## Health Priority: Intentional and Unintentional Injuries and Violence
### Objective 1: Child Maltreatment (Logic Model)

**Long-term (2010) Subcommittee Outcome Objective:** By 2010, there will be a 10 percent reduction in the number of children who are abused and neglected in Wisconsin as reported by the Department of Health and Family Services and other appropriate governmental data sources.

Long-term outcome objective updated as of: Sept 2004

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<td>The Division of Children and Family Services in the Department of Health and Family Services has statewide authority to address issues of child abuse and neglect prevention.</td>
<td>The Department of Health and Family Services, Division of Children and Family Services, Bureau of Programs and Policies, is charged with collecting information on child abuse and neglect across Wisconsin. Prevent Child Abuse Wisconsin is the state chapter of a national organization, Prevent Child Abuse America. The Division of Public Health, will need to work with local human services departments and public health departments to collect data that will help state and local entities better understand the realities of child abuse and neglect at the community level.</td>
<td>Department of Health and Family Services, Bureau of Programs and Policies, Division of Children and Family Services Department of Health and Family Services, Division of Public Health Department of Public Instruction Prevent Child Abuse Wisconsin Children’s Trust Fund The Child Abuse Prevention Fund University of Wisconsin Cooperative Extension family living agents and community resource development specialists Local human service agencies</td>
<td>By 2003, a coordinating agency for primary prevention is identified. By July 2004, Wisconsin Child Welfare Information System, the statewide automated child welfare information system, is fully implemented across Wisconsin. By 2003, 80 percent of staff from agencies serving families that attend state-sponsored trainings on child abuse and neglect prevention will report an increased understanding of child abuse and neglect, including demographics of child abuse and neglect, existing programs to prevent child abuse and neglect, the rate at which prevention programs are being accessed by families, barriers to accessing prevention programs, and public</td>
<td>By 2005, technical assistance will be provided to at least ten communities that are already using a comprehensive, accessible, interdisciplinary approach to preventing child abuse and neglect in order to help them strengthen their prevention efforts. By 2007, technical assistance for creating a comprehensive, accessible, interdisciplinary approach to preventing child abuse and neglect will be provided to at least ten communities.</td>
<td>By 2008, there will be at least a 10 percent increase in the number of comprehensive, accessible, interdisciplinary programs to prevent child abuse and neglect across Wisconsin.</td>
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## Health Priority: Intentional and Unintentional Injuries and Violence
### Objective 1: Child Maltreatment (Logic Model)

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<td>Local prevention program direct service providers</td>
<td>perception of child abuse and neglect.</td>
<td>By 2004, a document is created that identifies elements of effective, comprehensive, accessible, interdisciplinary child abuse and neglect prevention programs at the community level, including strength-based family support programs.</td>
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<td>Community members (professional and nonprofessional) involved in child abuse and neglect prevention (may include people from health, education, social services, law enforcement, nonprofits serving families, businesses, local civic groups, faith based groups, etc.)</td>
<td>By 2004, existing programs that are using a comprehensive, accessible, interdisciplinary approach to preventing child abuse and neglect will be identified.</td>
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<td>Families using services of prevention programs</td>
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<td>The general public</td>
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<td>Policymakers</td>
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## Health Priority: Intentional and Unintentional Injuries and Violence
### Objective 5: Injury Surveillance System (Logic Model)

**Long-term (2010) Subcommittee Outcome Objective:**
By 2010, combine or coordinate existing data systems into a surveillance system.
Long-term outcome objective updated as of: Sept 2004

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
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<tr>
<td><strong>Activities</strong></td>
<td><strong>Participation/Reach</strong></td>
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| Department of Health and Family Services, Bureau of Emergency Medical Services and Injury Prevention, and Bureau of Health Care Information; Department of Transportation, Center for Health Systems Research and Analysis, Wisconsin Health and Hospital Association; Department of Justice; and coroners must research and evaluate data sources for overlap. Data managers and stakeholders must agree to develop a common data set, identify and develop common data elements, and begin data collection. Key data managers and stakeholders will need to agree that the goal of an injury surveillance system transcends specific, individual databases. Department of Health and Health Care Information; Bureau of Emergency Medical Services and Injury | Development and dissemination of a standardized presentation package and educational materials on the merits and workings of a statewide injury surveillance system. Meeting of data stakeholders occurs and agreements are made to share data and consolidate data collection efforts when possible. An annual state injury profile is created and disseminated. A user friendly injury data internet site is made available so local programs can analyze their local data to identify needs. Injury programs focus their activities based on the state injury | By 2002, educate and influence the 3 “Ps” on the issue - Policymakers (e.g., state, county, local); direct care Providers; and the general Public. By 2002, research and evaluate data sources for overlap. Data managers and stakeholders agree to develop a common data set, identify and develop common data elements, and begin data collection. By 2002, agreements are made to access data so analysts from various organizations can look at issues and barriers. By 2002, convene annual meeting of partners to update members on the status of a surveillance system and to discuss and put in place agreements to share data and consolidate data collection efforts. By 2003, develop and deliver training for professionals to accomplish the following:  
• To familiarize them with existing data | By 2005, Wisconsin will have a functional injury surveillance system in place that allows for easier collection of data, access to data, and analysis in order to affect outcomes. By 2006, various data sources all collect and analyze data with common elements (Department of Health and Family Services, Bureau of Emergency Medical Services and Injury Prevention, and Bureau of Health Care Information; Department of Transportation; Center for Health Systems Research and Analysis; Wisconsin Health and Hospital Association; Department of Justice; and coroners). By 2007, develop a method to do systematic evaluation of injuries based on the data. By 2008, program objectives and decisions are driven by available data and effectiveness of decreasing injuries in a cost-effective way. | By 2010, the goal is to combine or coordinate existing data systems into a more functional system. |
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<th>Inputs</th>
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<th>Outcomes</th>
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<tr>
<td>Prevention staff and the Bureau of Health Care Information must meet and agree to share data and work towards a more uniform data system that meets multiple data needs. Department of Health and Family Services, Bureau of Emergency Medical Services and Injury Prevention, and Bureau of Health Care Information; Department of Transportation; University of Wisconsin-Madison; Medical College of Wisconsin; Center for Health Systems Research and Analysis; and other interested parties will need to develop and implement an educational campaign to raise awareness and educate and influence policymakers (e.g., state, county local), direct care providers, and the general public about injury data collection, analysis, and applied use for program reduction plan, state injury profile, and the use of local data that has identified key injury areas. Regular meetings of data stakeholders and injury program managers will be ongoing to improve the system. Data indicates impact of statewide injury data system in decreasing injuries and death by concentrating prevention efforts.</td>
<td>• To understand the benefits of collection and use of common data elements • To understand the benefits of sharing data • To establish uniform reporting criteria By 2003, develop and distribute educational materials to targets and to the general public. Provide data to communities and decision makers so more people are aware of and using the data by applying data analysis to programs.</td>
<td>By 2008, agencies collaborate in their use of data to address overarching goals and systemic injury issues.</td>
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Health Priority: Intentional and Unintentional Injuries and Violence
Objective 5: Injury Surveillance System (Logic Model)

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<td>functions. These same groups will also need to develop and deliver training for professionals to educate them on the surveillance system and how it influences their work. An injury data stakeholders group meets on a regular basis to discuss and solve data issues. Department of Health and Family Services, Bureau of Emergency Medical Services and Injury Prevention, and Bureau of Health Care Information; Department of Transportation; University of Wisconsin-Madison; Medical College of Wisconsin; and Center for Health Systems Research and Analysis will all collect and analyze data with common elements.</td>
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Logic Model - Health Priority: Intentional and Unintentional Injuries and Violence -- Objective 5
Health Priority: Intentional and Unintentional Injuries and Violence  
Objective 5: Injury Surveillance System (Logic Model)

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<td>Department of Transportation; Center for Health Systems Research and Analysis; Wisconsin Health and Hospital Association; Department of Justice; and coroners will develop a method to do systematic evaluation of injuries based on the data. Injury programs agree that program objectives and decisions are driven by available data and the ability to decrease injuries in a cost-effective way. A state injury reduction plan is put in place with clearly articulated objectives that are agreed on and widely disseminated to injury programs statewide. Data is collected and analyzed at the local, regional, and state level.</td>
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A state injury reduction plan is put in place with clearly articulated objectives that are agreed on and widely disseminated to injury programs statewide. Data is collected and analyzed at the local, regional, and state level.
Health Priority: Intentional and Unintentional Injuries and Violence
Objective 1: Prevention of Child Maltreatment (Template)

Long-term (2010) Subcommittee Outcome Objective:
By 2010, there will be a 10 percent reduction in the number of children who are abused and neglected in Wisconsin as reported by the Department of Health and Family Services and other appropriate governmental data sources.
Long-term outcome objective updated as of: Sept 2004

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<tr>
<th>Wisconsin Baseline</th>
<th>Wisconsin Sources and Year</th>
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<tbody>
<tr>
<td>While measurement issues make it difficult to identify a baseline figure, some possible measures include:</td>
<td>2000 data, Annual Report to the Governor and Legislature on Wisconsin Child Abuse and Neglect, Office of Policy, Evaluation and Planning, Division of Children and Family Services, Department of Health and Family Services.</td>
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<td>27.8 reports per 1,000 population (ages 17 and under). A total of 38,010 maltreatment reports were filed in Wisconsin in 2000.</td>
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<td>26.7 percent maltreatment substantiation rate</td>
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<td>10 substantiated cases of a child having died from maltreatment.</td>
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<tr>
<th>Federal/National Baseline</th>
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<td>12.9 child victims of maltreatment per 1,000 children under age 18 were reported in 1998.</td>
<td>National Child Abuse and Neglect Data System, Administration on Children, Youth and Families, Administration for Children and Families, Children’s Bureau <em>(Healthy People 2010)</em></td>
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<tr>
<td>1.6 child maltreatment fatalities per 100,000 children under age 18 years occurred in 1998.</td>
<td>National Child Abuse and Neglect Data System, Administration on Children, Youth and Families, Administration for Children and Families, Children’s Bureau <em>(Healthy People 2010)</em>.</td>
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<tr>
<td>In 1997, there were 984,000 victims of maltreatment in the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam. The rate of child victims was 13.9 per 1,000 children in the general population in 1997.</td>
<td><em>Healthy People 2010.</em> 2nd Edition. United States Department of Health and Human Services.</td>
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<td>• There were an estimated 1,196 fatalities due to child maltreatment in the 50 States and the District of Columbia. The findings regarding the type of maltreatment were as follows: 55.9% neglect; 24.6% physical abuse; 12.5% sexual abuse; and, 6.1% emotional abuse.</td>
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<td>• 58.8% of the substantiated or indicated reports of maltreatment were from professional sources: legal, medical, social service, or education professionals.</td>
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Based on data from 39 states, 75.4% of the perpetrators were the victim’s parents; 10.2% were relatives; and 1.9% were individuals in other care-taking relationships.

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### Related USDHHS Healthy People 2010 Objectives

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Goal</th>
<th>Objective Number</th>
<th>Objective Statement</th>
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<tbody>
<tr>
<td>15 – Injury and Violence Prevention</td>
<td>Reduce injuries, disabilities, and deaths due to unintentional injuries and violence.</td>
<td>15-6</td>
<td>(Developmental) Extend State-level child fatality review of deaths due to external causes for children aged 14 years and under.</td>
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<td>15-33</td>
<td>Reduce maltreatment and maltreatment fatalities of children.</td>
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<td>15-34</td>
<td>Reduce the rate of physical assault by current or former intimate partners.</td>
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<td>15-35</td>
<td>Reduce the annual rate of rape or attempted rape.</td>
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<td>15-36</td>
<td>Reduce sexual assault other than rape.</td>
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### Definitions

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<th>Term</th>
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<tr>
<td>Child maltreatment</td>
<td>Consists of physical abuse and neglect, sexual abuse, and emotional abuse. Refer to s. 48.02, Wis. Stats.</td>
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<td>Primary prevention</td>
<td>Primary prevention activities are generally available to all members of a population and are designed to prevent child maltreatment from occurring. This is distinguished from secondary prevention, which targets persons who are at risk of maltreating their child (or, if a child, of being maltreated), or tertiary prevention, which consists of interventions after child maltreatment has occurred in order to prevent further maltreatment.</td>
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<tr>
<td>Strength-based family support programs</td>
<td>A set of beliefs and a community-based program approach to strengthening and empowering families and communities so they can foster the optimal development of children, youth, and adult family members.</td>
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Rationale:
According to Healthy People 2010, the 1997 Child Maltreatment report from the states to the National Child Abuse and Neglect System found there were approximately 984,000 victims of maltreatment, a decrease from more than one million victims in 1996 in the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam. National surveys of new cases are needed to describe the magnitude of the problem. However, issues of data collection and management make it difficult to know if there is an actual decline or not in the number of children being abused and neglected.

Numbers for Wisconsin also show a decline: from 40,840 reports in 1998 to 38,261 reports in 1999; and from a rate of 33.9 reports per 1,000 population (age 17 and under) to 28.9 reports per 1,000 in 1999. Maltreatment substantiation rates also show a decline, from a rate of 34 percent in 1998 to 29.7 percent in 1999. These are the reports that are investigated; an unknown number of reports are screened out and not investigated and, consequently, not included in this data. Also, in 1999 there were 11 deaths of children attributed to child abuse and neglect (Bureau of Programs and Policies, 2000). Again, this number may be misleading as we do not know if there were additional deaths from child maltreatment that were officially attributed to another cause. (For example, it has been found that Shaken Baby Syndrome, which often results in death, is often misdiagnosed.)

The costs of child abuse and neglect to society include direct costs associated with intervening to help and treat the medical and emotional problems suffered by abused and neglected children, as well as the indirect costs associated with the long-term consequences of abuse and neglect to both the individual and society at large (Prevent Child Abuse America, 2001). Children who have been abused and neglected are more likely to perform poorly in school and to experience emotional problems, depression, suicidal thoughts, sexual problems, and alcohol/substance abuse (English, 1998). Children who are abused often experience interpersonal problems as adults, which may be seen in their adult lives as interpersonal violence against their partner or their children (Elam and Kleist, 1999). In addition, it has been found that those who had been abused or neglected as children were more likely to be arrested as juveniles and/or adults for violent crimes (Office for Victims of Crime, 1999).

The U.S. Centers for Disease Control and Prevention (CDC) is currently working with Prevent Child Abuse America to explore strategies for framing child abuse and neglect as a public health issue. It has been found that when health concerns are framed as a public health issue, such as wearing seatbelts or smoking in public places, the public is more likely to become engaged with the issue and take positive steps in the direction of health promotion. Framing child abuse and neglect as a public health issue may increase the likelihood that the public will become more involved in primary prevention of child maltreatment and that we will see the number of maltreated children decrease. By identifying child maltreatment as an objective to be included in the state public health plan and by putting forth an objective that focuses on interdisciplinary community efforts, there is a stronger likelihood that Wisconsin will move in the direction of framing child maltreatment as a public health issue.

In Wisconsin, there are a number of agencies that provide intervention and treatment services in cases where child maltreatment is suspected or found to have occurred. Decisions to use
programming resources in this way may be made based on the “visibility” of these situations and the immediate need for something to be done. These are important services and need to continue with adequate support. However, when the majority of resources are used for intervention and treatment, it leaves a gap in services for primary prevention of child maltreatment which can prevent the need for intervention/treatment. We need to find a way to be able to continue a needed level of intervention/treatment services until the prevention programs that are proposed in this objective can lead to a decrease in the need for post-abuse intervention services.

Nationally, child abuse experts have identified several critical components of effective community prevention programs. Among these is the need for community-wide child abuse prevention coordinating bodies. Prevention must take place in the local communities, with programs based on an understanding of community needs and characteristics. Communities have an inherent responsibility to create environments and provide resources to ensure that children and their families can be healthy. This is consistent with the vision statement of *Healthiest Wisconsin 2010*: “healthy people in healthy Wisconsin communities.”

