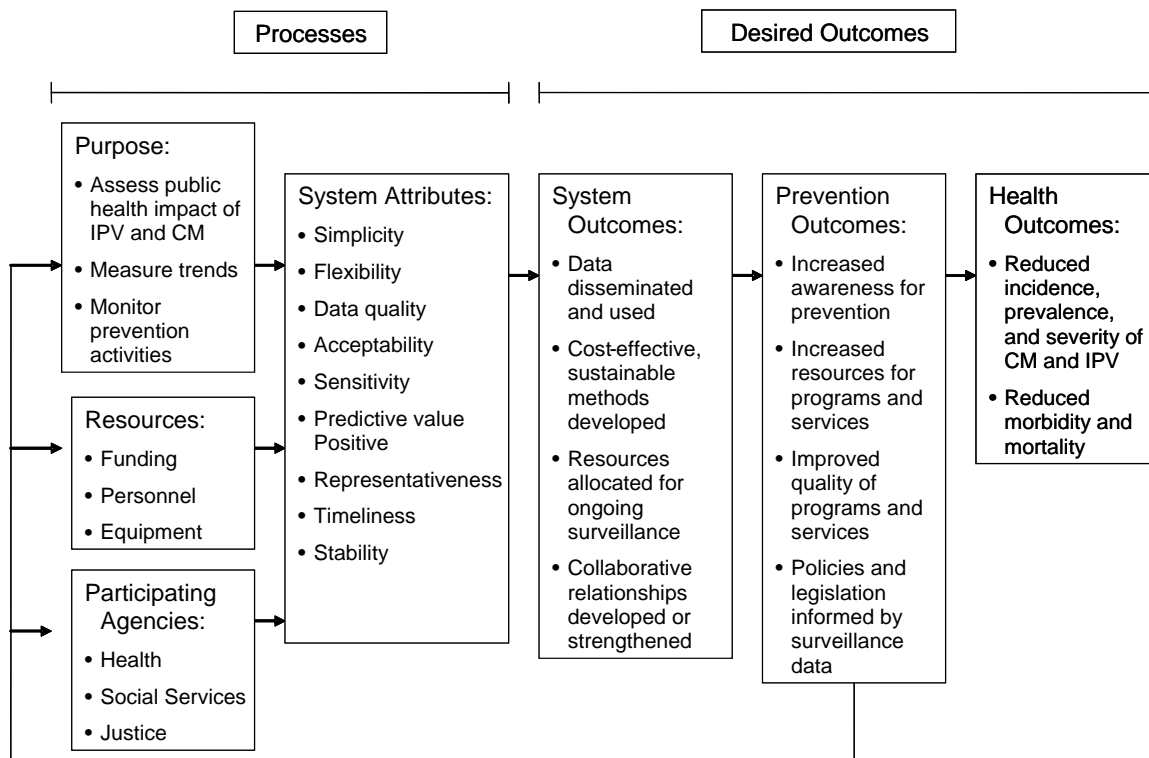
In order to obtain a richer description of the impact of the IPV and CM surveillance initiatives, we spoke with state stakeholders. Before this step, however, it was important to define *impact*. From conversations with the project officer and other staff in ESB, it was decided that there are multiple levels of outcomes for these programs, as shown in Figure 3-1.

Of these levels, the focus of our work was desired system and prevention outcomes. We focused on these types of outcomes because programs were charged with assessing system attributes, and linkage between surveillance program activities and long-term health outcomes is not feasible within this task. Focusing on the domains of system and prevention outcomes, the following working definitions of *impact* were proposed.