Furthermore, for the community prevention coordinating body to be effective in impacting child maltreatment, it must be interdisciplinary and in partnership with families. The many professionals and organizations that families interact with in the community can work together to form a coordinated effort to prevent child abuse and neglect; an effort that recognizes what each entity, including families, can contribute to this important work and that can help maximize the use of community resources and avoid duplication (Family Support America). Interdisciplinary refers to professions that may include but are not limited to: medical (e.g., public health, mental health, clinics, hospitals), social work (e.g., social service department, social work agencies, hospital based, school based), law enforcement, educational services (e.g., schools, after school programs, child care settings), faith-based organizations, nonprofit organizations working with families, businesses, and others as identified locally. While the focus of the objective being proposed is on primary prevention of children maltreatment, it is expected that there will be other agencies or partnerships that will provide intervention and treatment in cases where child maltreatment has occurred.

Finally, embracing the principles of family support in community programs is key to developing a continuum of effective primary prevention efforts and decrease child abuse and neglect. Programs that are integrated within the community respect the diversity of families and are responsive and accountable to their members. Formal and informal services are integrated and mobilized to support family development across the life span. Emerging community needs are best addressed in this process as families are considered integral members in program planning, administration, and evaluation. Programs and services are universal and diverse to meet the varying needs of the community members and strengthen the skills and abilities of families to better provide environments that are supportive to healthy growth and development of children and youth (Family Support America).

**Outcomes:**

**Short-term Objectives Outcome (2002-2004)**

- By 2003, a coordinating agency for primary prevention is identified.
• By July 2004, Wisconsin Child Welfare Information System, the statewide automated child welfare information system, is fully implemented across Wisconsin.

• By 2003, 80 percent of staff from agencies serving families that attend state-sponsored trainings on child abuse and neglect prevention will report an increased understanding of child abuse and neglect, including demographics of child abuse and neglect, existing programs to prevent child abuse and neglect, the rate at which prevention programs are being accessed by families, barriers to accessing prevention programs, and public perception of child abuse and neglect.

• By 2004, a document is created that identifies elements of effective, comprehensive, accessible, interdisciplinary child abuse and neglect prevention programs at the community level, including strength-based family support programs.

• By 2004, existing programs that are using a comprehensive, accessible, interdisciplinary approach to preventing child abuse and neglect will be identified.

**Medium-term Outcome Objectives (2005-2007)**

• By 2005, technical assistance will be provided to at least ten communities that are already using a comprehensive, accessible, interdisciplinary approach to preventing child abuse and neglect in order to help them strengthen their prevention efforts.

By 2007, technical assistance for creating a comprehensive, accessible, interdisciplinary approach to preventing child abuse and neglect will be provided to at least ten communities.

**Long-term Outcome Objectives (2008-2010)**

By 2008, there will be at least a 10 percent increase in the number of comprehensive, accessible, interdisciplinary programs to prevent child abuse and neglect across Wisconsin.

**Inputs/Outputs**

The Division of Children and Family Services in the Department of Health and Family Services has statewide authority to address issues of child abuse and neglect prevention. In partnership with the Department, the list that follows identified potential partners to carry out the plan set forth in this template. Moreover, in order to insure that activities relative to this objective are carried out, it will be necessary to identify an agency to act as the coordinating body for the activities. This might be a state agency, nonprofit, or some other type of group.

• The Department of Health and Family Services, Division of Children and Family Services, Bureau of Programs and Policies, is charged with collecting information on child abuse and neglect across Wisconsin. As of 1998, the Wisconsin Automated Child Welfare Information System was not fully implemented. It will be important for the Department to develop the capacity to fully implement the system in order to provide accurate information on child abuse and neglect, including demographics of abuse and abusers. This will be vital information to have in order for communities to create an effective prevention effort. In addition, the objective put forth by this subcommittee related to development of an injury surveillance system will provide useful data for understanding the extent of child maltreatment in Wisconsin.
• Prevent Child Abuse Wisconsin is the state chapter of a national organization, Prevent Child Abuse America. The nonprofit will be carrying out a statewide survey in 2001-2002 to identify community groups involved in child abuse and neglect prevention efforts. This information will complement the survey being proposed for implementation by the Division of Public Health, and their local partners will help to identify communities that have existing prevention programs that could be strengthened as well as identifying communities where no programs exist. In addition, Prevent Child Abuse America is currently working with the U.S. Centers for Disease Control and Prevention to explore strategies for re-framing child abuse and neglect as a public health issue. There may be opportunities to learn from this work and, possibly, to be a pilot site for such an initiative, which would strengthen the community-based focus of this objective.

• The Division of Public Health, will need to work with local human services departments and public health departments to collect data that will help state and local entities better understand the realities of child abuse and neglect at the community level. (Note: Some communities have already collected this type of information, in which case the information will need to be evaluated for its usefulness based on when it was collected and what type of information was collected.) The Division of Public Health must work together with the aforementioned partners to create surveys to be used with local prevention program direct service providers, as well as families using these services, in order to learn: (1) what prevention services exist in communities for families; (2) which services families are accessing and why they are accessing these particular services; and, (3) barriers to accessing prevention services. This will be important information to have in order to create comprehensive local prevention efforts that will effectively serve families and achieve the desired goal of preventing child abuse and neglect.

As part of the initial phase of understanding the realities of child abuse and neglect in Wisconsin, a public survey could be undertaken in communities across Wisconsin. The purpose of this survey would be to gain a better understanding of how the public views child abuse and neglect and how communities might best engage the public in prevention of child abuse and neglect. The Child Abuse Prevention Fund located in Milwaukee is currently engaged in a survey of the public in Milwaukee to learn more about public perceptions of child abuse and neglect. Their experience could provide guidance in conducting a larger survey across the state. The survey itself could be carried out by local public health offices and/or the University of Wisconsin Cooperative Extension Family Living Agents/Community Resource Development Specialists. Cooperative Extension has a strong history of conducting community assessments, making them a logical partner in this effort.

Once there is a general understanding about the realities and perceptions of child abuse and neglect prevention in Wisconsin, a statewide group will convene to identify elements of an effective comprehensive, accessible, interdisciplinary child abuse and neglect prevention program. Programs that make use of an interdisciplinary model for provision of services (such as some hospitals, nursing homes, schools) will be looked at for what can be learned from these examples. The identified elements will be the basis for recommendations to local communities as they create their community prevention programs. The statewide group might consist of a number of stakeholders who work in the area of child abuse and neglect prevention, and might
include: Division of Public Health, Division of Children and Family Services, Safe and Stable Families, Prevent Child Abuse Wisconsin, Children’s Trust Fund, Child Abuse Prevention Fund, Tribes, other nonprofits, Department of Public Instruction, representatives from the fields of health services, education, law enforcement, juvenile justice, social services, faith-based communities, the business community, families, and others to be identified.

Communities with a continuum of prevention programs will, optimally, build on the strengths of families to promote positive developmental outcomes for both parents and children. The Division of Public Health could take the lead in providing education and resources to people in communities who work in prevention about how to create interdisciplinary prevention teams, as well as a variety of strategies that might be used for prevention. Community groups that are already using an interdisciplinary, strength-based model for prevention programs might serve as resources for other communities. As appropriate, the Division of Children and Family Services, the Department of Public Instruction, and the Division of Public Health will work with Prevent Child Abuse Wisconsin, Children’s Trust Fund, Child Abuse Prevention Fund, and other prevention-focused organizations to help provide this information to communities and the general public.

Local communities will bring together the appropriate partners from their community, including families, to create a plan for and to implement a comprehensive, accessible, strength-based interdisciplinary child abuse and neglect prevention program. These partners will be identified based on the resources available, as well as the specific nature of child abuse and neglect in each community, may require a community to seek out specific partners that have something to offer in addressing a specific abuse/neglect issue. Coordinated investments in family support by a variety of prevention programs best promote positive outcomes for children and their families over time. Positive outcomes for children, families, and communities are, in part, the result of increased parental competency and improved knowledge of parenting skills and child development. In addition to fewer occurrences of child abuse and neglect, a continuum of comprehensive, family support prevention programs improves the likelihood of school success for children, job, and education successes for parents, and reductions in teen pregnancy and juvenile delinquency.

Participants/Reach:

- Department of Health and Family Services, Bureau of Programs and Policies, Division of Children and Family Services
- Department of Health and Family Services, Division of Public Health
- Department of Public Instruction
- Prevent Child Abuse Wisconsin
- Children’s Trust Fund
- The Child Abuse Prevention Fund
- University of Wisconsin Cooperative Extension family living agents and community resource development specialists
- Local human service agencies
- Local prevention program direct service providers
• Community members (professional and nonprofessional) involved in child abuse and neglect prevention (may include people from health, education, social services, law enforcement, nonprofits serving families, businesses, local civic groups, faith based groups, etc.)
• Families using services of prevention programs
• The general public
• Policymakers

**Evaluation and Measurement**

It is difficult to accurately determine the number of children being maltreated, both nationally and within Wisconsin, making it difficult to measure progress toward an objective of reducing child maltreatment. This is true for a number of reasons.

Nationally, there is no mandatory national child maltreatment reporting system. In 1988, a voluntary national data collection and analysis program was developed, the National Child Abuse and Neglect Data System. This program is sponsored by the Children’s Bureau; Administration on Children, Youth, and Families; Administration for Families; U.S. Department of Health and Human Services. As stated in the 1999 report, “This report presents annual national data about child abuse and neglect known to child protective services agencies in the United States.” Here we have two possible avenues for inaccuracy: (1) states are not required to submit this data and, indeed, the report indicates that submission was inconsistent across items; and, (2) this statement acknowledges that there may be cases unknown to child protective service agencies across the country. In addition, while the passage of the Child Abuse and Prevention Treatment Act established a set of uniform operating standards with respect to the identification and management of child abuse cases, individual states are able to determine definitions of child maltreatment, investigative procedures, service systems, and data collection procedures (U.S. Advisory Board on Child Abuse and Neglect, 1995).

Another potential source of data error is misidentification of child maltreatment, and especially child deaths due to maltreatment. As reported in *A Nation’s Shame: Fatal Child Abuse and Neglect in the United States*: “It has been estimated that 85 percent of childhood deaths from abuse and neglect are systematically misidentified as accidental, disease related, or due to other causes…. As a result of this misclassification or misdiagnosis, we do not have a reliable source to determine accurately why or exactly how many children die from abuse and neglect. Each national information system is incomplete as a source of comprehensive information on child abuse and neglect deaths” (National Center on Child Abuse Prevention Research, 2001).

State-specific data challenges are highlighted in the *Wisconsin Child Abuse and Neglect Report, 1999 Data*. This report states that “the quality of the data in this report is dependent on the accuracy of data submitted by the local agencies.” The report further states that “The State of Wisconsin looks forward to full implementation of the statewide automated child welfare information system (WiSACWIS) as it will greatly expand the type of data collected and improve the timeliness and accuracy of child welfare data throughout the state.”

Thus, when we see trends that indicate that child maltreatment is decreasing, it is difficult to know whether to attribute the decrease to fewer children actually being maltreated or changes in classification, investigation, or reporting procedures.
Even if we were able to feel confident about numbers, there are some problems with choosing indicators to reflect a decrease in child maltreatment. For example, if we propose that we work to “decrease the number of reports of child maltreatment,” we run the risk of discouraging reports of cases that should be reported. Instead, we might want to be working to increase the number of people who report as we increase public awareness of child abuse and neglect and how we can prevent it from occurring.

In another example, if we propose to work toward “decreasing the rate of maltreatment substantiation,” we run the risk of discouraging findings of substantiation in order for departments to meet this goal. Furthermore, as stated in the Wisconsin Child Abuse and Neglect Report, 1999 Data, variance in county substantiation rate is affected by a number of factors, including the quality of information gathered at phone intake, the screening criteria and rates, the quality of information gathered during the investigation assessment, prevailing community standards, and worker and agency judgment.” This makes the accuracy of this data questionable, to say the least.

It will be important as part of the Healthiest Wisconsin 2010 plan to develop strong, reliable databases within the state that will allow us to measure child maltreatment. One data system that is being proposed in Healthiest Wisconsin 2010 is an injury surveillance plan that will allow better tracking of injuries, including their cause. In addition, it will be important that databases that exist within sectors be able to be linked to insure that accurate numbers are being produced.

Success will be measured by the existence of functioning comprehensive, accessible, interdisciplinary child abuse and neglect prevention programs to serve all communities in Wisconsin by 2008. The ultimate evaluation of the effectiveness of these prevention programs will be assessed by looking at Department data on child abuse and neglect in 2010, with the goal being a 10 percent decrease in the number children being maltreated. This 10 percent figure will be determined by taking the best data available to us at the time.

Crosswalk to Other Health and System Priorities in Healthiest Wisconsin 2010

Access to Primary and Preventive Health Services: The objective put forth is a preventive health issue/service, and may fall under the work of this subcommittee.

Adequate and Appropriate Nutrition: Some cases of child neglect are premised on the caregiver failing to provide adequate and appropriate nutrition (when it is within the caregiver’s means to do so). Some of the actions taken in this subcommittee may help to address this issue.

Alcohol and Other Substance Use and Addiction: There is a link between alcohol and other substance use/addiction and abuse and the neglect of children. It may be that some of the strategies implemented in this subcommittee will contribute to the prevention efforts in communities.

Social and Economic Factors that Influence Health: Stress (including stress associated with inadequate resources) is a leading contributor to child abuse and neglect. The work that this
subcommittee does to address these issues may contribute to the prevention efforts of communities.

*Integrated Electronic Data and Information Systems:* There may be databases not identified here that would contribute to community understanding of child abuse and neglect.

**Significant Linkages to Wisconsin’s 12 Essential Public Health Services**

*Monitor health status to identify community health problems:* This will be addressed through surveys and full implementation of Wisconsin Automated Child Welfare Information System.

*Identify, investigate, control, and prevent health problems and environmental health hazards in the community:* In seeking to gain a better understanding of the realities of child abuse and neglect in Wisconsin, we will be in a better position to plan community efforts to prevent abuse and neglect.

*Educate the public about current and emerging health issues:* Surveys are a way of educating the public. There will also be educational efforts built into the work of prevention groups in communities.

*Promote community partnerships to identify and solve health problems:* A variety of partnerships are created within the design of this plan, including partnerships between public health, human services, Cooperative Extension, and various community stakeholders involved with child abuse and neglect issues.

*Create policies and plans that support individual and community health efforts:* The focus in the proposed plan is on strengthening community efforts to prevent child abuse and neglect.

*Link people to needed health services:* It is anticipated that the community prevention programs will have this as one of their goals.

*Evaluate effectiveness, accessibility, and quality of personal and population-based health services:* Since the proposed objective seeks to insure accessible prevention programs, part of the assessment will be to determine the degree to which the programs are accessible to all people in a community.

*Foster the understanding and promotion of social and economic conditions that support good health:* As we learn more about the current realities of child abuse and neglect in Wisconsin, we will learn more about the risk factors for child abuse and neglect and be better able to address those risk factors to decrease the incidences of abuse and neglect.

**Connection to the Three Overarching Goals of Healthiest Wisconsin 2010**

*Protect and promote health for all:* The proposed plan seeks to insure that children, one of the groups in society least able to speak for themselves, are protected from being abused or neglected. At the same time, the proposed activities are designed to strengthen families, thereby promoting overall family health and, by extension, promoting the health of the community.
Eliminate health disparities: The proposed plan states that prevention programs must be “accessible.” The idea of accessibility includes a number of components. It means that the programs must be made available to families and others who care for children within the communities in which these persons live and in settings that these persons would typically frequent, making it more likely that the programs and services will be utilized. Special efforts will have to be made to ensure that prevention programs exist and are available to people living in rural areas. In addition, accessibility means that program services and activities will be provided in languages that are used by the people being served and will be provided in culturally appropriate ways. Accessibility means providing appropriate services and programs for people who have a disability. Finally, accessibility means that we need to make prevention programs available to anyone in the community, regardless of their socioeconomic status or other demographic characteristics (e.g., religion, race).

Transform Wisconsin’s public health system: The comprehensive, interdisciplinary approach outlined in the proposed plan would involve many partners, some of whom might not traditionally be part of the public health system but who are involved in prevention efforts in some way. Through development of interdisciplinary community teams working together to prevent child abuse and neglect, it is more likely that a “safety net” of programs and services will be provided to keep children safe in their homes and the other environments in which they exist, and would strengthen families, thereby strengthening communities.

Key Interventions and/or Strategies Planned:
- Assessment (surveys) of the current realities of child abuse and neglect and prevention in Wisconsin.
- Identification of key elements of an effective comprehensive, accessible, interdisciplinary child abuse and neglect program at the community level.
- Education to community members involved in child abuse and neglect prevention relative to creating effective interdisciplinary prevention groups and the variety of ways to prevent child abuse and neglect.
- Creation of local prevention programs.
References:


**Health Priority: Intentional and Unintentional Injuries and Violence**  
**Objective 2: Motor Vehicle Related Injuries and Death (Logic Model)**

### Long-term (2010) Subcommittee Outcome Objectives

**2a:** By 2010, the rate of motor vehicle crash-related deaths and incapacitating injuries will be 104 per 100,000 population.

**2b:** By 2010, the rate of fatality and incapacitating injuries will be 9.4 per hundred million vehicle miles traveled.

**2c:** By 2010, the age-adjusted overall motor vehicle death rate will be 14.0 per 100,000 population.

Long-term outcome objective updated as of: Sept 2004

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<td><strong>Funds:</strong> Highway safety grant funds; Federal Maternal and Child Health Block Grant; Preventive Health and Health Services Block Grant; State-Level Injury grant funds; and volunteer and advocacy organization funds</td>
<td>Department of Health and Family Services will organize an interdisciplinary and intersectoral State Injury Coordinating Committee that will provide input into the oversight and publication of injury prevention and control efforts throughout Wisconsin’s public health system. The committee will include both public and private agencies and organizations, professional organizations, safety committees, and volunteer and benevolent groups, who have been educated to understand their role in coordinated injury prevention and control. The committee will serve as a coordinating group for injury and injury control information. The committee will provide input into identifying injury data needs and resources at the state and local level.</td>
<td>State agencies and organizations: health care, public safety, enforcement, planning, engineering Professional organizations Committees / coalitions: Traffic Record Coordinating Committee, Wisconsin Highway Safety Partners, WSBC, Mothers Against Drunk Driving, volunteer and benevolent groups Local agencies, Tribes, and organizations:</td>
<td>The Department of Transportation, through its Safe Communities Program, in partnership with the Division of Public Health, Bureau of Emergency Medical Services and Injury Prevention will identify Wisconsin communities who want to decrease motor vehicle related deaths and serious injuries in their communities. Division of Public Health will provide leadership to link the Safe Communities model to the Community Health Improvement Processes and Plans currently underway or being planned in these local communities.</td>
<td>State coordinating group provides input and assists in the development of a data-driven evaluation to evaluate effectiveness of policies, strategies, and programs. Additional state-level programs are coordinated through the existing statewide injury coordinating group. The leading causes of injury are addressed. Motor vehicle crashes are fully integrated into the state injury control system. Decrease in occurrence and rate of motor vehicle deaths and serious injuries in participating communities and statewide by 3 percent.</td>
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## Health Priority: Intentional and Unintentional Injuries and Violence
### Objective 2: Motor Vehicle Related Injuries and Death (Logic Model)

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<td>Wisconsin professional staff and county program specialists; police, sheriff, and state patrol; and professional, volunteer, and advocacy organizations.</td>
<td>Level, developing standards for data reporting, and publishing these in a timely fashion.</td>
<td>The committee will assist in identifying high-risk populations and locations for all types of injury based upon injury data and will promote the publication of this information in a timely fashion.</td>
<td>The committee will promote effective strategies and will distribute information about best practices in injury control.</td>
<td>The Department of Transportation and the Division of Public Health, Bureau of EMS and Injury Prevention will collaborate to develop standards for the Safe Communities model.</td>
<td>Fifty percent more communities in Wisconsin will have effective Safe Community Model coalitions in place.</td>
<td>Decrease in occurrence of injury crashes in participating communities by 5 percent.</td>
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<td>Material: Free printed materials; free local videos and costumes.</td>
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<td>State-level coordination of injury, programs, and resources are institutionalized within the Division of Public Health, Bureau of EMS and Injury Prevention.</td>
<td>Statewide decrease in injury crash occurrence by 5 percent.</td>
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<td>Facilities: Hospitals, clinics, and public safety facilities.</td>
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<td>State agencies, such as the Department of Transportation and Department of Health and Family Services, share strategic resources by means of institutionalized injury program coordination.</td>
<td>Statewide decrease in work-related motor vehicle fatalities by 5 percent.</td>
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<td>Data: Department of Transportation annual crash data and evaluations; driver license and vehicle registration data; travel and roadway data; Department of Health and Family Services hospital discharge data and hospital emergency room department data; Occupational fatality data; Department of Public Instruction Youth Risk Behavior Surveillance Survey Data; census data; Department of Justice</td>
<td>The committee, in collaboration with the Department of Transportation, will develop standards for the Safe Communities Model.</td>
<td>Member organizations will support the development of injury coalitions meeting state standards at the county and municipal level.</td>
<td>A statewide injury prevention coordinating group facilitated by the Division of Public Health, Bureau of EMS and Injury Prevention distributes “best practices” of coordinated</td>
<td></td>
<td>Decrease in deaths and serious injuries to high-risk populations and those involved in high-risk behaviors: youthful drivers, elderly vehicle occupants, Native Americans, pick-up truck drivers, motorcycle riders, pedestrians, rural roadway users, impaired drivers, speeders, those not wearing safety belts, and</td>
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**Health Priority: Intentional and Unintentional Injuries and Violence**  
**Objective 2: Motor Vehicle Related Injuries and Death (Logic Model)**

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<td>uniform crime report data; various opinion and observation surveys; and local and national data.</td>
<td>coalition oversight and evaluation of grant effectiveness as a condition of receiving injury grants.</td>
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<td>community action as developed in the Safe Communities Model.</td>
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<td>drivers and workers in highway construction and maintenance work zones.</td>
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<td><strong>Linkages to Programs/Special Initiatives:</strong> Occupant protection; child passenger safety; alcohol and other drug prevention programs; youth alcohol/risk prevention programs; traffic law enforcement; safety data improvements; emergency medical services; motorcycle safety; pedestrian safety and bicycle safety programs; pupil transportation safety; large truck safety; and community and corridor safety programs.</td>
<td>The committee will discover, develop, and make available coalition and community-building training as needed for local coalition development.</td>
<td></td>
<td>Participating agencies, federal, state, and local, permit grant funds to be used for a wide variety of program strategies proven to be effective. The statewide injury coordinating group coordinates the development and distribution of motor vehicle injury data in a user-friendly format related to other injury data.</td>
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<td>Learn about successful strategies from other sectors: Engineering; enforcement and enactment; education; empowerment; evaluation; economic incentives; and emergency response.</td>
<td>The committee will assist with annual evaluations of the state injury program and project effectiveness including dissemination of results; promote the collection of aggregate program and project data from communities; disseminate aggregate data and best practices on a regular basis.</td>
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<td>Local coordinated injury coalitions (utilizing the Safe Communities model) are organized in 10 more communities across the state (5 per year x 2 years).</td>
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<td>Coordination of member organization activities will increase as strategic resources and effective strategies are identified, and areas of effective collaboration become the norm.</td>
<td>Additional organizations with a role in injury prevention and control will be brought to the committee as important resources.</td>
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<td>Coalition building and maintenance skills are improved at both state and local levels.</td>
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<td>Data collection and analysis skills are improved at both state and local levels.</td>
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<tr>
<td>Other: Training; assessment; outreach; community program assistance; technical support; and data collection and analysis.</td>
<td>The committee will recommend standards for collection of additional injury data and will regularly include such data in reports. For all highway safety programs (e.g., occupant protection, child passenger safety, alcohol and other drugs, youth alcohol/risk prevention, traffic law enforcement, safety data improvements, emergency medical services, motorcycle safety, pedestrian safety, bicycle safety, pupil transportation safety, large tuck safety, and community and corridor safety programs). For all effective strategies (Engineering, Enforcement, Enactment, Education, Empowerment, Evaluation, Economic Incentives, Emergency Response). As needed activities including training, assessment, outreach, community program assistance, technical support, data collection and analysis. The number and variety of community-coalition driven</td>
<td>Increase to 30 communities that have effective injury coalitions in place. [Note: Current status reflects that as of the year 2000, twenty communities have effective injury coalitions in place. Project an increase of five new effective injury coalitions in place each year for two years.]</td>
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### Health Priority: Intentional and Unintentional Injuries and Violence

**Objective 2: Motor Vehicle Related Injuries and Death (Logic Model)**

|--------|---------|------------|---------------------|----------------------|----------------------|---------------------|

- Programs will be increased by 50 percent.
- Multiple and overlapping strategies will be coordinated to achieve the greatest effectiveness for behavior change.
- Local strategic resources will be used in the most efficient and effective manner due to coordination.
- Local evaluation of project effectiveness and cost-effectiveness will result in more effective use of resources in programs that actually affect knowledge, attitudes, and behaviors resulting in fewer crashes, injuries, and deaths.
Health Priority: Intentional and Unintentional Injuries and Violence
Objective 2: Motor Vehicle-Related Injuries and Death (Template)

Long-term (2010) Subcommittee Outcome Objectives

2a: By 2010, the rate of motor vehicle crash-related deaths and incapacitating injuries will be 104 per 100,000 population.

2b: By 2010, the rate of fatality and incapacitating injuries will be 9.4 per hundred million vehicle miles traveled.

2c: By 2010, the age-adjusted overall motor vehicle death rate will be 14.0 per 100,000 population.

Long-term outcome objective updated as of: Sept 2004

<table>
<thead>
<tr>
<th>Wisconsin Baseline</th>
<th>Wisconsin Sources and Year</th>
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<tbody>
<tr>
<td>Rate of motor vehicle crash-related deaths and serious injuries was 135 per 100,000 population in 2000.</td>
<td>Department of Transportation Five Year Summary of Motor Vehicle Crashes – July 2002</td>
</tr>
<tr>
<td>Rate of fatality and incapacitating injuries per hundred million vehicle miles travel was 12.6 in 2000.</td>
<td>Department of Transportation Five Year Summary of Motor Vehicle Crashes – July 2002</td>
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<tr>
<td>Age-adjusted overall motor vehicle death rate was 16.5 per 100,000 in 2000.</td>
<td>WISQARS Injury Mortality Report</td>
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<tr>
<td>In 2000, there were a total of 43,145 injury crashes, 718 of these were fatal.</td>
<td>Department of Transportation Drivers and Vehicles Final Year Crash Statistics (2002 crash statistics with comparison to prior years).</td>
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<tr>
<td>In 2000, there were a total of 1,657 pedestrian crashes, 50 of these were fatal.</td>
<td>Department of Transportation Drivers and Vehicles Final Year Crash Statistics (2002 crash statistics with comparison to prior years).</td>
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<tr>
<td>In 2000, there were a total of 9,096 alcohol-related crashes, 301 of these were fatal.</td>
<td>Department of Transportation Drivers and Vehicles Final Year Crash Statistics (2002 crash statistics with comparison to prior years).</td>
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<tr>
<td>36 work related deaths from motor vehicle related crashes; 30% of all work-related fatalities.</td>
<td>Department of Health and Family Services, 2000</td>
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<tr>
<td><strong>Federal/National Baseline</strong></td>
<td><strong>Federal/National Sources and Year</strong></td>
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<td>15.6 deaths per 100,000 population (age-adjusted)</td>
<td><em>Healthy People 2010</em>, November 2000, United States Department of Health and Human Services</td>
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<tr>
<td>1.6 deaths per 100 million vehicle miles traveled</td>
<td><em>Healthy People 2010</em>, November 2000, United States Department of Health and Human Services</td>
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<tr>
<td>1,181 nonfatal injuries per 100,000 population were caused by motor vehicle crashes in 1998.</td>
<td><em>Healthy People 2010</em>, November 2000, United States Department of Health and Human Services</td>
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<td>69% of the total population used safety belts in 1998</td>
<td><em>Healthy People 2010</em>, November 2000, United States Department of Health and Human Services</td>
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<td>92% of motor vehicle occupants aged 4 years and under in 1998 used child restraints.</td>
<td><em>Healthy People 2010</em>, November 2000, United States Department of Health and Human Services</td>
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<td>67% of motorcycle operators and passengers used helmets in 1998.</td>
<td><em>Healthy People 2010</em>, November 2000, United States Department of Health and Human Services</td>
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<td>0.7 occupational motor-vehicle fatalities per 100,000 workers.</td>
<td>Worker Traffic-Related Motor Vehicle Crashes, July 1998, United States Department of Health and Human Services</td>
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<td>5.9 alcohol related deaths per 100,000 population</td>
<td><em>Healthy People 2010</em>, November 2000, United States Department of Health and Human Services</td>
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<tr>
<td>113 alcohol related injuries per 100,000 population</td>
<td><em>Healthy People 2010</em>, November 2000, United States Department of Health and Human Services</td>
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<td>33% of students in grades 9 through 12 reported in 1999 riding during the previous 30 days with a driver who had been drinking alcohol.</td>
<td>Youth Risk Behavioral Surveillance System, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention &amp; Health Promotion as cited in <em>Healthy People 2010</em>, November 2000, United States Department of Health and Human Services</td>
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<tr>
<td>41 states and District of Columbia in 1998 have administrative license revocation laws for persons who drive under the influence of intoxicants.</td>
<td>U.S. Department of Transportation National Highway Traffic Safety Administration, as cited in <em>Healthy People 2010</em>, November 2000, United States Department of Health and Human Services</td>
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</table>
### Federal/National Sources and Year

16 states in 1998 had legal requirements for maximum blood alcohol concentration level of 0.08% for motor vehicle drivers aged 21 years and older.