At the system level, desired outcomes include production of useful findings, using sustainable methods, and collaborative efforts. Examples include the following:

- dissemination of data in formats (such as reports, journal articles, and presentations) that are useful to multiple audiences
- development and implementation of surveillance methods that are cost-efficient and sustainable over the long term
- institutionalization of surveillance activities through dedication of ongoing resources for data reporting, analysis, and dissemination

Figure 3-1. Conceptual Model for Evaluation of the Impact of Intimate Partner Violence and Child Maltreatment Surveillance Systems



- development or enhancement of collaborative working relationships across organizations with an interest in IPV and CM that provide data resources and/or use system products

At the prevention level, desired outcomes include the use of surveillance data to increase awareness and support improved programs and policies. Examples include the following:

- Heightened awareness among the general public and policy makers regarding the extent and impact of IPV and CM, as a result of dissemination of surveillance data
- Expanded resource allocation to programs that prevent IPV and CM or respond to those affected by it
- Programs and services that respond more effectively to geographic areas or populations at greatest risk of IPV and CM, as a result of surveillance data
- Development of policies and legislation that expand or improve responses to IPV and CM, as a result of better data on their extent, nature, and impact.

As a next step, we spoke with senior CDC staff to place this work in the context of CDC's thinking about surveillance and intentional injury and to test our formulation of impact.

3.2 FEDERAL STAKEHOLDER (CDC STAFF) INTERVIEWS

RTI conducted interviews with three CDC staff members with knowledge and expertise in various areas related to surveillance activities at CDC (see Appendix A for the full interview template). These staff members held the positions of Acting Director of NCIPC, Associate Director for Science in the Division of Violence Prevention, and Public Health Analyst in the Office of the Director of NCIPC. Respondents were asked a series of questions regarding their perspectives on CDC's focus on IPV and CM surveillance activities, and they were asked to give feedback on the operating definition of *impact* and on related examples of outcomes developed by RTI staff. The information provided by respondents is summarized below along with supporting statements (these are taken from notes and may not be exact quotes).

Respondents' responsibilities in relation to the development of surveillance within the Division of Violence Prevention

All respondents played some role in surveillance activities at CDC, ranging from the actual decision making regarding the surveillance activities conducted to hands-on activities with partnering agencies that collect and utilize surveillance data.

Respondents felt that surveillance is necessary to define problems, and a goal is to be able to use surveillance for monitoring changes over time, including program evaluation activities. They felt that the work happening in that branch should feed into program evaluation.

Respondents' perspectives on how interest in and support for surveillance developed within NCIPC and the Division of Violence Prevention

Respondents held a similar view that surveillance is recognized as an important activity intramurally and is often utilized to demonstrate public health needs within communities. As one respondent noted,

Surveillance has been important from the beginning. Most data used by intramural scientists is surveillance data. It's used to get the message out

that violence is a public health issue. They're using surveillance to characterize the magnitude and nature of violence. Use of data and developing data systems where there are gaps is a fundamental priority.

All respondents did indicate, however, that it has been a challenge to convey the importance of surveillance to CDC partners. Respondents noted that this was particularly problematic in the areas of IPV and CM, where there is often limited funding in general and a greater emphasis on victim services and prevention. This is evident in the statement below:

CDC scientists believe that surveillance is important. Our state partners also believe surveillance is important. However, we have had difficulty selling people on the value of surveillance. It's not apparent to most people what the utility of surveillance is. In the violence community specifically, there is an emphasis on services and prevention and surveillance is lost in that. Our advocates and partners who help us get resources are not as interested in surveillance.

CDC's goals for surveillance with respect to IPV and CM and how the goals relate to prevention activities

Respondents noted the following as CDC's goals for IPV and CM surveillance:

- Increase the importance of the role of surveillance.
- Show that surveillance buys you something in order to get support to build systems.
- Build support from legislators and others for resources.
- Develop surveillance systems to fill existing gaps in these two substantive areas.
- Help states develop surveillance systems that will have greater utility than existing data from national surveys.
- Develop one system that includes both CM and IPV.

Respondents described a link between surveillance and prevention activities through the use of data in demonstrating both need and effectiveness of prevention programming.

Respondents noted,

Traditionally we have used surveillance information in a way that has limited the importance of it. But for both evaluation and targeting programs we need surveillance. Eventually without surveillance

information we can't tell whether we are improving the situation.

Advocates use data to target activities, to advocate for funds to support their work. Data can lead to new insights about the magnitude and nature, determine whether changes and trends are occurring, and to see differences across areas. All this helps target and evaluate interventions.

Modifications to the operating definition of surveillance system impact proposed

For the purposes of this assessment, *impact* is defined in terms of both system outcomes and prevention outcomes. System outcomes are changes that represent increased capacity to conduct surveillance, disseminate information, and maintain surveillance efforts over time. Prevention outcomes are changes in awareness, programs and policies that result from the interpretation, dissemination and use of available surveillance data.

Overall, respondents agreed that this is a good operating definition. One respondent indicated that a focus on health outcomes would be important:

There are good reasons for documenting system impact, but that is a hard sell. How you create that capacity and infrastructure are important, but we need resources and support, so we need to think about health impact. Something that we can call a health impact. If at all possible, the health impact should be information that is already accessible to demonstrate what surveillance is already doing.

The respondent did think, however, that examples of prevention outcomes provided in a subsequent question would overlap with health outcomes (e.g., a change in program or policy would be considered a health impact). It was suggested that information be obtained from an upcoming CDC discussion on defining health impacts.

Another respondent noted that the collaborative activities of partners needs to be captured and it did not appear to be an explicit part of the definition. RTI staff pointed out that this is described in the system level outcomes examples provided and noted that we would ensure that this is clear.

In the prevention outcomes description, it was strongly recommended that we not use the word *advocacy*. *Increasing*

awareness and *building support* were suggested as useful euphemisms.

There was some discussion about increasing capacity but no problem with our use of the term. It was also noted by a respondent that sometimes the connection between data and how it is disseminated is lost. It is important to understand that although a state has the capacity to collect data, it does not necessarily have the capacity to disseminate the data.

Modifications to the examples of desired outcomes at the system level

At the system level, desired outcomes include production of useful findings, using sustainable methods and collaborative efforts. Examples include the following:

- Dissemination of data in formats (such as reports, journal articles, and presentations) that are useful to multiple audiences
- Development and implementation of surveillance methods that are cost-efficient and sustainable over the long term
- Institutionalization of surveillance activities through dedication of ongoing resources for data reporting, analysis, and dissemination
- Development or enhancement of collaborative working relationships across organizations with an interest in IPV and CM that provide data resources and/or use system products

For the first example, it was suggested that dissemination should include materials for lay audiences, such as white papers or mass media, and noted that translation of data into these materials is important.

For the third example, it was suggested that institutionalization should recognize the dedication of ongoing local resources, in addition to the CDC grant, since CDC funds will not always be available.

Modifications to the examples of desired outcomes at the prevention level

At the prevention level, desired outcomes include the use of surveillance data to increase awareness and support improved programs and policies. Examples include the following:

- Heightened awareness among the general public and policy makers regarding the extent and impact of IPV and CM, as a result of dissemination of surveillance data
- Expanded resource allocation to programs that prevent IPV and CM or respond to those affected by it
- Programs and services that respond more effectively to geographic areas or populations at greatest risk of IPV and CM, as a result of surveillance data
- Development of policies and legislation that expand or improve responses to IPV and CM, as a result of better data on their extent, nature, and impact

For the first example, respondents noted that heightened awareness is hard to measure and that it may be best to provide examples of indicators such as bills introduced to legislature, hearings held, or news stories.

The kinds of documentation of impact that would be most useful to the Division of Violence Prevention

Respondents recommended obtaining hard copies of information from states. It was also suggested that we capture outcomes that show change in health and the effectiveness of prevention programming. As one respondent described,

The closer we can get to document saving lives and preventing injuries the better. The types of outcomes on the list are the realistic types of health outcomes that we're likely to be able to show. Show any changes in health at all is important. Like tracking risk factors over time. The extent to which data from any kind of surveillance system was used to create a program or any kind of intervention.