### Related USDHHS *Healthy People 2010* Objectives

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Goal</th>
<th>Objective Number</th>
<th>Objective Statement</th>
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<tbody>
<tr>
<td>15-Injury Prevention</td>
<td>Reduce injuries, disabilities, and deaths due to unintentional injuries and violence.</td>
<td>15-15</td>
<td>Reduce deaths caused by motor vehicle crashes.</td>
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<td>15-16</td>
<td>Reduce pedestrian deaths on public roads.</td>
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<td>15-17</td>
<td>Reduce nonfatal injuries caused by motor vehicle crashes.</td>
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<td>15-18</td>
<td>Reduce nonfatal pedestrian injuries on public roads.</td>
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<td>15-19</td>
<td>Increase use of safety belts.</td>
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<td>15-20</td>
<td>Increase use of child restraints.</td>
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<td>15-21</td>
<td>Increase the proportion of motorcyclists using helmets.</td>
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<td>15-22</td>
<td>Increase the number of States and the District of Columbia that have adopted a graduated driver licensing model law.</td>
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<td>15-23</td>
<td>(Developmental) Increase use of helmets by bicyclists.</td>
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<td>15-24</td>
<td>Increase the number of States and the District of Columbia with laws requiring bicycle helmets for bicycle riders.</td>
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<td>20 – Occupational Safety and Health</td>
<td>Promote the health and safety of people at work through prevention and early intervention.</td>
<td>20-1</td>
<td>Reduce deaths from work-related injuries.</td>
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<td>Chapter</td>
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<td>26 – Substance Abuse</td>
<td>Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.</td>
<td>26-1</td>
<td>Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes.</td>
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<td>26-24</td>
<td>Extend administrative license revocation laws, or programs of equal effectiveness, for persons who drive under the influence of intoxicants.</td>
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<td>26-25</td>
<td>Extend legal requirements for maximum blood alcohol concentration levels of 0.08 percent for motor vehicle drivers aged 21 years and older.</td>
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### Definitions

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<td>Motor vehicle related deaths and injuries</td>
<td>Defined by Wisconsin Statutes {Sec.346.70, 346.70(1)} as those occurring in a crash on a Wisconsin traffic way, involving at least one motor vehicle in transport and resulting in injury or death to any person, or damage to any property. In 2000, the reporting threshold was $1,000 damage to any one person’s property. The existence and severity of injury (fatal, incapacitating, non-incapacitating, possible, or unknown defined by ANSI D.16 and ANSI D.21) is determined at the site by the reporting law enforcement officer. Fatalities are counted if the injured person dies within 30 days of the crash and state-level data are available approximately 3 months after the quarter in which the crash occurred. Incapacitating injuries are those in which the victim was transported from the scene or appeared to the reporting officer to be severely injured. Note: Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services, data differs slightly from the Department of Transportation data used here. Death is not limited to 30 days post crash and severity information is not quantified.</td>
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<tr>
<td>Term</td>
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<td>Causation</td>
<td>Motor vehicle deaths and serious injuries are the results of collisions in which the forces involved are extreme or in which human behavior creates additional risk of injury. Crash causation is multi-factorial, resulting from a mixture of human, environmental, and vehicle factors, each of which can be affected by multiple disciplines at state and local government and individual action.</td>
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<td>State leadership and facilitation</td>
<td>The Department of Transportation, Bureau of Transportation Safety, serves as the State Highway Safety Office required by federal law for the acceptance and distribution of state and community highway safety grant funds. The Department of Natural Resources is responsible for enforcement of laws governing off-road or recreational motor vehicles. The Department of Health and Family Services is responsible for programs affecting all types of injury, and the Department of Public Instruction governs school injury. The Department of Justice trains traffic enforcement officers.</td>
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<td>Safe community model</td>
<td>This is a model comprised of partnerships in a community that develop, implement, and evaluate safety strategies based upon a data-driven, inclusive, multidisciplinary and performance-based decision-making process. Studies have shown that self-directed safety programs at the local level have greater and more long-lasting effects than programs developed at the state level and delivered to the community. Models for coordinated, data-driven health and safety programs are well-known and several have been applied here. In 2000, fewer than 20 “Safe Community” coalitions were active in Wisconsin, and no standards or coordinated state program existed.</td>
</tr>
<tr>
<td>Local Programs</td>
<td>At the local level, the organization of programs affecting injury is similarly fragmented and may vary from county to county or in adjacent municipalities, depending upon local knowledge, political will and access to strategic resources. Since 1995, a number of Wisconsin communities have begun organizing local injury coalitions in order to make most effective use of their limited local resources.</td>
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<td>Wisconsin’s public health system</td>
<td>Public health is defined as a system, a social enterprise, whose focus is on the population as a whole. The public health system seeks to extend the benefits of current knowledge in ways that will have maximum impact on the health status of the entire population (Turnock, <em>Healthiest Wisconsin 2010</em>, January 2001). The public health system is comprised of many partners that include state and local health departments, government, the public, private, nonprofit, and voluntary sectors. These partners include traditional sectors (physicians, emergency rooms) and new non-traditional sectors (faith communities).</td>
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**Rationale:**

Motor vehicle related injuries are the leading cause of injury death in Wisconsin and nationally they account for more than half of all unintentional deaths (*Healthy People 2010*). In 1998, 712 (37 percent) of a total of 1,924 injury deaths were motor-vehicle related; for many years it has been the leading cause of injury death for all ages from 1 through 65, and, because of their disproportionate effect on the young are the leading cause of years of potential life lost. Forty-five percent of traumatic brain injuries resulted from motor vehicle collisions. In 1998, hospital charges associated with motor
vehicle crash injury totaled over $50 million and the total estimated economic cost of deaths and incapacitating injuries from motor vehicle crashes was over $1 billion.

At-risk groups for disproportionate crash involvement and injury experience are young drivers (ages 15-20), elderly drivers, and those engaging in high-risk behaviors. Only 40 percent of hospitalized crash victims used safety belts, although statewide average belt use was 61 percent. In 1998, 282 deaths and 1,665 serious injuries were alcohol related; 209 deaths and 1,774 serious injuries were speed related; 116 deaths and 605 injuries occurred in crashes involving large trucks; 64 pedestrians died and 450 were seriously injured; 54 motorcycle riders died and 631 were seriously injured; and 11 bicycle riders died and 189 were injured. Rural crashes resulted in worse outcomes than urban crashes.

Wisconsin, like the rest of the nation, has experienced falling death and injury rates from motor vehicle crashes since the 1980s. In the past few years the downward curve has flattened and both numbers and rates have begun to rise. Causes for the 20-year decline include improved highway and vehicle design and safety equipment, demographic changes decreasing the number and percent in the highest risk age categories, and changes in social mores and laws about behaviors such as impaired driving, safety equipment use, etc.

The demographic trends toward increasing numbers of elderly drivers, as well as increasing roadway congestion with increased speeds and greater vehicle incompatibility may be responsible for some of the upward trend in deaths seen in the past few years.

Motor vehicle crashes remain a major public health problem. They are the leading cause of death for persons in the United States aged 5 to 29 years. In 1998, 41,471 persons died in motor vehicle crashes. Thirty-eight percent of these deaths occurred in alcohol-related crashes. The motor vehicle death rate per 100,000 persons is especially high among persons aged 16 to 24 years and persons aged 75 years and older. Safety belts, when worn correctly, are the most effective way for occupants to reduce the risk of death and serious injury in a motor vehicle crash on public roads (including those on Indian Reservations). As of December 1998, the national safety belt use rate was 69 percent.

In 1998, 69,000 pedestrians were injured and 5,220 were killed in traffic crashes in the United States. On average, a pedestrian is killed in a motor vehicle crash every 101 minutes, and one is injured every 8 minutes.

In 1998, persons aged 70 years and older made up 9 percent of the population but accounted for 14 percent of all traffic fatalities and 18 percent of all pedestrian fatalities. Compared with the fatality rate for drivers aged 25 through 69 years, the rate for drivers in the oldest group is 9 times higher. Older persons also are more susceptible than younger persons to medical complications following motor vehicle crash injuries. Thus, they are more likely to die from their injuries.

Fewer persons aged 70 years and older are licensed to drive, compared to younger persons, and they drive fewer miles per licensed driver. Persons in this older age group, however, have higher rates of fatal crashes per mile driven, per 100,000 persons, and per licensed driver than any other group except young drivers (aged 16 to 24 years).
Pedestrians account for about 13 percent of motor vehicle deaths. The problem of pedestrian deaths and injuries is worse among young children and older adults. Children are more likely to be injured, while older adults are more likely to die in pedestrian crashes.

As of December 1997, 49 states had safety belt laws. Eleven states had primary enforcement laws, and the remaining 38 states had secondary enforcement laws. In 1998, the average observed belt use rate by states with secondary enforcement laws was 62 percent, compared to 79 percent in states with primary enforcement laws.

Among children aged 1 to 14 years, crash injuries are the leading cause of death. In 1998, 2,549 children aged 14 years and under died in motor vehicle crashes. The use of age-appropriate restraint systems can reduce this problem. Because all states have child restraint laws, more children now ride restrained. But loopholes in the laws exempt many children from coverage under either safety belt or child restraint use laws. Another problem is the persistence of incorrectly used child restraints and safety belts.

Motorcycles are less stable and less visible than cars, and they have high-performance capabilities. When motorcycles crash, their riders lack the protection of an enclosed vehicle, so they are more likely to be injured or killed. The number of deaths on motorcycles per mile traveled is about 16 times the number of deaths in cars. Wearing a motorcycle helmet reduces the chances of dying in a motorcycle crash by 29 percent and reduces the chances of brain injury by 67 percent. An "unhelmeted" rider is 40 percent more likely to suffer a fatal head injury, compared with a helmeted rider. In 1998, 2,284 motorcyclists died in crashes.

Teenagers accounted for 10 percent of the U.S. population in 1997 and 15 percent of the motor vehicle deaths. In 1998, 3,427 drivers aged 15 to 20 years were killed, and an additional 348,000 were injured in motor vehicle crashes. Graduated licensing laws allow a young driver to gain driving experience at incremental levels. Graduated licensing is a system for phasing in on-road driving that allows beginners to obtain their initial experience under lower risk conditions.

The National Committee on Uniform Traffic Laws and Ordinances has developed a model law that calls for a minimum of 6 months in the learner stage and a minimum of 6 months in the intermediate license stage with night driving restrictions. Twenty-three states have all the core provisions of the model graduated licensing model law developed by the National Committee on Uniform Traffic Laws and Ordinances. This model also requires applicants for intermediate and full licenses to have no safety belt or zero tolerance violations and to be conviction-free during the mandatory holding periods.

Outcomes:

**Short-term Outcome Objectives (2002-2004)**

- The Department of Transportation, through its Safe Communities Program, in partnership with the Division of Public Health, Bureau of Emergency Medical Services (EMS) and Injury Prevention will identify Wisconsin communities who want to decrease motor vehicle related deaths and serious injuries in their communities.
- Division of Public Health will provide leadership to link the Safe Communities model to the Community Health Improvement Processes and Plans currently underway or being planned in these local communities.
- The Department of Transportation and the Division of Public Health, Bureau of EMS and Injury Prevention will collaborate to develop standards for the Safe Communities model.
State-level coordination of injury, programs, and resources are institutionalized within the Division of Public Health, Bureau of EMS and Injury Prevention.

State agencies, such as the Department of Transportation and Department of Health and Family Services, share strategic resources by means of institutionalized injury program coordination.

A statewide injury prevention coordinating group facilitated by the Division of Public Health, Bureau of EMS and Injury Prevention distributes “best practices” of coordinated community action as developed in the Safe Communities Model.

Participating agencies, federal, state, and local, permit grant funds to be used for a wide variety of program strategies proven to be effective.

The statewide injury coordinating group coordinates the development and distribution of motor vehicle injury data in a user-friendly format related to other injury data.

Local coordinated injury coalitions (utilizing the Safe Communities model) are organized in 10 more communities across the state (5 per year x 2 years).

Coalition building and maintenance skills are improved at both state and local levels.

Data collection and analysis skills are improved at both state and local levels.

Increase to 30 communities that have effective injury coalitions in place. [Note: Current status reflects that as of the year 2000, twenty communities have effective injury coalitions in place. Project an increase of five new effective injury coalitions in place each year for two years.]

**Inputs:** (What we invest – staff, volunteers, time money, technology, equipment, etc.)

- **Funds:** Highway safety grant funds; Federal Maternal and Child Health Block Grant; Preventive Health and Health Services Block Grant; State-Level Injury grant funds; and volunteer and advocacy organization funds
- **Personnel:** State Highway Safety Office program specialists; analysts and community outreach; state injury, emergency medical services and trauma system staff; Department of Health and Family Services occupational safety staff; Wisconsin Division of Health Care Financing, Bureau of Health Information; local health departments and their partners; University of Wisconsin Cooperative Extension; University of Wisconsin professional staff and county program specialists; police, sheriff, and state patrol; and professional, volunteer, and advocacy organizations.
- **Material:** Free printed materials; free local videos and costumes.
- **Facilities:** Hospitals, clinics, and public safety facilities.
- **Data:** Department of Transportation annual crash data and evaluations; driver license and vehicle registration data; travel and roadway data; Department of Health and Family Services hospital discharge data and hospital emergency room department data; Occupational fatality data; Department of Public Instruction Youth Risk Behavior Surveillance Survey Data; census data; Department of Justice uniform crime report data; various opinion and observation surveys; and local and national data.
- **Linkages to Programs/Special Initiatives:** Occupant protection; child passenger safety; alcohol and other drug prevention programs; youth alcohol/risk prevention programs; traffic law enforcement; safety data improvements; emergency medical services; motorcycle safety; pedestrian safety and bicycle safety programs; pupil transportation safety; large truck safety; and community and corridor safety programs.

**Learn about successful strategies from other sectors:** Engineering; enforcement and enactment; education; empowerment; evaluation; economic incentives; and emergency response.
• *Other:* Training; assessment; outreach; community program assistance; technical support; and data collection and analysis.

**Outputs:** *(What we do – workshops, meetings, product development, training. Who we reach– community residents, agencies, organizations, elected officials, policy leaders, workers and employers, etc.)*
- Department of Health and Family Services will organize an interdisciplinary and intersectoral State Injury Coordinating Committee that will provide input into the oversight and publication of injury prevention and control efforts throughout Wisconsin’s public health system.
- The committee will include both public and private agencies and organizations, professional organizations, safety committees, and volunteer and benevolent groups, who have been educated to understand their role in coordinated injury prevention and control.
- The committee will serve as a coordinating group for injury and injury control information.
- The committee will provide input into identifying injury data needs and resources at the state and local levels, developing standards for data reporting, and publishing these in a timely fashion.
- The committee will assist in identifying high-risk populations and locations for all types of injury based upon injury data and will promote the publication of this information in a timely fashion.
- The committee will promote effective strategies and will distribute information about best practices in injury control.
- The committee will coordinate its activities with requirements of its participants for planning and resource allocation.
- The committee, in collaboration with the Department of Transportation, will develop standards for the Safe Communities Model.
- Member organizations will support the development of injury coalitions meeting state standards at the county and municipal level. Member organizations will require coalition oversight and evaluation of grant effectiveness as a condition of receiving injury grants.
- The committee will discover, develop, and make available coalition and community-building training as needed for local coalition development.

**Participants/Reach:**
- State agencies and organizations: health care, public safety, enforcement, planning, engineering
- Professional organizations
- Committees/coalitions: TRCC, WHSP, WSBC, MADD, volunteer and benevolent groups
- Local agencies, Tribes, and organizations: health care, public safety, enforcement, planning, engineers
- Volunteer and community groups
- Committees/coalitions: public safety, public health, community development

**High-risk populations Identified:** With crash data by age, gender, location, outcome. Identified with other data for ethnic groups.
Medium-term Outcome Objectives (2005-2007)

- State coordinating group provides input and assists in the development of a data-driven evaluation to evaluate effectiveness of policies, strategies, and programs.
- Additional state-level programs are coordinated through the existing statewide injury coordinating group. The leading causes of injury are addressed. Motor vehicle crashes are fully integrated into the state injury control system.
- Decrease in occurrence and rate of motor vehicle deaths and serious injuries in participating communities and statewide by 3 percent.
- Fifty percent more communities in Wisconsin will have effective Safe Community Model coalitions in place.

Inputs: *(What we invest – staff, volunteers, time money, technology, equipment, etc.)*

- **Funds:** Highway safety grant funds; Federal Maternal and Child Health Block Grant, Preventive Health and Health Services Block Grant; state-level injury grant funds; and volunteer and advocacy organization funds
- **Personnel:** State Highway Safety Office program specialists, analysts and community outreach; state injury, emergency medical services and trauma system staff; Department of Health and Family Services Occupational Safety staff; Wisconsin Division of Health Care Financing, Bureau of Health Information; local health departments and their partners; University of Wisconsin Cooperative Extension; University of Wisconsin professional staff and county program specialists; police, sheriffs, and state patrol; and professional, volunteer, and advocacy organizations.
- **Material:** Free printed materials; free local videos and costumes.
- **Facilities:** Hospitals, clinics, and public safety facilities.
- **Data:** Department of Transportation annual crash data and evaluations; driver license and vehicle registration data; travel and roadway data; Department of Health and Family Services hospital discharge data and hospital emergency room department data; occupational fatality data; Department of Public Instruction Youth Risk Behavior Surveillance Survey data; census data; Department of Justice uniform crime report data; various opinion and observation surveys; and local and national data.
- **Linkages to Programs/Special Initiatives:** Occupant protection; child passenger safety; alcohol and other drug prevention programs; youth alcohol/risk prevention programs; traffic law enforcement; safety data improvements; emergency medical services; motorcycle safety; pedestrian safety and bicycle safety programs; pupil transportation safety; large truck safety; and community and corridor safety programs.
- **Learn about successful strategies from other sectors:** Engineering; enforcement and enactment; education; empowerment; evaluation; economic incentives; and emergency response.
- **Other:** Training; assessment; outreach; community program assistance; technical support; and data collection and analysis.
Outputs: *(What we do – workshops, meetings, product development, training. Who we reach–community residents, agencies, organizations, elected officials, policy leaders, etc.)*

- The committee will assist with annual evaluations of the state injury program and project effectiveness including dissemination of results; promote the collection of aggregate program and project data from communities; disseminate aggregate data and best practices on a regular basis.
- Coordination of member organization activities will increase as strategic resources and effective strategies are identified, and areas of effective collaboration become the norm.
- Additional organizations with a role in injury prevention and control will be brought to the committee as important resources.
- The committee will recommend standards for collection of additional injury data and will regularly include such data in reports.