Respondents also noted the importance of including anecdotal information that may not typically be captured in written documents, such as activities that lead to legislative change. As one respondent described,

... Anecdotes are becoming more and more important. Need evidence of program change because of new data, that data is being translated for multiple audiences, that program evaluation is enhanced, or new programs developed. All those are key outcomes—how the data is being used. But at the same time, other things are important to capture, like a problem being found that led to changes in legislation. Those are things that haven't been a focus, but they show how data has an impact.

Additional information regarding IPV and CM surveillance initiatives that would be helpful

A respondent noted that the topic for the current advisory committee meeting is health impact: what are the health impacts that we can set up for ourselves? It was suggested that the RTI team get the information from the CDC advisory committee meeting because the Injury Center's committee will be having a meeting that focuses on the definition of *health impact*. The committee will be charged with the full range of intermediate outcomes, as well as injury and death, including concrete change in behaviors and the scope of the problem. Rodney Hammond will be attending and summarizing deliberations of the group on violence measures. The committee received some articles and issues related to defining health impact that should also want be obtained.

Respondents noted that in general, we should be cognizant of terminology such as *surveillance*. Some stakeholders may recognize other terms such as *data collection* or *data monitoring* as opposed to *surveillance* and associate surveillance with agencies such as the Federal Bureau of Investigation.

Given the feedback from CDC staff, it was determined that the definitions for system and prevention impacts were acceptable and, as recommended, only minor revisions were made to examples. The RTI research team initiated contact with state stakeholders to schedule interviews regarding the impact of their state surveillance systems. Themes that were deduced from these interviews are described below.

4

State Interviews

Interviews were conducted with stakeholders from all nine states (see Appendix B for the full interview template). The majority of state stakeholders had served on the surveillance project for the duration of the project. Respondents included project managers, co-investigators, epidemiologists, and project directors. Responsibilities on the surveillance project for respondents included activities such as management of the entire project in terms of fiscal and programmatic oversight to specific epidemiological work.

The program description information presented in Section 2 provided a general overview of programs in terms of program structure, goals and objectives, case definition and data sources, and program products. This section provides further descriptions of prevention and system impacts reported by states. Atlas.ti 5.0 qualitative software was used to manage and analyze data from the state interviews. Documents were reviewed for the development of a codebook (see Appendix C). Coded data were analyzed to develop themes across interviews. These themes fell into six broad categories: the respondent's role on the project, the structure of the surveillance system, prevention and system impacts, factors affecting implementation and sustainability of surveillance systems, efforts to ensure sustainability of systems, and guidance to other states attempting to implement systems. Because the program overview sections describe much of what is included in the first two themes, we focus on the remaining four themes for this section of the report.

4.1 IMPACTS

As previously noted, this project focused on prevention and system impacts of surveillance systems. The sections below describe themes across the two types of impacts and are followed by a summary of products directly reported by state stakeholders.

4.1.1 Prevention Impacts

Prevention impacts are increased awareness, programs, and policies that result from the interpretation, dissemination, and use of available surveillance data. Equal numbers of respondents noted the following prevention impacts:

- **Heightened awareness of violence:** The existence and dissemination of data increases both the government's and the public's awareness of problems. Being able to provide regional data was effective in generating public involvement in IPV prevention.
- **Demonstrated need for resources:** Data have been used to justify funding for continued or expanded surveillance activities, such as inclusion of IPV in state BRFSS, and to justify prevention programming in other agencies, such as tribal health programs.
- **Improve prevention programs:** Within state government, use of surveillance data has led to examinations of the relationship of substance abuse and IPV, greater attention to home safety by Temporary Assistance for Needy Families (TANF) agencies, inclusion of IPV in state strategic plan for injury prevention, integration of CM into state health department, and greater attention by CPS to children witnessing IPV.
- **Inform policy and legislation:** Surveillance data have been used to support changes in restraining order policy, shift Rape Prevention and Education (RPE) funds from crisis support to prevention, require review by social service directors after any child death in client families, and require full investigation after three reports of CM. Legislative changes supported by surveillance data include the domestic violence fatality bill and legislation for preventing shaken baby syndrome.