Long-term Outcome Objectives (2008-2010)

- Decrease in occurrence of injury crashes in participating communities by 5 percent.
- Statewide decrease in injury crash occurrence by 5 percent.
- Improved crash outcome: 12 percent fewer deaths and serious injuries statewide.
- Statewide decrease in work-related motor vehicle fatalities by 5 percent.
- Decrease in deaths and serious injuries to high-risk populations and those involved in high-risk behaviors: youthful drivers, elderly vehicle occupants, Native Americans, pick-up truck drivers, motorcycle riders, pedestrians, rural roadway users, impaired drivers, speeders, those not wearing safety belts, and drivers and workers in highway construction and maintenance work zones.

Inputs: *(What we invest – staff, volunteers, time money, technology, equipment, etc.)*

- **Funds:** Highway safety grant funds; Federal Maternal and Child Health Block Grant, Preventive Health and Health Services Block Grant; state-level injury grant funds; and volunteer and advocacy organization funds
- **Personnel:** State Highway Safety Office program specialists, analysts and community outreach; state injury, emergency medical services and trauma system staff; Department of Health and Family Services Occupational Safety staff; Wisconsin Division of Health Care Financing, Bureau of Health Information; local health departments and their partners; University of Wisconsin Cooperative Extension; University of Wisconsin professional staff and county program specialists; police, sheriffs, and state patrol; and professional, volunteer, and advocacy organizations.
- **Material:** Free printed materials; free local videos and costumes.
- **Facilities:** Hospitals, clinics, and public safety facilities.
- **Data:** Department of Transportation annual crash data and evaluations; driver license and vehicle registration data; travel and roadway data; Department of Health and Family Services hospital discharge data and hospital emergency room department data; occupational fatality data; Department of Public Instruction Youth Risk Behavior Surveillance Survey data; census data; Department of Justice uniform crime report data; various opinion and observation surveys; and local and national data.
Activities include:

- For all highway safety programs (e.g., occupant protection, child passenger safety, alcohol and other drugs, youth alcohol/risk prevention, traffic law enforcement, safety data improvements, emergency medical services, motorcycle safety, pedestrian safety, bicycle safety, pupil transportation safety, large tuck safety, and community and corridor safety programs).
- For all effective strategies (Engineering, Enforcement, Enactment, Education, Empowerment, Evaluation, Economic Incentives, Emergency Response).
- As needed activities including training, assessment, outreach, community program assistance, technical support, data collection and analysis.

Outputs: *(What we do – workshops, meetings, product development, training. Who we reach – community residents, agencies, organizations, elected officials, policy leaders, etc.)*

- The number and variety of community-coalition driven programs will be increased by 50 percent.
- Multiple and overlapping strategies will be coordinated to achieve the greatest effectiveness for behavior change.
- Local strategic resources will be used in the most efficient and effective manner due to coordination.
- Local evaluation of project effectiveness and cost-effectiveness will result in more effective use of resources in programs that actually affect knowledge, attitudes, and behaviors resulting in fewer crashes, injuries, and deaths.

Evaluation and Measurement
Success in achieving the 2010 outcome objective will be determined by evaluation of crash and medical data, with standard measures and rates used for all types of injury. Intervening factors (which include factors such as vehicle type, vehicle mix, roadway design, roadside vegetation, physical/medical condition, safety equipment use and the like, that change the outcome of the crash) will be isolated and their influence will be determined to the greatest extent possible. It will require linking and analyzing current databases in key state agencies to include the Department of Health and Family Services, Department of Transportation, Department of Public Instruction, Department of Administration, and the Department of Justice. Data development will be needed in key areas to include pre-hospital and emergency data. Evaluation and measurement will also require evaluating local community capacity, including training, to implement and link the Safe Communities Model to the Community Health Improvement Model used by local health departments and their partners.

Crosswalk to Other Health and System Priorities in Healthiest Wisconsin 2010
*Alcohol and Other Substance Use and Addiction*: Many motor vehicle related crashes and deaths involve alcohol and addictive substances.

*Environmental and Occupational Health Hazards*: Motor vehicle crashes are one of the leading causes of deaths to workers while on the job.

*Integrated Electronic Data and Information Systems*: Comprehensive data and information that are linked and analyzed are critical to the prevention and control of injuries and deaths due to motor...
vehicle and related crashes. It is important to remember that data development in new areas, such as pre-hospital and emergency room data, are equally important.

Community Health Improvement Processes and Plans: Assessing need, developing priorities, and taking action by the community requires a comprehensive view. It will be important that community assessment and development efforts to reduce motor-vehicle deaths and injuries are integrated into the larger community health improvement efforts required of local health departments, boards of health, and their partners as set forth in Ch. 251, Wis. Stats.

Significant Linkages to Wisconsin’s 12 Essential Public Health Services

Monitor health status to identify community health problems: State and local health departments must provide leadership to assure that high quality data and information is available to the partners in order to take action.

Identify, investigate, control, and prevent health problems and environmental health hazards in the community: Given that substantial deaths and injuries are attributable to on-the-job motor vehicle related crashes, it is important that government and the private sector work together to decrease morbidity and mortality in the work site through multiple levels of prevention. Prevention efforts should include a combination of education, enforcement, and engineering controls. Companies and agencies with large fleets of motor vehicles can provide unique opportunities for researchers to study injury prevention strategies. It is important that such prevention efforts be culturally competent.

Educate the public about current and emerging health issues: All public health system partners have a responsibility to plan, develop, and sustain effective health education and social marketing campaigns that are data guided and built off current knowledge of evidence-based interventions to reduce death and injuries from motor vehicle related crashes.

Promote community partnerships to identify and solve health problems: Assessing need, developing priorities, and taking action by the community requires a comprehensive view. Inviting all partners to the table within a community is key to receiving buy-in that is necessary to identify and solve community health problems.

Create policies and plans that support individual and community health efforts: For traffic related preventive strategies to be effective and supported, a plan and policies are necessary through engineering, enforcement, enactment, education, empowerment, evaluation, economic incentives, and emergency response activities.

Enforce laws and regulations that protect health and insure safety: It has been shown with enactment, education, and enforcement, lives have been saved. (Examples: Implementation of the Graduated Driving License law in states such as Michigan has shown a reduction in youth deaths and injuries from motor vehicle related crashes. Moving from a secondary seat belt law in our state to a primary seat belt law could save 20 to 40 lives in one year.)

Connection to the Three Overarching Goals of Healthiest Wisconsin 2010

Protect and promote health for all: Integrate electronic data and information systems connecting Department of Transportation, Department of Health and Family Services, and Department of Justice data, integrate highway safety into community health improvement processes and plans, integrate
state-level highway safety activities across disciplines, and coordinate these with local level cross-discipline activities.

**Eliminate Health Disparities:** Decrease the disproportionate number and percent of injuries to rural highway users, youthful and elderly drivers, and Native Americans.

**Transform Wisconsin’s public health system:** Require collaboration for injury prevention and control at all levels of government and for all proposed activities, encouraging public and private as well as multi-disciplinary sharing of strategic resources.

**Key Interventions and/or Strategies Planned:**
- Increased electronic communication and enhanced injury data collection and linkages.
- Development of the statewide injury coordinating committee.
- Development of Safe Communities Projects integrating disciplines and based upon data.
- Institutionalization of coordinated state injury effort.
- Development of standards and publications of best practices.
- Development and distribution of community-level data – Internet query-based system.
- Training in coalition development, community development skills, data analysis.
References:


Wisconsin Department of Transportation, Alcohol Facts, 2001

Wisconsin Department of Transportation, Crash Facts, 2001.

Wisconsin Department of Transportation, Motorcycle Facts, 2001 Edition

Wisconsin Highway Safety Performance Plan, 2001

Wisconsin Highway Safety Strategic Plan, 2001
Health Priority: Intentional and Unintentional Injuries and Violence
Objective 3: Fall-Related Injuries and Death (Logic Model)

Long-term (2010) Subcommittee Outcome Objective:
3a: By 2010, the age adjusted fall death rate will be 9.0/100,000 population.

3b: Between 2000 and 2010, reduce the age-adjusted rate of hospitalizations due to falls.
Long-term outcome objective updated as of: Sept 2004

Future Interim Goal:
By 2005, there will be an increase in comprehensive falls prevention programs at the local/community level. Goal for 2010 is to look at comparative mortality and morbidity data from 2000 and 2010 (or the most recent year available) and show a decrease in overall falls death rates and hospitalizations.

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<td>Department of Health and Family Services, the Bureaus of Emergency Medical Services and Injury Prevention, Section on Aging, Long Term Care, and Resources; Family and Community Health; Occupational Health, local public health departments and aging offices, University of Wisconsin-Madison and Milwaukee and other committed partners will develop and implement an educational campaign to raise awareness, educate, and influence the 3 P’s—policymakers (local, county, state), direct care providers and general public on the impact of falls and need for falls prevention</td>
<td>The statewide initiative partners identified will develop and disseminate standardized presentation packages and educational materials on impact of falls, needs for fall prevention activities/programs, components and tools to be used in a comprehensive fall prevention program. The statewide falls prevention advisory workgroup will meet routinely to assist in coordination of falls prevention activities/programs and formation of local community and/or state coalitions. Technical support and promotion of data collection will be provided to communities and decision/policy makers. Approximately 25, or one third, of counties/communities will have received standardized and/or model materials and developed programs supporting the additional three falls clinics and comprehensive falls prevention program</td>
<td>The partners will provide education statewide to heighten awareness and increase knowledge on the impact of falls and falls prevention through a statewide media campaign developed by key partners and disseminated widely. Training by the partners will be provided for public health and health care professionals and volunteers in one third (25) of Wisconsin counties through improved communication and collaboration between professional associations with centers for higher learning and development of model curricula for health care professionals and allied healthcare providers to be</td>
<td>Additional resources such as Tribal, county, and locally--specific falls and falls prevention informational materials (such as in-home assessment and screening tools, curricula, and programs) are available and in use in one half (36) of Wisconsin counties, regions, and tribes. Emergency medical services and trauma registry data (inclusive of falls) is available by 2004. State falls advisory group (and/or injury coordinating group) provides input and assists in the development of a data-</td>
<td>Wisconsin will “fall off” the Centers for Disease Control and Prevention’s “Top 10 list” of states with the most deaths related to falls. Interdisciplinary falls clinics will exist across the state with at least one per Department of Health and Family Services’ region. Most counties in Wisconsin will have a comprehensive falls prevention program in place. (Comprehensive falls prevention programs will include the following: in home assessments, follow</td>
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<td>activities/programs. These same groups will develop and deliver training for professionals to educate them on impact of falls and falls prevention. Department of Health and Family Services, the Bureaus of Emergency Medical Services and Injury Prevention, Section on Aging, Long Term Care, and Resources; Family and Community Health; Occupational Health, and other interested parties will work to support community collaborations and provide falls prevention information to them and their policy/decision makers.</td>
<td>Activities: models—which include in-home assessments, follow up screenings, education of consumers, in home exercise, and home safety checks with improvements--in the state. Falls prevention curricula will begin to be introduced into schools of medicine, nursing, physical and occupational therapy, etc., in Wisconsin by key partners. Evaluation of falls prevention efforts will be enhanced due to improved access to falls data for partners and interested parties through the availability of falls data in the web-based query system, trauma registry, and emergency medical services data. Data indicates effectiveness of statewide falls prevention activities/programs in decreasing fall-related injuries and deaths by concentrating prevention efforts.</td>
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<td>Participation/Reach: providers to be incorporated into trainings/education models at institutes of higher learning, training videos of clinical and in-home assessments at the local community level. Local partners will promote and develop community coalitions building partnerships to improve access to assessment, screening, and intervention materials and training opportunities, provide resources to carry out programs, and identify best practice models. A statewide falls prevention advisory group will be established to assist with the overall coordination of education, training, data collection and analysis and achievement of statewide goals and objectives of the plan. The access and reporting of falls related data will improve through the</td>
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<td>Short-term 2002-2004: driven evaluation to evaluate effectiveness of programs and strategies. The injury web based query system is operational improving access to falls data by interested stakeholders.  The Bureau Emergency Medical Services and Injury Prevention, Section on Aging, Long Term Care, and Resources, will expand data surveillance to look at other noncaptured causes, location, etc.</td>
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<td>Medium-term 2005-2007: Model curricula of falls risk and prevention is initiated in five different centers/specialty education facilities for higher learning (Physical Therapy, Occupational Therapy, Nursing, Medical, Nutrition, and Vision) in Wisconsin. Balance and strengthening programs will be available to older adults in at least each Department of Health and Family Services’ region of the state. Web based query system for falls data will be available to provide systematic and timely data and information.</td>
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<td>Long-term 2008-2010: up screenings, education of consumers, exercise programs, and home safety checks with modifications.)</td>
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<td>Occupational Health; University of Wisconsin Madison and Milwaukee, and other interested parties will work to improve falls-related reporting, availability and access to data for communities and decision/policymakers.</td>
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<td>Wisconsin will see a reduction of injury and mortality from falls.</td>
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<td>State Advisory and community falls prevention coalitions will identify and promote model comprehensive falls prevention programs, standardized materials, and model falls prevention curricula for health and allied health professionals schools of higher learning.</td>
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<td>The Bureau of Emergency Medical Services and Injury Prevention, Section on Aging, Long Term Care, and Resources, in partnership with Bureau of Health Information will enhance the web based query system to provide increased falls-related injury/death data.</td>
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<td>Data is collected, analyzed, and accessible at the local, regional, and state levels as provided by the Bureau of Emergency Medical Services and Injury Prevention, Section on Aging, Long Term Care, and Resources, and Bureau of Health Information and other key partners.</td>
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Health Priority: Intentional and Unintentional Injuries and Violence
Objective 3: Fall-Related Injuries and Death (Template)

Long-term (2010) Subcommittee Outcome Objective:

3a: By 2010, the age adjusted fall death rate will be 9.0/100,000 population.

3b: Between 2000 and 2010, reduce the age-adjusted rate of hospitalizations due to falls.
Long-term outcome objective updated as of: Sept 2004

Future Interim Goal:
By 2005, there will be an increase in comprehensive falls prevention programs at the
local/community level. Goal for 2010 is to look at comparative mortality and morbidity data
from 2000 and 2010 (or the most recent year available) and show a decrease in overall falls
death rates and hospitalizations.

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<tr>
<th>Wisconsin Baseline</th>
<th>Wisconsin Sources and Year</th>
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<tr>
<td>In 2000, the Wisconsin’s age adjusted fall death rate was 10.8 per 100,000 population.</td>
<td>Web-based Injury Statistics Query and Reporting System Injury Mortality Report, 2000</td>
</tr>
<tr>
<td>In 2000, 44% of all injury hospitalizations were due to falls.</td>
<td>Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information Wisconsin Interactive Statistics on Health Query System, 2004</td>
</tr>
<tr>
<td>In 2000, 87% of all fall deaths were in the 65+ age groups.</td>
<td>Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information Wisconsin Interactive Statistics on Health Query System, 2004</td>
</tr>
<tr>
<td>In 2000, 73% of all fall-related injury hospitalizations were in the age groups 65+.</td>
<td>Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information Wisconsin Interactive Statistics on Health Query System, 2004</td>
</tr>
<tr>
<td>In 2000, 41% off all traumatic brain injury hospitalizations were due to falls.</td>
<td>Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information, 2000 Principal Diagnosis codes 800-801, 803-804, &amp; 850-854.19.</td>
</tr>
<tr>
<td>In 2000, falls were the underlying cause of 37% of all spinal cord injuries.</td>
<td>Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information, 2000 Principal Diagnosis codes 806 and 952.</td>
</tr>
</tbody>
</table>
### Wisconsin Baseline

<table>
<thead>
<tr>
<th>Wisconsin Sources and Year</th>
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</thead>
<tbody>
<tr>
<td>An average of 11 work-related fatalities per year (1992-2001) were due to falls from elevations. This is 10% of all work-related fatalities. An average of 2 fatalities per year were caused by slips and trips.</td>
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</tbody>
</table>

### Federal/National Baseline

<table>
<thead>
<tr>
<th>Federal/National Sources and Year</th>
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<tbody>
<tr>
<td>In 1997, 75.5 per 100,000 populations hospitalizations for nonfatal head injuries related to falls</td>
</tr>
<tr>
<td>In 1997, 4.8 per 100,000 population hospitalizations for nonfatal spinal cord injuries related to falls</td>
</tr>
<tr>
<td>4.5 deaths per 100,000 population (age-adjusted) were caused by falls in 1998</td>
</tr>
<tr>
<td>1,120.9 hip fractures in women 65+ years of age per 100,000 population and 563.1 hip fractures in men 65+ years of age per 100,000 population</td>
</tr>
<tr>
<td>Falls from elevations accounted for 10% of all work-related fatalities from 1980 through 1994, for an average annual fatality rate of .49 per 100,000 workers</td>
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</tbody>
</table>

### Related USDHHS Healthy People 2010 Objectives

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Goal</th>
<th>Objective Number</th>
<th>Objective Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>15--Injury Prevention</td>
<td>Reduce injuries, disabilities, and deaths due to unintentional injuries and violence.</td>
<td>15-1</td>
<td>Reduce hospitalizations for nonfatal head injuries.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15-2</td>
<td>Reduce hospitalizations for nonfatal spinal cord injuries.</td>
</tr>
<tr>
<td>Chapter</td>
<td>Goal</td>
<td>Objective Number</td>
<td>Objective Statement</td>
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<tr>
<td></td>
<td></td>
<td>15-27</td>
<td>Reduce deaths from falls.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15-28</td>
<td>Reduce hip fractures among older adults.</td>
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</tbody>
</table>

**Definitions**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Web-based query system</td>
<td>Internet site that allows user to make injury data requests or inquiries at a state and/or county level.</td>
</tr>
<tr>
<td>Falls Clinic</td>
<td>A specialized interdisciplinary clinic composed of nursing, physician, and social work, focusing on falls prevention and treatment of mobility disorders.</td>
</tr>
</tbody>
</table>

**Rationale:**

Within the Department of Health and Family Services, the Bureaus of Emergency Medical Services and Injury Prevention, Section on Aging, Long Term Care, and Resources; Family and Community Health; Occupational Health; local public health departments; University of Wisconsin-Madison and Milwaukee; and other interested public and private partners have been motivated to initiate a statewide effort to address the disproportionate number of falls and falls related injuries and deaths in Wisconsin. (There is no statutory language mandating this responsibility.)

Falls are one of the leading causes of severe, disabling, and costly injuries in Wisconsin. Falls accounted for one quarter of all Wisconsin hospitalizations in 1998 and were the second most common reason for hospitalization in all age groups except 75+ where falls were the leading cause of hospitalizations. In 1998, hospital stays due to falls lasted an average of 5.3 days and charges averaged $10,311 per patient. Altogether, fall-related hospitalizations cost more than $213 million in 1998, or about 20% of all hospitalization charges. Falls caused 14% of the hospitalizations of people under 65 years of age, and 39% of older people’s hospitalizations. Under the age of 14 years of age, 16% of hospitalizations were due to falls. Among those aged 0-4 years, falls account for 15% of hospitalizations. When hospitalizations in the aging population involved a hip fracture, they lasted slightly longer (6 days) and charges were somewhat higher ($13,444) on average.

Wisconsin’s rate of accidental death from falls has increased steadily over the past 10 years. Wisconsin ranks very high nationally in numbers of deaths per 100,000. Men suffer fatal falls more often than women. Also, older people die from falls more often than do younger people (although in Wisconsin falls are also a leading cause of hospitalization among youths). In Wisconsin, 90% of those who die from falls are age 60 and older.

Studies of traumatic brain injuries and spinal cord injuries in Wisconsin identify falls as the leading cause of these unintentional injuries. Falls were the underlying cause of 38% of all spinal cord injuries, with males sustaining about 3 times as many injuries as females. The proportion of spinal cord injuries that are due to falls increases with age. Among those aged 65 and over, more than two-thirds of all spinal cord injuries are caused by falls.

In 1998, 39% of all traumatic brain injury hospitalizations were due to falls (surpassed only by motor vehicle crashes, which accounted for 45%). Fall-related traumatic brain injury hospitalizations cost a total of $19,017,323 in 1998, or 30% of the cost of all traumatic brain injury hospitalizations. Compared to females, males have a greater number of traumatic brain injury hospitalizations due to falls. However, a larger share of women’s traumatic brain injuries are caused by falls (almost half, compared to just over one-third of men’s traumatic brain injuries). As with spinal cord injuries, the proportion of traumatic brain injuries attributed to falls increases with age.

For older adults, about 40% of nursing home admissions involve a fall or a tendency to fall due to physical instability. Even when a fall does not cause a specific injury, older adults who have fallen often become afraid of falling again. Fear of falling, declining quality of life, and ability to participate in community activities as well as decreased physical activity can result. Along with this consequent decrease in physical activity, there is a general loss of muscle tone, strength, flexibility, and balance. In this way even a moderately serious fall can set in motion a process of general physical decline leading to institutionalization.

An average of 11 Wisconsin workers die each year from falls from elevation (6 feet or over). Falls from ladders, scaffolds, buildings, trees, and silos were the most frequent causes. An average of 2 workers a year die as a result of slips and trips and falls to the same level. Over $44,000,000 is paid each year by Wisconsin Workers’ Compensation insurance carriers for claims due to non-fatal work-related falls.

Outcomes:
Short-term Outcome Objectives (2002-2004)
• The partners will provide education statewide to heighten awareness and increase knowledge on the impact of falls and falls prevention through a statewide media campaign developed by key partners and disseminated widely.
• Training by the partners will be provided for public health and health care professionals and volunteers in one third (25) of Wisconsin counties through improved communication and collaboration between professional associations with centers for higher learning and development of model curricula for health care professionals and allied healthcare providers.
to be incorporated into trainings/education models at institutes of higher learning, training videos of clinical and in-home assessments at the local community level.

- Local partners will promote and develop community coalitions building partnerships to improve access to assessment, screening, and intervention materials and training opportunities, provide resources to carry out programs, and identify best practice models.
- A statewide falls prevention advisory group will be established to assist with the overall coordination of education, training, data collection and analysis and achievement of statewide goals and objectives of the plan.
- The access and reporting of falls related data will improve through the education, training and coalition building efforts identified.

**Inputs:** *(What we invest – staff, volunteers, time money, technology, equipment, etc.)*

- Department of Health and Family Services, the Bureaus of Emergency Medical Services and Injury Prevention, Section on Aging, Long Term Care, and Resources; Family and Community Health; Occupational Health, local public health departments and aging offices, University of Wisconsin-Madison and Milwaukee and other committed partners will develop and implement an educational campaign to raise awareness, educate, and influence the 3 P’s—policymakers (local, county, state), direct care providers and general public on the impact of falls and need for falls prevention activities/programs. These same groups will develop and deliver training for professionals to educate them on impact of falls and falls prevention.
- Department of Health and Family Services, the Bureaus of Emergency Medical Services and Injury Prevention, Section on Aging, Long Term Care, and Resources; Family and Community Health; Occupational Health, and other interested parties will work to support community collaborations and provide falls prevention information to them and their policy/decision makers.
- Department of Health and Family Services, the Bureaus of Emergency Medical Services and Injury Prevention, Section on Aging, Long Term Care, and Resources; Family and Community Health; Occupational Health, University of Wisconsin Madison and Milwaukee, and other interested parties will work to improve falls-related reporting, availability and access to data for communities and decision/policymakers.

**Outputs:** *(What we do – workshops, meetings, product development, training. Who we reach–community residents, agencies, organizations, elected officials, policy leaders, etc.)*

- The statewide initiative partners identified will develop and disseminate standardized presentation packages and educational materials on impact of falls, needs for fall prevention activities/programs, components and tools to be used in a comprehensive fall prevention program.
- The statewide falls prevention advisory workgroup will meet routinely to assist in coordination of falls prevention activities/programs and formation of local community and/or state coalitions.
- Technical support and promotion of data collection will be provided to communities and decision/policy makers.
Medium-term Outcome Objectives (2005-2007)

• Additional resources such as Tribal, county, and locally-specific falls and falls prevention informational materials (such as in-home assessment and screening tools, curricula, and programs) are available and in use in one half (36) of Wisconsin counties, regions, and tribes.
• Emergency medical services and trauma registry data (inclusive of falls) is available by 2004.
• State falls advisory group (and/or injury coordinating group) provides input and assists in the development of a data-driven evaluation to evaluate effectiveness of programs and strategies.
• The injury web based query system is operational improving access to falls data by interested stakeholders.
• The Bureau Emergency Medical Services and Injury Prevention, Section on Aging, Long Term Care, and Resources, will expand data surveillance to look at other noncaptured causes, location, etc.

Inputs: (What we invest – staff, volunteers, time money, technology, equipment, etc.)
- State Advisory and community falls prevention coalitions will identify and promote model comprehensive falls prevention programs, standardized materials, and model falls prevention curricula for health and allied health professionals schools of higher learning.
- The Bureau of Emergency Medical Services and Injury Prevention, Section on Aging, Long Term Care, and Resources, in partnership with Bureau of Health Information will enhance the web based query system to provide increased falls-related injury/death data.

Outputs: (What we do – workshops, meetings, product development, training. Who we reach- community residents, agencies, organizations, elected officials, policy leaders, etc).
- Approximately 25, or one third, of counties/communities will have received standardized and/or model materials and developed programs supporting the additional three falls clinics and comprehensive falls prevention program models--which include in-home assessments, follow up screenings, education of consumers, in home exercise, and home safety checks with improvements--in the state.
- Falls prevention curricula will begin to be introduced into schools of medicine, nursing, physical and occupational therapy, etc., in Wisconsin by key partners.
- Evaluation of falls prevention efforts will be enhanced due to improved access to falls data for partners and interested parties through the availability of falls data in the web-based query system, trauma registry, and emergency medical services data.

Long-term Outcome Objectives (2008-2010)

• Wisconsin will “fall off” the Centers for Disease Control and Prevention’s “Top 10 list” of states with the most deaths related to falls.
• Interdisciplinary falls clinics will exist across the state with at least one per Department of Health and Family Services’ region.
• Most counties in Wisconsin will have a comprehensive falls prevention program in place. (Comprehensive falls prevention programs will include the following: in home assessments, follow up screenings, education of consumers, exercise programs, and home safety checks with modifications.)
• Model curricula of falls risk and prevention is initiated in five different centers/specialty education facilities for higher learning (Physical Therapy, Occupational Therapy, Nursing, Medical, Nutrition, and Vision) in Wisconsin.
• Balance and strengthening programs will be available to older adults in at least each Department of Health and Family Services’ region of the state.
• Web based query system for falls data will be available to provide systematic and timely data and information.
• Wisconsin will see a reduction of injury and mortality from falls.

Inputs: *(What we invest – staff, volunteers, time money, technology, equipment, etc.)*
- Data is collected, analyzed, and accessible at the local, regional, and state levels as provided by the Bureau of Emergency Medical Services and Injury Prevention, Section on Aging, Long Term Care, and Resources, and Bureau of Health Information and other key partners.

Outputs: *(What we do – workshops, meetings, product development, training. Who we reach – community residents, agencies, organizations, elected officials, policy leaders, etc.)*
- Data indicates effectiveness of statewide falls prevention activities/programs in decreasing fall-related injuries and deaths by concentrating prevention efforts.

Evaluation and Measurement
Success in achieving the 2010 outcome objectives will be determined by monitoring the progress of county, regional, and tribal programs and coalitions with the help of the advisory structure established and monitoring the performance based contracting process of the local public health departments and falls prevention funding of local aging offices. Evaluation and measurement will also require evaluating local community capacity, including training, implementation of the in-home assessments and screenings and ultimately the number of injuries and deaths related to falls identified in the data sources. The development of such resources as clearinghouses for falls prevention educational programs and contact lists of trained professionals, allied health professionals and institutes of higher learning who have incorporated model falls prevention curricula will also provide insight into the success of falls prevention in Wisconsin.

Crosswalk to Other Health and System Priorities in Healthiest Wisconsin 2010
Integrated Electronic Data and Information Systems: There is a need to address technical and resource issues unable to be addressed by the injury surveillance system such as timeliness, accessibility, flexibility, and accuracy of the falls data.

Community Health Improvement Processes and Plans: Assessing need, developing priorities, and taking action by the community requires a comprehensive review. It will be important that community assessment and development efforts to reduce fall injuries and deaths are integrated
into the larger community health improvement efforts required of local health departments, boards of health, and their partners as set forth in Ch. 251, Wis. Stats.

Coordination of State and Local Public Health System Partnerships: For effective assessments, development of priorities and resources and implementation or taking the necessary action at a local, regional, or state levels, partnerships must be developed and coordinated to use our limited yet valuable resources wisely in order to prevent falls deaths and injuries.

Sufficient, Competent Workforce: For the promotion of comprehensive falls prevention and education in such locations as falls clinics or programs across the state, there must be competent and highly trained professionals with the knowledge and skill base to perform the assessments and screenings and intervene when necessary.

Equitable, Adequate, and Stable Financing: Currently there is no statutory mandate to provide falls prevention activities, yet Wisconsin is in the top five states in the country with its residents dying from falls at an alarming rate. Funding and support is necessary for the development of the resources required to education, train, intervene and treat, and evaluate the effectiveness of the programs we have implemented to reduce fall deaths and injuries.

Access to Primary and Preventive Health Services: Along with better trained professionals and volunteers, people need to have access to preventive health services such as falls prevention in-home assessments, modifications, and screenings.

Adequate and Appropriate Nutrition: Prevention of falls is multifactoral. Not only is home modification important, but also such things as review of medications, use of alcohol and other nonprescription drugs, and a person’s nutritional status.

Alcohol and Other Substance Use and Addiction: There is documentation that identifies alcohol and/or other substance use as contributing factors to falls.

Environmental and Occupational Health Hazards: In-home assessments and environmental modifications are an important prevention strategy to reduce injuries and deaths from falls. They are not the end-all, but need to be part of a comprehensive falls prevention program. Fall prevention systems (e.g., guardrails, hole covers) and personal fall-arrest systems (full-body harness with lanyards and connection hardware) are effective in reducing injuries and fatalities from falls in occupational settings. Additionally, slip-resistant footwear and walking surfaces have proven to be effective in preventing slips.

Significant Linkages to Wisconsin’s 12 Essential Public Health Services

Monitor health status to identify community health problems: Falls have been identified as a leading cause of hospitalizations and deaths among the citizens of Wisconsin.

Identify, investigate, control, and prevent health problems and environmental health hazards in the community: In-home assessment and environmental modifications is an important prevention strategy to reduce fall injuries and deaths.
Educate the public about current and emerging health issues: By heightening the awareness and knowledge about the impact of falls and falls prevention opportunities, improvement in the identification of fall hazards and prevention of falls in our communities is more likely to occur which will lead to reducing fall injuries and deaths.

Promote community partnerships to identify and solve health problems: For effective assessments, identification of priorities and resources needed to take the necessary action at a local, regional, or state level, partnerships must be developed and coordinated to use our limited yet valuable resources wisely in order to prevent falls deaths and injuries.