4.1.2 System Impacts

System impacts are changes that represent increased capacity to conduct surveillance, disseminate information, and maintain surveillance efforts over time. The following themes emerged from state stakeholders' feedback on system impacts.

- **Collaboration:** All states reported building new collaborations or enhancing old ones. Most frequently mentioned were state and local Violence against Women coalitions, hospital associations, and law enforcement. The list of partners also includes advocacy groups, medical schools, dental associations, coroners' offices, prosecutors' offices, law enforcement, Latino coalitions, tribal councils, adult protective services, mental health, substance abuse, researchers, and other offices within the state health department.
- **Improved quality of surveillance data produced:** Data produced by surveillance are an improvement either because no data were available previously, or because surveillance systems have improved data quality (i.e., by unduplicating data or using better case-finding methods).
- **Dissemination of data:** Data have been distributed for use by others, including legislators, state ways & means committees, university researchers, state and local domestic violence coalitions, health care providers, state councils on child maltreatment, the National Child Abuse Reporting System (NCANDS), and local child welfare agencies.
- **Improved input data:** The validity of data used by surveillance has been improved by the use of more detailed survey data being collected from women, mothers, crime victims, and adolescents. Data quality has been improved through increased e-coding, improved identification of the relationship between victim and perpetrator, coding sexual violence examination so that it won't appear on bills but will be detected for surveillance, and producing unduplicated counts of victims.
- **Improved case-finding methodology:** Improvements include development of a model to estimate fatalities based on emergency room visits, integration of child death review with CM surveillance, and improving communications between state laboratories and police regarding rape kits.
- **Institutionalization of system:** Three systems are reported to have, or be in the process of securing, ongoing funding. Two states indicated that system will definitely not be continued.

4.1.3 Products

- **Reports:** All programs provided some type of reports for dissemination of data. These included reports to

CDC, state agencies, advocacy groups, and other local, regional, and state stakeholders.

- **Web sites:** Eight programs reported posting data or reports on Web sites, with as many as 3,000 page views recorded.
- **Presentations:** Seven programs reported specific data on presentations, including 24 presentations at national or international conferences, 15 at regional or state conferences, and 17 at local conferences.
- **Professional journals:** Three state programs are collaborating on an article on CM surveillance; in addition, four IPV programs and three CM programs report either preparing or having published articles in professional journals. Journals include *Morbidity and Mortality Weekly Report*, state medical journals, *Public Health Reports*, *American Journal of Preventive Medicine*, *Journal of Emergency Nursing*, *Annals of Emergency Medicine*, *Pediatrics*, and *Women's Health Issues*.
- **Factsheets:** Three programs distributed factsheets summarizing state data through community partners, legislators, state child abuse councils, and Web sites.
- **Professional training:** The most common audiences for trainings by surveillance system staff were medical ones, including doctors, nurses, dentists, physical therapists and residents.
- **News articles:** Programs report having distributed a newsletter (for emergency departments) and press releases on the extent and costs of IPV.
- **Legislative testimony:** One program reported having given legislative testimony.

4.2 FACTORS AFFECTING IMPLEMENTATION AND SUSTAINABILITY

- **Data Access:** Six programs noted that data access issues were primarily focused on internal/external capacity and confidentiality/human subjects. Obtaining data from both large and small agencies is a challenge in terms of data access and the agency's capacity to collect and abstract data.
 - Access to data sources remains an ongoing issue because of new confidentiality and security changes. States specifically noted difficulty in working with hospitals since HIPAA changes, working with forensic labs that have concerns about victim confidentiality,

and using telephone surveys that may put victims at risk. They also noted several issues regarding accessing people through survey methodology, including wider use of caller ID and cell phones, lack of Spanish-speaking interviewers, and low phone density areas.

- The cost of identifying cases and the limited funds that states make available for surveillance also affect data access. Reported issues include expenses associated with abstracting data and archaic electronic systems that make abstraction difficult. Respondents noted the need for funding and personnel to collect and provide data, user-friendly mechanisms for collecting data, and mechanisms for providing feedback and finalized data to local teams.
- **Data Quality:** Five respondents noted issues regarding the accuracy of some surveillance information (i.e., incomplete capture because of issues with coding, variations in how cases are identified, and a general lack of capacity within agencies to capture the data). Respondents noted that issues arise with death determination because of inconsistent approaches across agencies. They also expressed concern about misinterpretation of data (e.g., interpretation suggesting that only poor and minority women have problems). Two respondents suggested that many of the data quality issues could be alleviated if multiple data sources were used in surveillance efforts.
- **Relationship/conflicts:** Five respondents indicated that conflicts related to turf issues (e.g., the domestic violence community, advisory board members), issues related to funding streams (particularly with the domestic violence community—*noted by two IPV respondents*), and approaches to identifying cases often proved challenging to system implementation and sustainability. These conflicts were heightened by staff turnover in other agencies, which made collaboration difficult. One respondent noted having initial conflicts between agencies providing data, but that once people were redirected to the primary focus of the project and away from turf issues, a good relationship was established. Another respondent indicated that preexisting partnerships prevented conflicts in their surveillance efforts and placed the state in a unique position (compared with other states) to have a great deal of support.
- **Organizational support:** Five respondents noted organizational support as a key factor in system

implementation and sustainability. This was described in terms of both external agencies' capacity and the respondent's internal agency's capacity.

- **External Capacity:** The low capacity of other agencies inhibits the agencies from utilizing the surveillance information for prevention purposes. Many of these agencies are overtaxed in focusing on intervention efforts and do not feel that they are able to use personnel and other resources for surveillance purposes.
- **Internal Capacity:** Internal resources are often too scarce for strong support of surveillance, and agencies are not willing to continue collecting surveillance information or are politically not supportive (e.g., no support for domestic violence in the context of marriage). Changes in leadership and the organizational location of the surveillance system inhibited focus on IPV surveillance because of a broader focus on other injury issues. One respondent noted that the CDC funds helped get the system started, but that funding remained the greatest challenge as these funds came to an end. Another respondent concluded that additional funding would be necessary to take state surveillance efforts to CDC surveillance standards and to move beyond surveillance toward active prevention efforts.
- **Surveillance system quality:** One respondent noted continual issues with data linkage and finding useful software. An additional respondent noted that tracking systems, particularly medical, are inadequate—from coding approaches to ability to track over time.
- **Capacity to effectively utilize data:** One respondent noted that agencies need to be able to use the data and see that the data have utility for others (i.e., that others can interpret and apply the data to their work). One way of achieving this goal is to put the data in a format useful for widespread dissemination.
- **Lack of guidance on implementing surveillance activities:** One respondent noted that there is no gold standard for system comparison and no feedback regarding other states. It would be helpful for states to have more involvement in feedback for this particular effort and related surveillance activities, such as BRFSS question development.

4.3 EFFORTS TO ENSURE SUSTAINABILITY

- **Link to other surveillance and violence prevention efforts/ continuation of surveillance activities:**
 - For the majority of IPV respondents, BRFSS and NVDRS were the most prevalent surveillance activities that respondents anticipated using in future surveillance efforts. The BRFSS has an IPV module that was mentioned by a majority of IPV respondents. One respondent noted, *“There are real strengths to the BRFSS module—all states are using them and we can rely on CDC to make sure the questions are valid.”*
 - CM respondents more frequently noted child death review teams as a source for data and one that will be continued for CM surveillance. Responses point to unique issues with CM surveillance and IPV surveillance—CM data often come from agencies/entities such as CPS or child death review teams, whereas survey data on IPV are more easily obtained.
 - One respondent noted three efforts to ensure sustainability: building the capacity of the local teams to produce and use their own data, broadening the focus of the child death review team process to all preventable deaths and linking it to the broader public health infrastructure for prevention and injury prevention in particular, and demonstrating the critical role CM plays as a common risk factor for multiple negative health and safety outcomes (e.g., risk behaviors, nutrition, cancer).
- **Produce data that demonstrate value of system:** Six respondents noted the importance of analyzing existing survey data and developing manuscripts (some limitations were due to a lack of funding to cover the time needed for analysis/writing). It was also noted that other methods of disseminating findings and demonstrating utility of data were used, such as brochures, chart cards with doctors, and other documents. One respondent also indicated that developing and disseminating best practices in identifying and collecting IPV data was also used as a mechanism for ensuring sustainability.
- **Linked to/secured other funding sources:** As noted above, respondents emphasized using existing mechanisms such as BRFSS, child death review teams, and CPS. Five respondents noted the importance of