Create policies and plans that support individual and community health efforts: Buy-in of partners and formation of local coalitions will improve access to information, training opportunities, and fall prevention services (e.g., in-home assessments and screenings, balance and strengthening programs, falls clinics).

Link people to needed health services: For those at risk of falling or who a history of falling in the past, it is imperative they be linked with resources to assist them in reducing the likelihood of falling in the future.

Conduct research to seek new insights and innovative solutions to health problems: Multifaceted approaches to fall prevention have been scientifically shown to reduce the incidence of falls; therefore there is a need for the medical/community model of comprehensive falls prevention programs in Wisconsin. These programs will not be possible without the development of state and local support focusing on falls prevention program development, implementation and evaluation through use of the data.

Connection to the Three Overarching Goals of Healthiest Wisconsin 2010
Promote and Protect Health for All: Falls affect all people of Wisconsin.

Eliminate health disparities: Falls affect both the young and the aging population of Wisconsin. They rank in the top 5 leading causes of injuries and deaths in the state.

Transform Wisconsin’s public health system: Fall injuries and deaths continue to increase in Wisconsin. A new comprehensive approach to fall prevention is needed.

Key Interventions and/or Strategies Planned:
- Development of local and statewide falls prevention coalitions.
- Development and dissemination of a statewide media campaign.
- Implementation of an in-home assessment, screening, and follow-up training in at least every region of the state.
- Development and dissemination of a “Physician Tool Kit for Falls Prevention.”
- Standardized Home Safety Checklist with recommended modifications developed and implemented as part of a comprehensive falls prevention program.
- Model Curricula for Health and Allied Health Professionals developed and integrated into institutes of higher learning in Wisconsin; Model Playground Safety Curriculum is developed and introduced into day care settings and schools.
- Web-based Query Data System developed and accessible to counties in Wisconsin.
References:


CDC Vital Statistics


Wisconsin Hospital Discharge Database, Hospital E-Code Report, DHFS Bureau of Health Information.


**Internet Resources:**

http://www.cdc.gov/ncipc

http://www.nih.gov/nia

http://www.guideline.gov

http://www_nfpa.org

http://www.aarp.org

http://www.temple.edu/older_adult/fppmanual.html

http://www.bu.edu/roybal

http://wwwOLDERADULTINJURY.org
## Health Priority: Intentional and Unintentional Injuries and Violence
### Objective 4: Trauma System Development (Logic Model)

### Long-term (2010) Subcommittee Outcome Objective:
By 2010, evaluate the effectiveness of the system by looking at comparative mortality and morbidity data from 2001 and 2010 or the most recent year available

Long-term outcome objective updated as of: Sept 2004

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<tr>
<td>The Wisconsin Legislature needs to be well informed so they can provide the base for the statewide trauma system, including statutory authority and funding.</td>
<td>Development and dissemination of a standardized presentation package and educational materials on the merits and workings of a statewide trauma system.</td>
<td>By 2002, educate, influence and obtain commitment from policymakers (state, county and local), direct care providers and the general public.</td>
<td>By 2004, all laws and policies needed to support trauma system implementation are in place.</td>
<td>By 2010, compare data pre-trauma system (2000 data) and compare it with data during implementation and full development of the trauma system. By 2010, decrease death and serious injury due to trauma by 10 percent.</td>
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<tr>
<td>Department of Health and Family Services, Bureau of Emergency Medical Services and Injury Prevention staff, the State Trauma Advisory Council, and committed partners will need to develop and implement an educational campaign to raise awareness and educate and influence policymakers (e.g., state, county, local), direct care providers, and the general public about trauma. These same groups will develop and deliver training for professionals to educate them on the trauma system and how it influences their work.</td>
<td>Regional trauma advisory councils will be formed and will begin meeting to organize trauma care in their region.</td>
<td>By 2002, identify all potential partners that should or would like to be involved.</td>
<td>By 2004, have fully functional regional trauma councils in place.</td>
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<tr>
<td>Department of Health and Family Services, Bureau of Emergency Medical Services and Injury</td>
<td>All hospitals will have confirmed classification levels, and that information will be disseminated to local health care providers.</td>
<td>By 2002, develop and distribute educational materials to targets and the general public.</td>
<td>By 2004, have level one and two trauma hospitals reporting to a standardized trauma registry (database).</td>
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<tr>
<td>Level one and level two hospitals that currently have computerized trauma registries will submit data electronically to the State Trauma Registry. This information will be supplemented by reports obtained from the Bureau of Health Information hospital discharge database. Target date for completion of Phase I is July 1, 2004.</td>
<td>By 2002, develop and deliver training for professionals to educate them on the trauma system and how it influences their work.</td>
<td>By 2004, provide data to locals for decision making and to support community-level collaborations.</td>
<td>By 2005, have system review functions (continuous quality improvement) in place for each region.</td>
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<tr>
<td>By 2002, create a base for the statewide trauma system, including statutory authority and funding.</td>
<td>By 2002, develop and implement regional trauma advisory councils, based on recommendations from the Statewide Trauma Advisory Council.</td>
<td>By 2006, have a fully functional statewide trauma system in place.</td>
<td>By 2007, have a complete trauma registry established (includes level three and four hospitals).</td>
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**Health Priority: Intentional and Unintentional Injuries and Violence**  
**Objective 4: Trauma System Development (Logic Model)**

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<tr>
<td>Prevention, State Trauma Advisory Council, hospitals and interested regional parties must develop and implement regional trauma advisory councils, based on recommendations from the Statewide Trauma Advisory Council.</td>
<td>Level Three and Level Four hospitals will phase-in data collection and submission in a format that will be determined as database design is developed and refined. The maximum number of trauma cases fitting submission criteria is estimated at about 50 per year. The target date for completion of Phase II is July 1, 2007.</td>
<td>By 2003, begin data collection from level one and two trauma hospitals. By 2003, classify trauma care capabilities for all hospitals in the state.</td>
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<tr>
<td>Bureau of Emergency Medical Services and Injury Prevention staff must work with hospitals to assist with classification of trauma care capabilities for all hospitals in the state and begin data collection from level one and two trauma hospitals.</td>
<td>Regular meetings of regional trauma advisory councils will be ongoing to improve the system. Data indicates impact of statewide trauma system in decreasing injuries and death.</td>
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<tr>
<td>The Bureau of Emergency Medical Services and Injury Prevention, State Trauma Advisory Council and the regional trauma advisory councils must work to support community-level collaborations and provide trauma information to communities and decision makers.</td>
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<tr>
<td>The Wisconsin Legislature and the Bureau of Emergency Medical</td>
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Logic Model – Health Priority: Intentional and Unintentional Injuries and Violence – Objective 4
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<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>Funding must be provided to properly develop and implement a fully functional trauma system.</td>
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<tr>
<td>Bureau of Emergency Medical Services and Injury Prevention, the State Trauma Advisory Council, and the regional trauma advisory councils will establish regional trauma advisory councils to be fully functional and have system review functions for continuous quality improvement in place for each region.</td>
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<td>Levels one and two trauma hospitals will be reporting to a standardized trauma registry (database) by 2004 and a complete trauma registry that includes levels three and four hospitals will be established by 2007.</td>
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<tr>
<td>Bureau of Emergency Medical Services and Injury Prevention, the State Trauma Advisory Council, and the regional trauma advisory councils will provide data to locals for decision making and to support community-level collaborations. Bureau of Emergency Medical Services and Injury Prevention, the State Trauma Advisory Council, and the regional trauma advisory councils will ensure all the components of a fully functional statewide trauma system e.g., hospital classification, regional councils, continuous quality improvement, data, etc.) will be in place by 2006. (Bureau of Emergency Medical Services and Injury Prevention and the regional trauma advisory councils collect and analyze data at the regional and state level.)</td>
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</table>
Health Priority: Intentional and Unintentional Injuries and Violence
Objective 4: Trauma System Development (Template)

Long-term (2010) Subcommittee Outcome Objective:
By 2010, evaluate the effectiveness of the system by looking at comparative mortality and morbidity data from 2001 and 2010 or the most recent year available.
Long-term outcome objective updated as of: Sept 2004

Future Interim Goal:
By 2005 have a fully operational trauma system, including all the components identified in the Department of Health and Family Services Wisconsin Trauma Plan.

<table>
<thead>
<tr>
<th>Wisconsin Baseline</th>
<th>Wisconsin Sources and Year</th>
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<tr>
<td>None, this is a developmental objective.</td>
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<tr>
<th>Federal/National Baseline</th>
<th>Federal/National Sources and Year</th>
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<tbody>
<tr>
<td>As of 2004, over 40 States have or are in the process of establishing a trauma care system.</td>
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<tr>
<th>Related USDHHS Healthy People 2010 Objectives</th>
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<tbody>
<tr>
<td>Chapter</td>
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<tr>
<td>1 – Access to Quality Health Services</td>
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<table>
<thead>
<tr>
<th>Definitions</th>
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<tr>
<td>Term</td>
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<tr>
<td>Emergency medical services</td>
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<td>Levels one, two, three and four trauma hospitals</td>
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<td>Regional trauma advisory councils</td>
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<td>Statewide Trauma Advisory Council</td>
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<tr>
<td>Trauma system</td>
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</table>
Rationale:
- Studies of organized state trauma systems show a 15 percent reduction in all trauma deaths (Mullins 1999). Based on 2,708 deaths due to injury in 1998, 406 lives saved could have been saved in Wisconsin.
- One study of an organized state trauma system showed a 9 percent reduction in trauma deaths from motor vehicle crashes (Nathens 2000). Based on 713 deaths due to motor vehicle crashes in 1998, 64 lives saved could have been saved in Wisconsin.
- Injuries are the leading cause of death for persons ages 1 to 44 (Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System data 1998). Injury deaths account for 53 percent of all deaths in this age group.
- Statistics show injuries are the leading cause of years of productive life lost (Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System data 1998). Based on 1998 Wisconsin causes of death, injury deaths result in more years of productive life lost than any other cause and, in fact, are equal to the years lost due to heart disease and cancer combined.
- A trauma system creates a mechanism to ensure that an injured patient receives the right care from the appropriate facility in a timely manner. This means that a fully functional system is in place that ensures the appropriate steps are taken from initial reporting of the injury, to prehospital care and transport, to emergency room and hospital care, and all the way through release and rehabilitation.
- Wisconsin is among only a few states in the nation that does not have a statewide trauma system. Trauma (injury) is a major health issue and the number of deaths and serious injuries can be altered.

Outcomes:
(Initial list of potential implementation partners are in parentheses)

Short-term Outcome Objectives (2002-2004)
- By 2002, educate, influence and obtain commitment from policymakers (state, county and local), direct care providers and the general public.
- By 2002, identify all potential partners that should or would like to be involved.
- By 2002, develop and distribute educational materials to targets and the general public.
- By 2002, develop and deliver training for professionals to educate them on the trauma system and how it influences their work.
- By 2002, create a base for the statewide trauma system, including statutory authority and funding.
- By 2002, develop and implement regional trauma advisory councils, based on recommendations from the Statewide Trauma Advisory Council.
- By 2003, begin data collection from level one and two trauma hospitals.
- By 2003, classify trauma care capabilities for all hospitals in the state.

Inputs: (What we invest – staff, volunteers, time money, technology, equipment, etc.)
- The Wisconsin Legislature needs to be well informed so they can provide the base for the statewide trauma system, including statutory authority and funding.
- Department of Health and Family Services, Bureau of Emergency Medical Services and Injury Prevention staff, the State Trauma Advisory Council, and committed partners will need to develop and implement an educational campaign to raise awareness and
educate and influence policymakers (e.g., state, county, local), direct care providers, and the general public about trauma. These same groups will develop and deliver training for professionals to educate them on the trauma system and how it influences their work.

- Department of Health and Family Services, Bureau of Emergency Medical Services and Injury Prevention, State Trauma Advisory Council, hospitals and interested regional parties must develop and implement regional trauma advisory councils, based on recommendations from the Statewide Trauma Advisory Council.
- Bureau of Emergency Medical Services and Injury Prevention staff must work with hospitals to assist with classification of trauma care capabilities for all hospitals in the state and begin data collection from level one and two trauma hospitals.
- The Bureau of Emergency Medical Services and Injury Prevention, State Trauma Advisory Council and the regional trauma advisory councils must work to support community-level collaborations and provide trauma information to communities and decision makers.

Note: Lead for facilitation – Department of Health and Family Services, Bureau of Emergency Medical Services and Injury Prevention, which has statutory authority in sec. 146.56, Wis. Stats., to develop and implement a statewide trauma system.

**Outputs:** *(What we do – workshops, meetings, product development, training. Who we reach – community residents, agencies, organizations, elected officials, policy leaders, etc.)*

- Development and dissemination of a standardized presentation package and educational materials on the merits and workings of a statewide trauma system.
- Regional trauma advisory councils will be formed and will begin meeting to organize trauma care in their region.
- All hospitals will have confirmed classification levels, and that information will be disseminated to local health care providers.
- Level one and level two hospitals that currently have computerized trauma registries will submit data electronically to the State Trauma Registry. This information will be supplemented by reports obtained from the Bureau of Health Information hospital discharge database. Target date for completion of Phase I is July 1, 2004.

**Medium-term Outcome Objectives (2005-2007)**

- By 2004, all laws and policies needed to support trauma system implementation are in place.
- By 2004, have fully functional regional trauma councils in place.
- By 2004, have level one and two trauma hospitals reporting to a standardized trauma registry (database).
- By 2004, provide data to locals for decision making and to support community-level collaborations.
- By 2005, have system review functions (continuous quality improvement) in place for each region.
- By 2006, have a fully functional statewide trauma system in place.
- By 2007, have a complete trauma registry established (includes level three and four hospitals).

**Inputs:** *(What we invest – staff, volunteers, time money, technology, equipment, etc.)*

- The Wisconsin Legislature and the Bureau of Emergency Medical Services and Injury Prevention must write and implement laws and policies needed to support a statewide trauma system.
• Funding must be provided to properly develop and implement a fully functional trauma system.
• Bureau of Emergency Medical Services and Injury Prevention, the State Trauma Advisory Council, and the regional trauma advisory councils will establish regional trauma advisory councils to be fully functional and have system review functions for continuous quality improvement in place for each region.
• Levels one and two trauma hospitals will be reporting to a standardized trauma registry (database) by 2004 and a complete trauma registry that includes levels three and four hospitals will be established by 2007.
• Bureau of Emergency Medical Services and Injury Prevention, the State Trauma Advisory Council, and the regional trauma advisory councils will provide data to locals for decision making and to support community-level collaborations.
• Bureau of Emergency Medical Services and Injury Prevention, the State Trauma Advisory Council, and the regional trauma advisory councils will ensure all the components of a fully functional statewide trauma system e.g., hospital classification, regional councils, continuous quality improvement, data, etc.) will be in place by 2006.

Outputs: (What we do – workshops, meetings, product development, training. Who we reach—community residents, agencies, organizations, elected officials, policy leaders, etc.)
• Level Three and Level Four hospitals will phase-in data collection and submission in a format that will be determined as database design is developed and refined. The maximum number of trauma cases fitting submission criteria is estimated at about 50 per year. The target date for completion of Phase II is July 1, 2007.
• Regular meetings of regional trauma advisory councils will be ongoing to improve the system.

Long-term Outcome Objectives (2008-2010)
By 2010, compare data pre-trauma system (2000 data) and compare it with data during implementation and full development of the trauma system. By 2010, decrease death and serious injury due to trauma by 10 percent.

Inputs: (What we invest – staff, volunteers, time money, technology, equipment, etc.)
• (Bureau of Emergency Medical Services and Injury Prevention and the regional trauma advisory councils collect and analyze data at the regional and state level.)

Outputs: (What we do – workshops, meetings, product development, training. Who we reach—community residents, agencies, organizations, elected officials, policy leaders, etc.)
• Data indicates impact of statewide trauma system in decreasing injuries and death.

Evaluation and Measurement
Success in implementing the system will be marked by attaining the process goals identified. These include creation of laws and rules, classification of hospital capabilities, development of regional trauma advisory councils, and data collection and analysis.