tying the larger CM/IPV surveillance efforts into these types of previously established data sources. The preexisting mechanisms have organizational support and enable the newer surveillance efforts to have greater sustainability. This is of particular importance when these mechanisms are under legislative mandate, as noted by one respondent. Another respondent noted the importance of using an advisory committee to assess funding options.

- **None/system will be gone:** Two states noted that the systems would be gone when CDC money ran out; contributing factors to this include a lack of organizational support and a lack of resources for surveillance and personnel changes within agencies.
- **Develop collaborative relationships:** One respondent noted that developing, expanding, and improving existing collaborations are ongoing activities. They have developed better relationships, shared data, created a prevention focus, and expanded their efforts in disseminating information and stimulating interest in CM surveillance.
- **Efforts to standardize the approach for data collection and analysis:** One respondent indicated not having funding to repeat a statewide survey that was conducted, but that the methodology is in place to repeat survey surveillance activities when interest/funds are available.
- **Secured legislative mandate:** Only one state has state laws in place that guarantee a focus on the collection of domestic violence data.

4.4 GUIDANCE FOR OTHER SURVEILLANCE SYSTEMS

- **Develop effective partnerships:** Collaborate with service providers and those who control needed data by building understanding of the benefits of surveillance to partners. Partners mentioned by state systems include the advocacy community, service providers, law enforcement, the hospital association, occupational health and safety, citizen panels and child death review teams, CPS, and academic institutions. Collaborators will facilitate data access, identify resources to support surveillance, and “ensure that findings get translated into effective actions and improved outcomes.”
- **Disseminate data to demonstrate its usefulness:** Work with reporting partners and advocates to make

sure that data are in useful format and will be understood.

- **Expand types of data used:** Multiple data sources are essential to identifying cases. Recommended priority sources include medical record reviews, self-report surveys, and CPS data that include unsubstantiated reports.
- **Educate data providers to maintain data access and quality:** Hospital doctors and nurses, vital records offices, and child death review teams need training on coding of CM/IPV-associated injuries and deaths. One respondent reported, “It’s pretty bad that we have to get cases through newspaper clippings.” Communicating with data providers about HIPAA and Institutional Review Board issues can facilitate data access.
- **Recognize cost of systems/build appropriate funding base:** If additional Federal funding should become available, state representatives noted that the funding should be prioritized to states that have created systems to ensure sustainability, rather than fund new systems.
- **Organizational location makes a difference, but there is no consensus on best location:** Positioning within a programmatic entity helps avoid being overshadowed by general injury surveillance, and it is also helpful to be able to use the health department’s championship.
- **Build internal capacity:** Contracting out can simplify work, but it does not build internal capacity. Specific capacities include a statistical model to reduce need for case abstraction, and appropriate methods for data analysis.
- **Ensure that data captures all affected populations:** IPV surveillance should include women of all ages (no upper cutoff), workplace deaths, and IPV deaths for which no arrest was made.

5

Conclusion

Overall, states were able to demonstrate impacts at both prevention and system levels. States showed productivity in disseminating data through a variety of mechanisms, including journal articles, reports, brochures, trainings, and Web sites, as well as increasing awareness of violence and the need for surveillance funding, improving prevention programming, and informing policy and legislation. A few states made strides in setting up surveillance structures that are on track for some level of state institutionalization. Critical components of this ability include building and enhancing collaboration, improvements to the quality of data entered and produced by the system, and—perhaps most important—widely disseminating data with utility for various stakeholders.

There were, however, states that clearly indicated that their surveillance efforts would be discontinued at the end of CDC funding. Respondents for these states noted that a lack of organizational support and various leadership changes prevented stability for system resources. These two factors were mentioned by most states as important determinants of surveillance system impacts and sustainability.

There were general recommendations gleaned from state feedback regarding surveillance activities. First, there is a need and desire from states for guidance on criteria for successful surveillance systems. CDC has provided some general guidance in this area through *the Updated Guidelines for Evaluating Surveillance Systems* (2001).¹ Although direct evaluation of the system attributes was largely outside the scope of work for this

¹ Centers for Disease Control and Prevention (2001). Updated guidelines for evaluating public health surveillance systems. *Morbidity and Mortality Weekly Report*, 50(RR13), 1–35.

project, some components of the guidelines were used for RTI's approach to assessing and defining impact. States would likely benefit from explicit guidance on how these guidelines can be used to assess their IPV and CM surveillance systems. For example, as noted in the *Updated Guidelines for Evaluating Surveillance Systems*, systems should include clear descriptions of the purpose, resources, and participating agencies with a specific focus for IPV/CM systems on available and sustainable resources and abilities to build or enhance existing collaborations with agencies; assessment of system attributes with particular IPV/CM system focus on data access and quality issues; and information on assessing system and prevention outcomes with clear demonstration of products that demonstrate utility of data and that are widely disseminated for IPV/CM systems.

Second, several states noted that they were at the cusp of ensuring the sustainability of their systems. It is important that states are able to secure internal fiscal buy-in and leverage funding opportunities with outside stakeholders and agencies. Several respondents noted that the priority for surveillance within their states was aided by this support from the CDC through this IPV and CM surveillance initiative. Federal agencies' continued recognition of the importance of surveillance appears to be an important step in states' following this precedent and making surveillance a fiscal priority.

In addition, it appears critical for those working with surveillance systems to be fully aware of and in a position to build collaborations with IPV/CM stakeholders in their states and to utilize existing, valid surveillance data sources. Respondents noted negative fallout from conflicts over appropriate funding streams of federal monies, system location and lack of support, and histories of ineffective relationships within and among state and community stakeholders. However, states showing the most promise for sustainability and greatest impacts often reported an ability to move beyond "turf issues" and to bring stakeholders to the table to focus on the utility of surveillance data for all interested parties. Many of these states develop effective partnerships and data exchange processes with existing data sources such as BRFSS, NVDRS, medical examiner and coroners' offices, law enforcement, and hospitals to produce high-quality data from multiple sources while

putting mechanisms in place to ensure the sustainability of IPV/CM efforts overall.

Finally, it is important to ensure that there are venues for states to learn from one another. States are in the most appropriate position to provide feedback on best practices in surveillance efforts and to ensure that recommendations made regarding surveillance efforts are feasible and practical. It is important that they are provided opportunities to give feedback when surveillance systems and related components such as proposed data elements for BRFSS, NVDRS, child death review teams, and other surveillance data sources are considered. CDC currently has projects in place pertaining to both CM and IPV surveillance data that attempt to incorporate state perspectives. These efforts should continue and be made readily available to relevant state stakeholders.

As a part of deliverables for this study, the findings have been disseminated through presentations at the Society for Prevention Research Annual Meeting, May 31-June 2, 2006 in San Antonio, TX (Appendix D) and the 134th Annual Meeting of the American Public Health Association, November 4-8, 2006 in Boston, MA (Appendix E). A manuscript has also been developed and will be submitted to a peer reviewed journal upon receipt of CDC Clearances. These deliverables have and will allow for continued dissemination of the important information gathered through this impact evaluation.