Comparing injury and death data from pre-trauma system development to post-trauma system implementation will do the ultimate evaluation. The goal is a 10 percent decrease in serious injury and death.
Crosswalk to Other Health and System Priorities in Healthiest Wisconsin 2010

*Integrated Electronic Data and Information Systems:* Use of existing or linkable databases is necessary to measure the effectiveness of a trauma system. Some trauma data does exist in current data collected by the Bureau of Health Information. Additional data sources need to be developed to get a more detailed picture of trauma care.

*Community Health Improvement Processes and Plans:* A trauma system involves planning by many partners in the community and region. Prominent partners include hospitals, emergency medical services, local health departments, law enforcement departments, traffic safety professionals and injury prevention specialists. Trauma care and injury prevention should be part of any broad community health improvement process or plan.

*Coordination of State and Local Public Health System Partnerships:* A successful trauma system requires broad involvement from a varied group of participants. Anyone involved in injury prevention, prehospital care, hospital care, and rehabilitation in a potential trauma partner. Organizing these entities at the local, regional, and state level is key to a successful system.

*Sufficient, Competent Workforce:* Improvement in prevention of injuries and treatment for those who are injured requires a competent workforce, in particular, training of EMS and hospital staff and sufficient personnel to provide care are essential.

*Equitable, Adequate, and Stable Financing:* To build a trauma system will involve some investment to develop regional councils, coordinate regional and statewide activities, and collect and analyze data to evaluate and improve the system. Although much of this work will be done by in-kind contributions of time and resources, there is still a need for base funding to establish a minimal infrastructure.

**Significant Linkages to Wisconsin’s 12 Essential Public Health Services**

*Promote community partnerships to identify and solve health problems:* A successful trauma system requires broad involvement from a varied group of participants--anyone involved in injury prevention, prehospital care, hospital care, and rehabilitation in a potential trauma partner. Organizing these entities at the local, regional, and state level is key to a successful system.

*Create policies and plans that support individual and community health effort:* An organized effort will be necessary to plan, promote, and implement a trauma system. Widespread support will help make the system happen.

*Link people to needed health services:* A trauma system is an emergency safety net that will serve all Wisconsin citizens.

*Evaluate effectiveness, accessibility, and quality of personal and population-based health service:* Outcome data pre- and post-trauma system implementation will measure effectiveness. Regional and local continuous quality improvement processes will monitor and improve local care.

*Assure access to primary health care:* A trauma system is an emergency safety net that will serve all Wisconsin citizens. By dialing 911, all citizens will have access to trauma care.

**Connection to the Three Overarching Goals of Healthiest Wisconsin 2010**
Protect and promote health for all: A statewide trauma care system will provide a uniform standard of care and ensure timely access to the appropriate health care facility.

Eliminate health disparities: The nature of a trauma care system is to provide emergency access to all injured parties and sets up protocols to ensure the patient is taken to the appropriate health care facility.

Transform Wisconsin’s public health system: A statewide trauma care system involves participation by a large number of partners, particularly in providing input at the regional trauma councils.

Key Interventions and/or Strategies Planned:
- Regional partnership development in creating regional trauma advisory councils and impacting collaborative work in caring for and following-up on trauma patients.
- Focused prevention strategies based on regional data and trends.
References:

Miller, T.R, & Levy, D.T. (1995). Effect of regional trauma care systems on costs. *The Archives of Surgery*, 130(2):188-193. Their research showed that states with trauma care systems have 15.5 percent lower costs per hospitalized injury episode. This figure was for direct medical care only and does not include the additional societal savings from earlier return to work and the enhanced tax base.


Mullins, R.J., Mann, N.C., Hedges, J.R., Worrall, W., & Jurkovich, G.J. (1998). Preferential benefit of implementation of a statewide trauma system in one of two adjacent states. *The Journal of Trauma*, 44(4): 609-16. They compared data from Oregon and Washington prior to trauma system development (1985-1988) and then after Oregon's trauma system was in place (1990-1993). They found no difference between the states prior to 1990, but significantly lower death rates in Oregon after their trauma system was in place, particularly for head injuries and liver/spleen injuries.

Nathens, A.B., Jurkovich, G.J., Rivara, F.P., & Maier, R.V. (2000). Effectiveness of state trauma systems in reducing injury-related mortality: A national evaluation. *The Journal of Trauma*, 48(1):25-30. They found that states with trauma systems had a 9 percent lower crude injury death rate than those without a statewide system. Crude rates for reduction in motor vehicle crash deaths was 17 percent lower and after adjusting for age, state speed laws, restraint laws and population distribution, there remained a 9 percent reduction in motor vehicle crash-related death in states with a trauma system.


Sampalis, J.S., Denis, R. et. al., (1999). Trauma care regionalization: A process-outcome evaluation. *The Journal of Trauma*, 46(4): 565-79. The regional trauma system developed in 4 phases over a 6-year period. They found that the death rate for serious injuries decreased over the 4 phases from 52 percent to 32 percent to 19 percent to 18 percent. In addition, the mean prehospital time decreased from 62 to 44 minutes.
Health Priority: Intentional and Unintentional Injuries and Violence
Objective 5: Injury Surveillance System (Template)

Long-term (2010) Subcommittee Outcome Objective:
By 2010, combine or coordinate existing data systems into a surveillance system.

<table>
<thead>
<tr>
<th>Wisconsin Baseline</th>
<th>Wisconsin Sources and Year</th>
</tr>
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<tbody>
<tr>
<td>None, this is a developmental objective.</td>
<td>Not applicable.</td>
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</table>

<table>
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<tr>
<th>Federal/National Baseline</th>
<th>Federal/National Sources and Year</th>
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</table>

Related USDHHS Healthy People 2010 Objectives

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Goal</th>
<th>Objective Number</th>
<th>Objective Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 – Injury and Violence Prevention</td>
<td>Reduce injuries, disabilities, and deaths due to unintentional injuries and violence.</td>
<td>15-10</td>
<td>Increase the number of States and the District of Columbia with statewide emergency department surveillance systems that collect data on external causes of injury.</td>
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<tr>
<td>15-11</td>
<td>Increase the number of States and the District of Columbia that collect data on external causes of injury through hospital discharge data systems.</td>
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Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Injury surveillance system</td>
<td>A method to collect, analyze, and interpret injury data and then disseminate the findings to positively impact program activities.</td>
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</tbody>
</table>

Rationale:

An injury surveillance system is a method to collect, analyze, and interpret injury data and then disseminate the findings to all interested parties. The system utilizes relationships between people, organizations, and data to use injury information in identifying priorities and then designing, implementing, and evaluating injury prevention and control programs and activities. Information from the injury surveillance system needs to be widely disseminated to positively impact program activities.

Injuries are the leading cause of death for persons ages 1 to 44 (Centers for Disease Control, Web-based Injury Statistics Query and Reporting System data 1998). Injury deaths account for 53 percent of all deaths in this age group. Statistics show injuries are the leading cause of years of productive life
lost (Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System data 1998). Based on 1998 Wisconsin causes of death, injury deaths result in more years of productive life lost than any other cause and, in fact, are equal to the years lost due to heart disease and cancer combined.

Wisconsin currently has all 11 of the essential injury data sets that have been identified by Centers for Disease Control and Prevention (Vital records, hospital discharge, Fatality Analysis Reporting System, Behavioral Risk Factor Surveillance System, emergency departments, medical examiners, child death review, National Occupant Protection Use Survey, Uniform Crime Reporting, and emergency medical services). Unfortunately, utilizing data across the 11 data systems is difficult. Since injury is a major health issue and the number of deaths and serious injuries can be altered, it would be extremely helpful to maximize usage of the data by integrating data from all 11 systems.

**Coordinated data collection and sharing of data would allow the following to occur:**
- Development of common data elements so similar analysis could be performed because all data systems are using the same definitions and elements.
- Economies of scale in collecting, analyzing, and disseminating injury information.
- Utilization of technology advancements to make optimal use of existing data, including the identification of factors that contribute to the cause of the injury.

**Outcomes:**

**Short-term Outcome Objectives (2002-2004)**
- By 2002, educate and influence the 3 “Ps” on the issue - Policymakers (e.g., state, county, local); direct care Providers; and the general Public.
- By 2002, research and evaluate data sources for overlap. Data managers and stakeholders agree to develop a common data set, identify and develop common data elements, and begin data collection.
- By 2002, agreements are made to access data so analysts from various organizations can look at issues and barriers.
- By 2002, convene annual meeting of partners to update members on the status of a surveillance system and to discuss and put in place agreements to share data and consolidate data collection efforts.
- By 2003, develop and deliver training for professionals to accomplish the following:
  - To familiarize them with existing data
  - To understand the benefits of collection and use of common data elements
  - To understand the benefits of sharing data
  - To establish uniform reporting criteria
- By 2003, develop and distribute educational materials to targets and to the general public. Provide data to communities and decision makers so more people are aware of and using the data by applying data analysis to programs.

**Inputs:** *(What we invest – staff, volunteers, time money, technology, equipment, etc.)*
- Department of Health and Family Services, Bureau of Emergency Medical Services and Injury Prevention, and Bureau of Health Care Information; Department of Transportation, Center for Health Systems Research and Analysis, Wisconsin Health and Hospital Association; Department of Justice; and coroners must research and evaluate data sources for overlap. Data managers and stakeholders must agree to
develop a common data set, identify and develop common data elements, and begin
data collection.

- Key data managers and stakeholders will need to agree that the goal of an injury
  surveillance system transcends specific, individual databases.
- Department of Health and Family Services, Bureau of Emergency Medical Services and
  Injury Prevention staff and the Bureau of Health Care Information must meet and agree
to share data and work towards a more uniform data system that meets multiple data
needs.
- Department of Health and Family Services, Bureau of Emergency Medical Services and
  Injury Prevention, and Bureau of Health Care Information; Department of
  Transportation; University of Wisconsin-Madison; Medical College of Wisconsin;
  Center for Health Systems Research and Analysis; and other interested parties will need
to develop and implement an educational campaign to raise awareness and educate and
influence policymakers (e.g., state, county local), direct care providers, and the general
public about injury data collection, analysis, and applied use for program functions.
These same groups will also need to develop and deliver training for professionals to
educate them on the surveillance system and how it influences their work.

Note: Lead for facilitation – Department of Health and Family Services, Bureau of Emergency
Medical Services and Injury Prevention has authority in sec. 255.20, Wis. Stats., to maintain an
injury prevention program that includes data collection and surveillance. The grant-funded
epidemiologist in the Bureau of Emergency Medical Services and Injury Prevention will do
data analysis and work with the Bureau of Health Information to make use of existing data.

**Outputs:** *(What we do – workshops, meetings, product development, training. Who we reach-
community residents, agencies, organizations, elected officials, policy leaders, etc.)*

- Development and dissemination of a standardized presentation package and educational
  materials on the merits and workings of a statewide injury surveillance system.
- Meeting of data stakeholders occurs and agreements are made to share data and
  consolidate data collection efforts when possible.
- An annual state injury profile is created and disseminated.

**Medium-term Outcome Objectives (2005-2007)**

- By 2005, Wisconsin will have a functional injury surveillance system in place that allows for easier
  collection of data, access to data, and analysis in order to affect outcomes.
- By 2006, various data sources all collect and analyze data with common elements (Department of
  Health and Family Services, Bureau of Emergency Medical Services and Injury Prevention, and
  Bureau of Health Care Information; Department of Transportation; Center for Health Systems
  Research and Analysis; Wisconsin Health and Hospital Association; Department of Justice; and
  coroners).
- By 2007, develop a method to do systematic evaluation of injuries based on the data.
- By 2008, program objectives and decisions are driven by available data and effectiveness of
decreasing injuries in a cost-effective way.
- By 2008, agencies collaborate in their use of data to address overarching goals and systemic injury
  issues.

**Inputs:** *(What we invest – staff, volunteers, time money, technology, equipment, etc.)*
• An injury data stakeholders group meets on a regular basis to discuss and solve data issues.
• Department of Health and Family Services, Bureau of Emergency Medical Services and Injury Prevention, and Bureau of Health Care Information; Department of Transportation; University of Wisconsin-Madison; Medical College of Wisconsin; and Center for Health Systems Research and Analysis will all collect and analyze data with common elements.
• Department of Health and Family Services, Bureau of Emergency Medical Services and Injury Prevention, and Bureau of Health Care Information; Department of Transportation; Center for Health Systems Research and Analysis; Wisconsin Health and Hospital Association; Department of Justice; and coroners will develop a method to do systematic evaluation of injuries based on the data.
• Injury programs agree that program objectives and decisions are driven by available data and the ability to decrease injuries in a cost-effective way.
• A state injury reduction plan is put in place with clearly articulated objectives that are agreed on and widely disseminated to injury programs statewide.

Outputs:  (What we do – workshops, meetings, product development, training.  Who we reach- community residents, agencies, organizations, elected officials, policy leaders, etc.)
• A user friendly injury data internet site is made available so local programs can analyze their local data to identify needs.
• Injury programs focus their activities based on the state injury reduction plan, state injury profile, and the use of local data that has identified key injury areas.
• Regular meetings of data stakeholders and injury program managers will be ongoing to improve the system.

Long-term Outcome Objectives (2008-2010)
• By 2010, the goal is to combine or coordinate existing data systems into a more functional system.

Inputs:  (What we invest – staff, volunteers, time money, technology, equipment, etc.)
• Data is collected and analyzed at the local, regional, and state level.

Outputs:  (What we do – workshops, meetings, product development, training.  Who we reach- community residents, agencies, organizations, elected officials, policy leaders, etc.)
• Data indicates impact of statewide injury data system in decreasing injuries and death by concentrating prevention efforts.

Evaluation and Measurement
Success in implementing the system will be marked by attaining the process goals identified in the short- and medium-term objectives. These include creation of a data stakeholders group, formal agreements by data holders, a formal annual evaluation of injury data, and consolidation of data collection methods where possible.

The ultimate evaluation will be to see whether injury data is both more accessible and utilized in determining injury prevention program focus.

Crosswalk to Other Health and System Priorities in Healthiest Wisconsin 2010
Template – Health Priority: Intentional and Unintentional Injuries and Violence – Objective 5
**Integrated Electronic Data and Information Systems:** Use of existing or linkable databases is essential to develop the injury surveillance system. There are currently multiple sources and data platforms where injury data is residing. The development of a single injury database is neither logistically possible nor cost effective. As a result, the emphasis will be on linking existing data to merge the information in various databases.

**Significant Linkages to Wisconsin’s 12 Essential Public Health Services**

*Promote community partnerships to identify and solve health problems:* Since injury data resides in several places, it is key that partnerships are formed to share and maximize the available information and data.

*Create policies and plans that support individual and community health efforts:* Injury prevention involves planning by many partners in the community and region. Prominent partners include hospitals, emergency medical services, local health departments, law enforcement departments, traffic safety professionals, and injury prevention specialists. Injury prevention should be part of any broad community health improvement process or plan.

*Link people to needed health services:* The goal of injury surveillance would be to provide focus to prevention efforts. By effectively targeting programs, health services will be directed for maximum impact.

*Evaluate effectiveness, accessibility and quality of personal and population-based health services:* A better picture of the causes, circumstances, and numbers of injuries and injury-related deaths will result in efforts to reduce those numbers using measurable outcomes.

**Connection to the Three Overarching Goals of Healthiest Wisconsin 2010**

*Protect and promote health for all:* An injury surveillance system will provide needed information in developing and implementing effective injury prevention programs.

*Eliminate health disparities:* Injury data can be used to first identify and then impact specific disparities that may exist. By identifying injury and death rates that fall outside of a normal range, efforts can be focused to solve the problem.

*Transform Wisconsin's public health system:* An injury surveillance system involves participation and cooperation by a large number of partners to attain meaningful and timely data.

**Key Interventions and/or Strategies Planned:**

- Partnership development in sharing of data and development of program focus.
- Focused prevention strategies based on state, regional, and local data and trends.
References:

