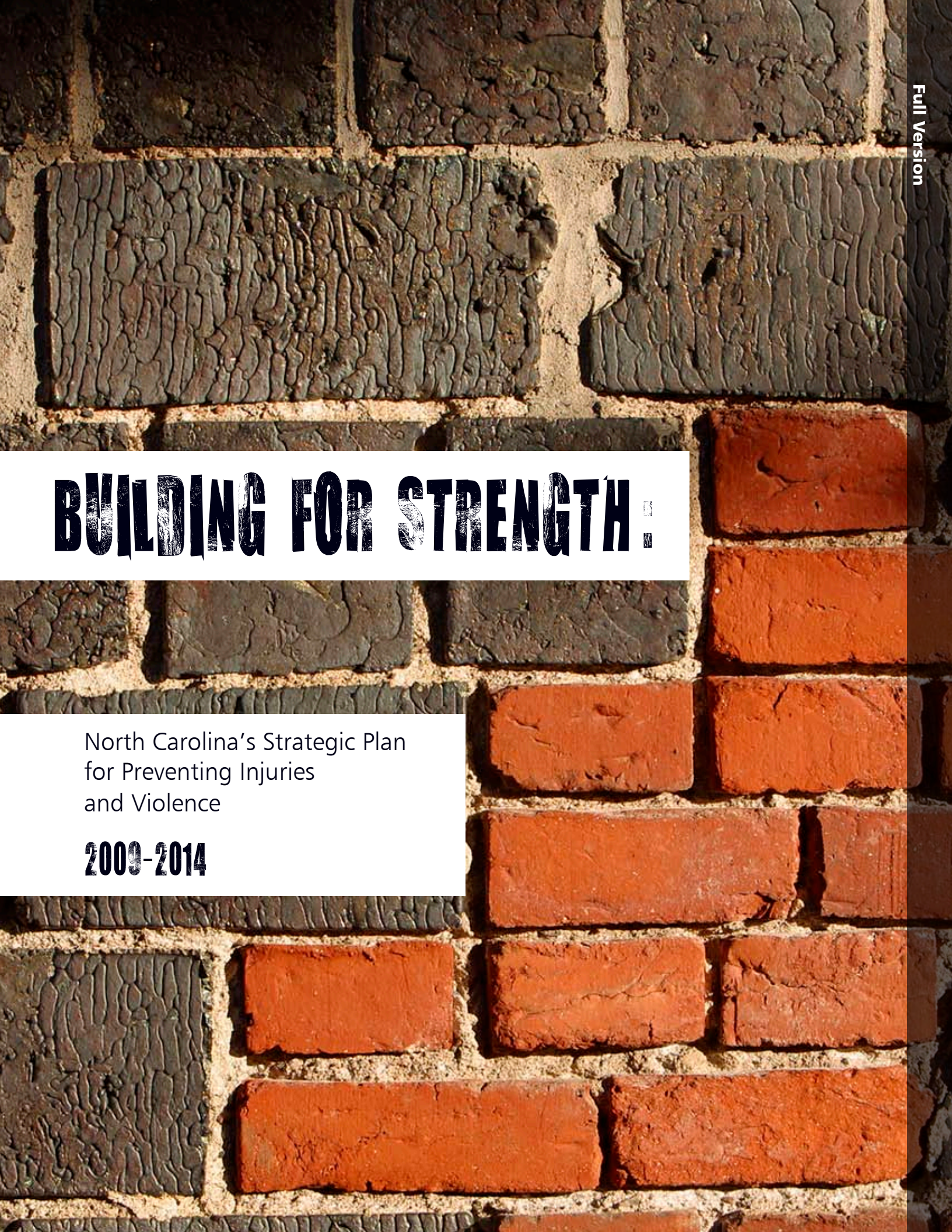

Full Version

BUILDING FOR STRENGTH:

North Carolina's Strategic Plan
for Preventing Injuries
and Violence

2009-2014

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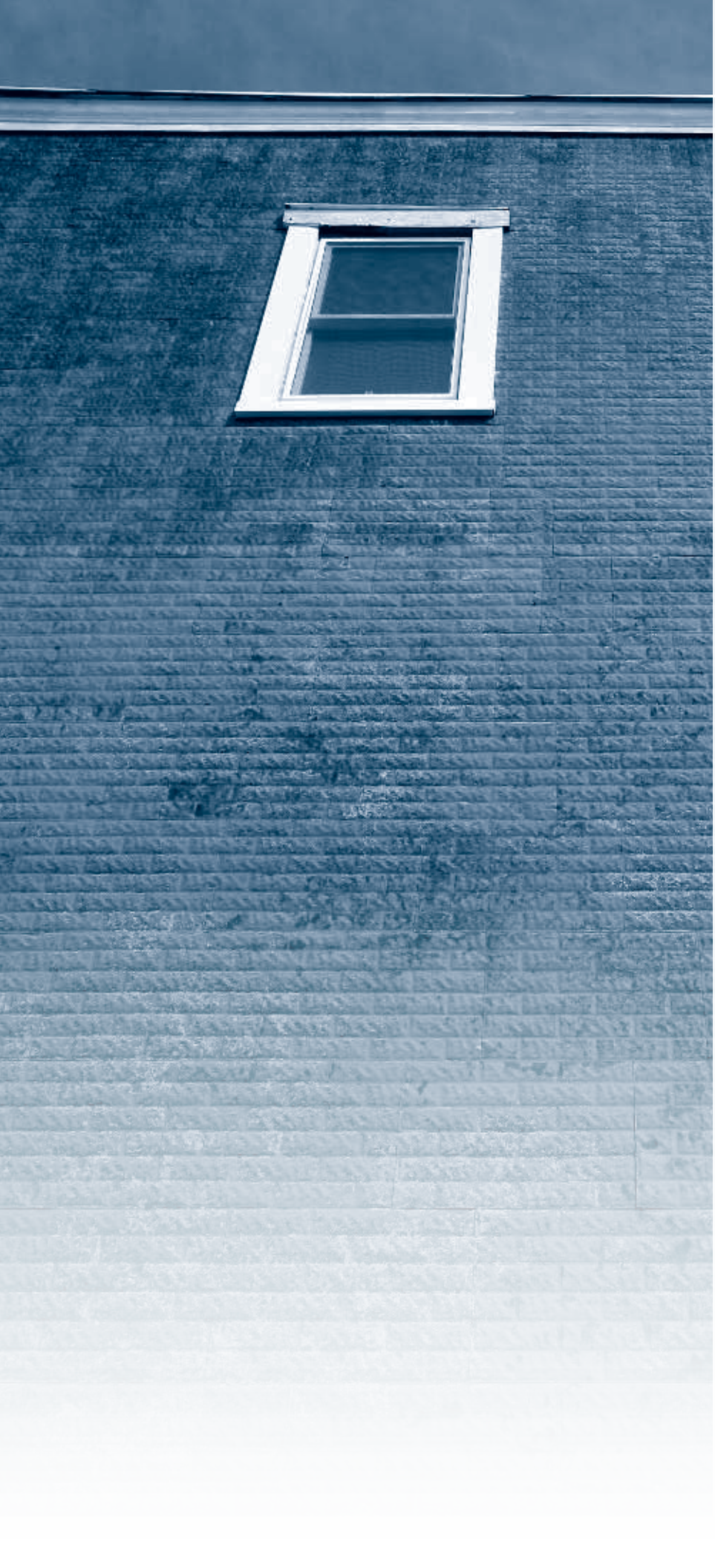


"Injury is probably the most under-recognized major public health problem facing the nation today, and the study of injury presents unparalleled opportunities for realizing significant savings in both financial and human terms—all in return for a relatively modest investment."

National Academy of Sciences,
Injury Control 1

There is a proverb that says "Thinking well is wise; planning well, wiser; but doing well is the wisest and best of all." In developing this plan, North Carolina has created a comprehensive roadmap to prevent injuries and violence and ensure that people can live to their fullest potential.

Amber Williams, Executive Director
STIPDA

"As we try to manage complex issues with dwindling resources, it is even more critical that we plan strategically, so that we build on organizational strengths and minimize weaknesses. Our present decisions will have future implications, and it is imperative that we use our resources wisely."

Shelli Stephens-Stidham,
President of STIPDA

LETTER FROM THE STATE HEALTH DIRECTOR

I want to congratulate the North Carolina Division of Public Health's Injury and Violence Prevention Branch and its multiple stakeholders on the completion of this pioneer document. Never before has the state designed and published a comprehensive injury and violence prevention strategic plan, let alone one with such broad collaboration by so many. Strong collaboration has come from state agencies, universities, private organizations, and advocacy groups that share a dedication and commitment to reducing the burden of injury on the people of North Carolina. These recommendations will be further complimented by parallel recommendations coming forth from both the N.C. Institute of Medicine's Adolescent Task Force and its Prevention Task Force.

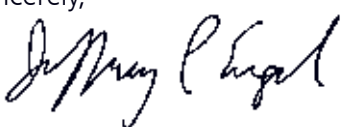
Injuries exact a heavy toll on North Carolinians and remain the leading cause of death for people ages 1 to 48. An average of 6,300 state residents of all ages die from their injuries each year, while even greater numbers are hospitalized (approximately 154,000) and treated in emergency departments (approximately 812,000). A statewide effort to combat these numbers is a necessity and will require innovative ideas, additional resources, continuous surveillance and strong evaluation of programs to make sure we remain on track to achieve the plan's six goals. In addition, while we continue to work to prevent all injuries, we must focus on those that exact the heaviest toll. These include motor vehicle crashes, poisonings, falls among older adults, homicides/assaults and suicides.

Success in reducing these numbers will demand increased attention to everyday behavior and to our culture, which often views injuries as "accidents." Most of these "accidents" are preventable, but prevention will require organized efforts including the implementation of evidenced-based prevention programs as well as environmental and policy changes.

Finally, it is important to realize that this five-year plan is not intended to replace the individual plans and goals of the many partners. Rather, it is to reflect these and provide a roadmap for further collaboration to build a stronger state infrastructure for injury and violence prevention efforts. No single agency, in and of itself, can effectively reduce the rate of injuries to the degree proposed in this plan – 15 percent in the next five years. The broad array of partners mentioned above will continue to be essential. The Injury and Violence Prevention State Advisory Council will assist in the plan's implementation and monitoring.

It is my sincere hope you will examine the plan and identify ways in which you can play a role in decreasing our injury and violence rates. If you are not directly engaged with any of the organizations that contributed to the plan, please consider participation with one or, alternatively, work in other state, regional or local level efforts.

Sincerely,



Jeffrey P. Engel, M.D.
State Health Director

If a disease were killing our children at the rate unintentional injuries are, the public would be outraged and demand that this killer be stopped.

C. Everett Koop, M.D., Sc.D., former Surgeon General of the United States and former Chairman of National Safe Kids Campaign, Safe Kids Voice, Winter 2003, p. 11.

With injury being the most costly disease in the United States, it is imperative that a collective organized effort be constructed and implemented to reduce health care costs. The State Strategic Plan for Injury and Violence Prevention is a beginning and will fit nicely into the North Carolina State Trauma System strategic plan as we evolve this very vital area of health care in our state.

Michael Barringer, M.D., Surgeon and Trauma Medical Director, Cleveland County Regional Medical Center

ACKNOWLEDGEMENTS

Over nine million people make North Carolina their home. On any given day, injuries and violence result in 2,225 visits to the emergency room, more than 400 hospitalizations, and sadly, 17 deaths. This plan and the people who created it seek to reduce the burden of injuries and violence.

Crafting a comprehensive injury and violence prevention plan required the expertise of professionals from a wide variety of disciplines in order to properly represent all facets of intentional and unintentional injury. A total of 58 stakeholders came together in meetings on October 2 and 3, 2008 and April 27, 2009 to develop a vision for a state plan for preventing injury and violence, complete with goals, objectives and action steps. These stakeholders and their agencies contributed to the plan and are listed in Appendix A. Additional stakeholders from throughout the state, along with the previously mentioned group, submitted input on portions of the plan as it was being written.

We sincerely thank all participants for their time and expertise, and give a special thanks to facilitators Shelli Bischoff-Turner and Betsy Randall-David. We would also like to thank the Children's Safety Network National Injury and Violence Prevention Resource Center and their assistant director, Ellen Schmidt, for providing support and expertise from the national level during this process.

The Injury and Violence Prevention Branch, Chronic Disease and Injury Section of the North Carolina Division of Public Health, initiated and led this process. Every staff member within the branch contributed their time, expertise and skills toward its completion. Thank you to all of these staff members for recognizing the importance of this document as a guide for the work we do.

The dedicated professionals who helped make this happen have the energy and commitment to put this plan into action and significantly reduce the serious consequences of injury and violence on the citizens of our state. Throughout this process there has been a feeling of excitement about creating a plan that will build the strength of the injury and violence prevention field.

Valerie Collins Russell, MSEd, DrHSc
Branch Head
Injury and Violence Prevention Branch
N.C. Division of Public Health

Jennifer Woody, MPA
Editor, State Strategic Plan
Planner/Evaluator
Injury and Violence Prevention Branch
N.C. Division of Public Health

"North Carolina has a history of being one of the most forward-thinking states in addressing the prevention of injury and violence. We have the capacity to lead the nation in developing, implementing and evaluating quality programs and contributing to the evidence base. This plan is an important next step in that direction."

Carol W. Runyan, MPH, PhD Director,
UNC Injury Prevention Research Center
Professor of Health Behavior and Health Education Professor of Pediatrics
University of North Carolina

"Educating citizens about injury prevention is the best tool we have to protect North Carolina's children from injury and even death. As a father, I know firsthand that lessons in safe behavior last children a lifetime."

N.C. Insurance Commissioner
Wayne Goodwin
State Fire Marshal and Chair,
Safe Kids North Carolina

ACRONYMS

AHEC	Area Health Education Center
AMCHP	Association of Maternal and Child Health Programs
ASIST	Applied Suicide Intervention Skills Training
CCGT	Coordination and Constituency Goal Team
CDC	Centers for Disease Control and Prevention
CFTF	Child Fatality Task Force
CGEC	Carolinas Geriatric Education Center
DAAS	Division of Aging and Adult Services
DGT	Data Goal Team
DHHS	Department of Health and Human Services
DMH	Division of Mental Health
DMV	Department of Motor Vehicles
DPH	Division of Public Health
ED	Emergency Department
FGT	Funding Goal Team
GDL	Graduated Driver's License
GHSP	Governor's Highway Safety Program
HPDP	Health Promotion and Disease Prevention
HSRC	Health Services Research Center
IOA	Institute on Aging at the University of North Carolina at Chapel Hill
IOM	Institute of Medicine
IPRC	The Injury Prevention Research Center at the University of North Carolina
IVPB	Injury and Violence Prevention Branch
IVP-SAC	Injury and Violence Prevention State Advisory Council
LHD	Local Health Department
MCH	Maternal and Child Health
MHA	Mental Health Association
MVCGT	Motor Vehicle Crash Goal Team
NCFPC	North Carolina Falls Prevention Coalition
NCUPTF	North Carolina Unintentional Poisoning Task Force
NCGV	North Carolinians Against Gun Violence
NCYSPTF	North Carolina Youth Suicide Prevention Task Force
NTI	National Training Initiative for Injury and Violence Prevention
OEMS	Office of Emergency Medical Services
OCME	Office of the Chief Medical Examiner
OSFM	Office of State Fire Marshal
PSMEC	Policy, Social Messaging and Environmental Change Goal Team

RACs	Regional Advisory Councils as in Trauma Center's Regional Advisory Councils
REGT	Research and Evaluation Goal Team
SAS	Substance Abuse Services
SafeTALK	Suicide Alertness for Everyone: Tell, Ask, Listen, and KeepSafe
SAMHSA	Substance Abuse & Mental Health Services Administration
SCHS	State Center for Health Statistics
STAC	State Trauma Advisory Council
STIPDA	State and Territorial Injury Prevention Directors Association
TWGT	Training and Workforce Development Goal Team
UPGT	Unintentional Poisonings Goal Team
VAGT	Violence/Assault Goal Team
VDRS	North Carolina Violent Death Reporting System
VMT	Vehicle miles of travel
WCHS	Women's and Children's Health Section
YPLL	Years of potential life lost

"Tens of thousands of lives have been saved during the last 50 years because of injury policy initiatives. Government-enforced changes in the automobile such as improved standards for brakes, installation of seat belts, and use of child passenger restraints have been policies that have significantly reduced motor vehicle injuries. This strategic plan will further organize injury stakeholders in North Carolina to most effectively advocate for injury and violence policy changes that better protect the public."

Marcus Plescia, M.D., MPH, 2003-2009
Section Chief, Chronic Disease and Injury,
N.C. Division of Public Health

EXECUTIVE SUMMARY

The toll from injuries and violence in North Carolina is unacceptable. In addition to injury being the number-one cause of death for North Carolinians ages 1 to 48, the picture of injury is changing and is a cause for concern: unintentional falls and unintentional poisonings/drug overdoses combined will eclipse motor vehicle crashes as the leading causes of injury death if corrective actions are not taken in the near future. Yet, until now, there has been no comprehensive strategic plan to address these problems. Whether from falls, homicides, suicides, motor vehicle crashes, drownings, youth violence or other types of injuries, the deaths and related disabilities keep people from living to their full potential. Mistakenly, these injuries are often viewed as inevitable parts of our lives and labeled as accidents. In short, injuries are not accidents and they do not occur at random — there are identified risk and protective factors that make injuries and violence preventable.

Acknowledging the toll of injury, the N.C. General Assembly charged the state's Division of Public Health (DPH) with the task of administering an injury prevention program and leading the development of a comprehensive statewide prevention plan. This work has involved many complex factors and disciplines, with success demanding long-term collaboration with an extensive group of partners. The Division's Injury and Violence Prevention Branch (IVPB) invested much of the last year building upon existing relationships and identifying new ones. Fortunately, partners with a wealth of knowledge who are recognized authorities on a broad range of injury and violence topics quickly came to the table, not only from fields previously mentioned, but from other areas such as occupational injuries, cyberbullying, burns and sexual assault.

These partners share a deep passion for prevention and often have well-developed prevention plans of their own for their specific area of expertise. Acknowledging this, portions of their plans are reflected whenever possible in this larger state strategic plan. The IVPB also kept abreast of, and contributed input to, the injury and violence prevention recommendations coming from the N.C. Institute of Medicine's Prevention and Adolescent Health Task Forces, providing consistency across documents.

A critical component for the success of this plan will be the procurement of increased and sustained funding. Insufficient funding to date has been a major obstacle, with the state lagging behind many other states in spending on injury prevention. Annual state appropriations for the injury prevention program equal only about $5.54 per death – less than the cost of a matinee ticket to the movies. Increased funding for injury prevention is certainly warranted, especially when considering injury is the leading cause of death for children.

Though this plan is ambitious, it is hoped that within five years, following the plan will result in a 15 percent reduction in the rate of morbidity and mortality from injury and violence. To increase the likelihood of success, the plan focuses on the three leading causes of death from unintentional injury – motor vehicle crashes, poisoning and falls – and the two leading causes of intentional injuries, suicide and homicide. The title of this document, *Building for Strength*, acknowledges its focus – partners working together in a strategic direction to accomplish six goals (listed on the next page) that will build and strengthen injury and violence prevention in North Carolina.

THE SIX GOALS OF BUILDING FOR STRENGTH:

North Carolina's Strategic Plan for Preventing Injuries and Violence

Goal 1: Data and Surveillance
Increase the use of injury and violence data through a comprehensive, coordinated injury surveillance system that is accurate, readily available and sustainable, and that is used to guide injury and violence prevention programs and policies at the local, regional and state levels.

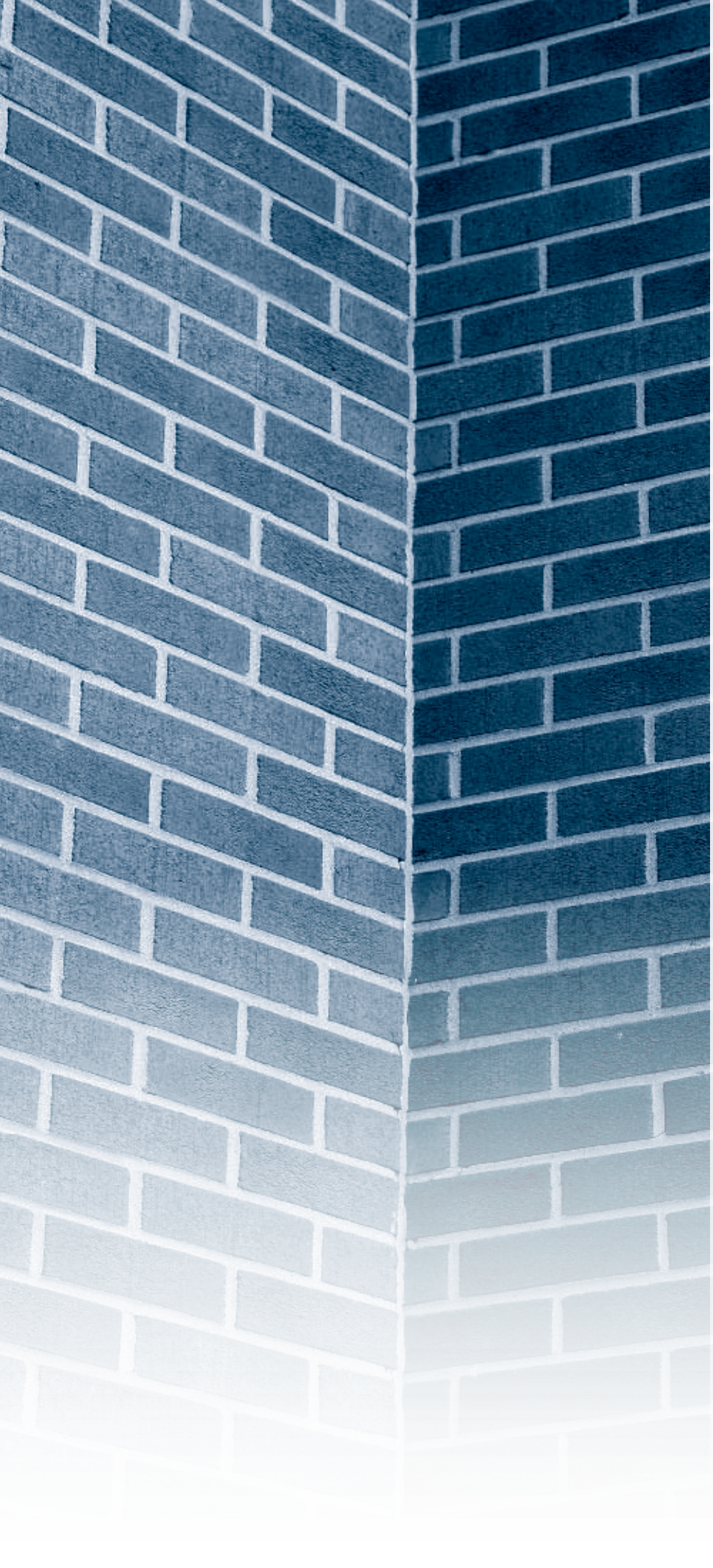
Goal 2: Research and Evaluation
Foster efforts to conduct useful injury and violence research and evaluation, and foster efforts to disseminate findings to promote innovation and promising practices.

Goal 3: Messaging, Policy and Environmental Change
Develop strong, vocal community support for injury and violence prevention and the creation of safe environments by reframing unintentional injuries and violence as unacceptable and by promoting policies that support prevention of injury and violence.

Goal 4: Saving Lives
Reduce the rate of morbidity caused by injury and violence by 15 percent, thus also reducing injury- and violence-related mortality, by implementing prioritized, data-driven strategies and programs, policies, and innovative and tested practices. From March 2009 to December 2014, address the three leading causes of unintentional injuries and the two leading causes of intentional injuries to strategically reduce the overall rate of injury morbidity by 15 percent. Data from 2007 show the leading causes of unintentional injuries are **motor vehicle crashes**, **poisonings** and **falls**. The leading causes of intentional injuries (violence) are **suicide** and **assault/homicide**.

Goal 5: Building the Injury Prevention Community
Increase coordination among injury and violence prevention partners at the local, regional and state levels to create a more efficient system and a broader, stronger constituency.

Goal 6: Workforce Development
Develop a statewide injury and violence prevention workforce that meets core injury and violence prevention competencies as outlined by the National Training Initiative for Injury and Violence Prevention (NTI) and the State and Territorial Injury Prevention Directors Association (STIPDA).



Injury has long been considered the most multidisciplinary area of public health, requiring a broad base of knowledge and skills to understand injury and develop effective prevention strategies. This plan was developed by a diverse group of partners with shared goals for prevention. Implementing the plan will require the efforts of many professions from a diverse group of agencies and organizations across North Carolina.

Jeanne Givens, Retired. Applications and Programs Unit Head, Injury and Violence Prevention Branch

North Carolina demonstrates the importance of partnerships in creating this State Strategic Plan for Injury and Violence Prevention. This critical public health issue must be addressed in multiple ways, at varying levels and with all populations. The plan will help N.C. to progress in making injury and violence prevention well integrated into many state systems and move towards a sustainable effort to reduce the toll of injuries in N.C.

Ellen Schmidt, MS, OTR, Assistant Director, National Partners, Children's Safety Network National Injury and Violence Prevention Resource Center

EVOLUTION OF THE PLAN

Building for Strength: North Carolina's Strategic Plan for Preventing Injuries and Violence 2009-2014 is a blueprint for building and strengthening injury and violence prevention efforts in North Carolina through a systems-level approach. The plan is meant to coordinate injury prevention activities at both the state and local levels, and can be used as a guide for any agency or group working to prevent injuries. Injury prevention partners can look to this plan for help determining priorities and making funding decisions.

The shared ownership of this plan can be seen from its origins — it came out of the collaborative effort of injury and violence prevention partners from across the state. Though the process was initiated and led by the DPH's IVPB, it was only possible because of the contributions of numerous injury and violence prevention professionals.

To lay the foundation for the plan, an initial meeting of key stakeholders took place on October 2 and 3, 2008. An outcome of that meeting was a statement of the plan's desired impact, which is to reduce morbidity and mortality related to injury and violence in North Carolina. Further, the group outlined a vision, purpose and guiding principles for the document, which are outlined below:

Vision

- People are living longer, with high-quality lives, and are fully productive.
- Environments have built-in safety and protective components.
- The consequences of violence are clear, and there is widespread recognition that violence is not acceptable.

Purpose

- Build a multi-disciplinary, unified approach to injury and violence prevention.
- Identify, prioritize and address issues for greatest impact on reducing morbidity and mortality rates.
- Identify injury and violence's root causes and effective prevention interventions.
- Coordinate policy and influence attitudes and behaviors around injury and violence prevention.
- Facilitate effective and integrated injury and violence prevention efforts at the local, regional and state levels.
- Institutionalize injury and violence prevention (IVP) as a major player in the public health system at all levels, appropriately reflecting the magnitude of the injury and violence problem in the state.

Guiding Principles

- Serve and treat all people equitably, being inclusive and socially and culturally relevant.
- Use best available data and/or evidence to guide decisions and practices, and be fair and transparent in decisions and actions.
- Foster an integrated, multi-disciplinary approach with due attention to root causes.
- Critically evaluate and monitor injury prevention initiatives, and adapt as necessary.

Once the impact, vision, purpose and guiding principles were set out, the partners completed the work of that meeting by creating the six goals of this plan, which are listed in the Executive Summary. The next building block for the plan was the creation of draft objectives setting strategies, timelines and benchmarks to achieving the goals. Partners met again to write the objectives using surveillance data, evidence-based prevention strategies, review of blue-ribbon expert panel recommendations such as Healthy People 2010, and input from key stakeholders. External factors such as current public opinion, availability of resources, and the political landscape were also considered.

Feedback on the draft objectives was solicited through an online survey that gathered input from a broader field of injury and violence prevention professionals. Nearly 50 respondents offered their opinions via the survey. To finalize the objectives, the input from the stakeholder survey and review of expert recommendations from the North Carolina Institute of Medicine task forces on prevention and adolescent health were combined. Further, the staff of the IVPB sought input from topic-area experts through a series of one-on-one meetings to gather in-depth feedback.

To complete the plan, a third in-person meeting took place on April 27, 2009. At that meeting, over 75 injury and violence prevention professionals came together to create the action steps that will be taken to achieve the objectives.

Another outcome of the April meeting was that groups known as goal teams were formed. Members of the goal teams are experts in the area covered by that goal. The goal team members will also work to carry out the action steps going forward. Crucial to the success of the plan will be the buy-in and commitment of the goal team members to be active participants in the plan's implementation.

In August 2009, the Injury and Violence Prevention State Advisory Council (IVP-SAC) was formed. This group is tasked with monitoring and advancing the overall plan by promoting collaboration among appropriate partners, fostering awareness of injury and violence prevention, supporting implementation of this plan and advocating for injury prevention at the local state and national levels. The Council's membership is appointed by the State Health Director and is made up of the leaders of the goal teams, staff from the Division of Public Health Injury and Violence Prevention Branch and other key content area experts.

The other partners involved in the construction of this plan are those traditionally involved in injury and violence prevention in North Carolina. These include hospitals; the state and local public health departments, including the DPH and Healthy Carolinians Partnerships; Trauma Center Regional Advisory Councils (RACs) that include representation from hospitals, pre-hospital providers, law enforcement and health agencies and others; researchers at North Carolina medical and academic institutions; the N.C. Governor's Highway Safety Program; the N.C. Department of Insurance's Office of State Fire Marshal, including Safe Kids Coordinators; and a number of nonprofits focused on specific prevention areas such as sexual violence, driving while impaired, and domestic violence. The long history of successful injury and violence prevention initiatives undertaken by these groups shows their commitment to and capacity for carrying out this plan to build the strength of North Carolina's injury prevention system.

FUNDING FOR INJURY AND VIOLENCE PREVENTION IN NORTH CAROLINA

The amount of funding for IVP in North Carolina pales in comparison to the huge toll paid in medical costs, lost productivity, disability and death. State dollars appropriated to the IVP program in North Carolina do not equal even half a cent per person. If adequate resources were put into IVP, it could mean thousands of lives saved, more than 154,000 hospitalizations prevented, and avoidance of over 800,000 trips to the emergency room. This is just a snapshot of the statistics that describe the enormous burden of injury and violence in the state. More in-depth information can be found in the next section entitled *The Burden of Injuries and Violence in N.C.*

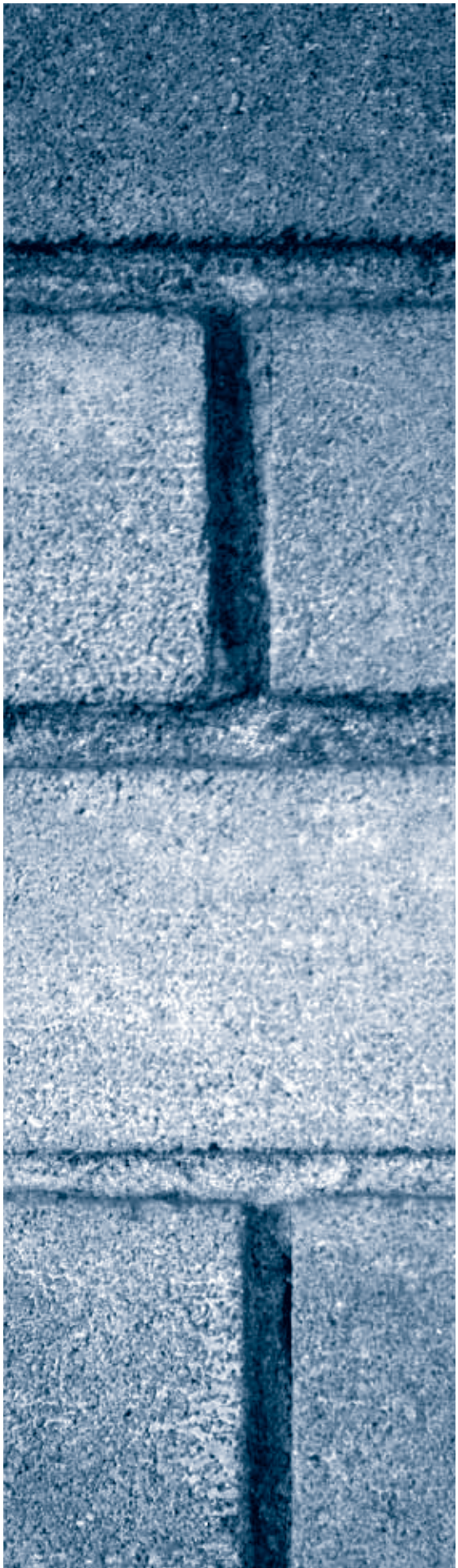
State Appropriations for the Injury and Violence Prevention Program Versus Chronic Disease Prevention Programs in N.C.:

	Total annual appropriation (2008)	Appropriation per person (2008 population)	Expenditure per death (all ages, 2008)	Expenditure per years of potential life lost (2008)
State appropriation for chronic disease prevention programs	$2,956,453	$0.32 per person	$71.30	$9.87
State appropriation for injury and violence prevention program	$23,599	$0.003 per person	$5.54	$0.21
Ratio of chronic disease : injury	125 : 1	107 : 1	13 : 1	47 :1

2008 population=9,222,414
2008 Injury deaths=MVC and Unintentional injuries= 4,257
2008 Chronic Disease deaths=Heart disease, cancer, stroke and diabetes= 41,461
2008 YPLLs from Injury deaths= 113,824
2008 YPLLs from CD deaths= 299,414

The table above outlines state appropriations for the IVP program versus appropriations for chronic disease prevention programs. No direct monies are appropriated by the North Carolina General Assembly to the IVP program. The IVP program has traditionally received limited funding from the Maternal and Child Health federal block grant because of the strong connection between injury prevention and the health and wellbeing of the state's children and adolescents. The $23,599 shown in the table equals the state match requirement for these federal funds. This funding, however, is appropriate and appreciated, as injury is the leading cause of death for children in North Carolina. Still, current state funding per injury death is only $5.54 – less than the cost of one ticket to the North Carolina State Fair.

Expenditures in North Carolina lag behind other states when looking at the amount spent on injury prevention per person, per year. In Oklahoma, about 11 cents is spent on prevention for each of its 3.6 million people; in Florida, with a population around 18 million, about 3 cents per person is spent on prevention. This shows us that North Carolina spends 10 times less than Florida and 36 times less than Oklahoma on its injury and violence prevention program.



Working to Increase Funding

To achieve the goals set out in this plan, it will be necessary to obtain increased and sustained funding from the North Carolina General Assembly and a variety of other funders. The IVP-SAC will oversee work to increase funding. The objectives that will guide the IVP-SAC's efforts are:

- By December 2010, or when available, seek core funding to support the injury and violence prevention program's basic operations from the Centers for Disease Control and Prevention's National center for Injury Prevention and Control.
- By June 2010, develop a plan for legislative fiscal requests to the North Carolina General Assembly for the 2011 and 2013 sessions.
- By January 2012, organize a group and/or a non-governmental agency with a mission that includes advocating for injury and violence prevention legislative initiatives and fiscal requests.
- By December 2014, increase the amount of funding state and local injury and violence prevention programs receive. The funding is to be directed toward or managed by a state government agency or university that works on injury and violence prevention. The goal is to receive a minimum of $500,000 from the North Carolina General Assembly.

The likelihood of obtaining funding for injury and violence prevention is increased by spreading the word that the dedicated professionals in this field are organized and working to achieve common goals. Promoting injury and violence prevention as a group will raise awareness throughout the state, which can help everyone obtain and sustain resources to go towards important and needed injury prevention programs.

THE BURDEN OF INJURIES AND VIOLENCE IN NORTH CAROLINA

Injury was the fourth leading cause of death for all North Carolinians in 2007. For younger people (ages 1 to 48), injury is the number-one cause of death.[1] Violence is the second (homicide) and third (suicide) leading cause of death for 15-to-24-year-olds.[1]

The two major categories that define injury data are *intentional* and *unintentional.* Intentional injuries result from interpersonal or self-inflicted violence, and include homicide, assaults, suicide and suicide attempts, child abuse and neglect (includes child sexual abuse), intimate partner violence, elder abuse, and sexual assault. Unintentional injuries include, but are not limited to, those that result from motor vehicle crashes, falls, fires, poisonings, drownings, suffocations, choking, and recreational and sports-related activities. In terms of injury-related deaths, intentional injuries generally account for one-third of the deaths, while unintentional injuries account for two-thirds of the deaths.

The economic burden of injury and violence in North Carolina is enormous. All told, the cost of injury exceeds $27 billion per year. This number encompasses fatal and non-fatal injuries' direct medical costs ($1.2 billion), work-loss costs ($6.8 billon), and quality of life costs ($19.4 billion). The costs associated with injury and violence are truly staggering. Among North Carolinians aged 45 to 64, total costs from fall injuries alone were over $1 billion in 2005. For residents aged 20 to 44, death from violence, both self-inflicted and assault, cost $3.8 million in direct medical costs alone. Non-fatal injuries suffered by victims of assault add up to a cost of $625 million per year.[2,3]

Injury data in North Carolina are collected by many agencies, using a variety of systems. Injury surveillance and analysis is primarily conducted by the Injury Epidemiology and Surveillance Unit of the DPH's IVPB. Death data are obtained from vital statistics records through the N.C. State Center for Health Statistics. Hospitalization data come from the N.C. State Center for Health Statistics' hospital discharge data set. The emergency department dataset is obtained from the North Carolina Disease Event Tracking and Epidemiologic Collection Tool (N.C. DETECT).

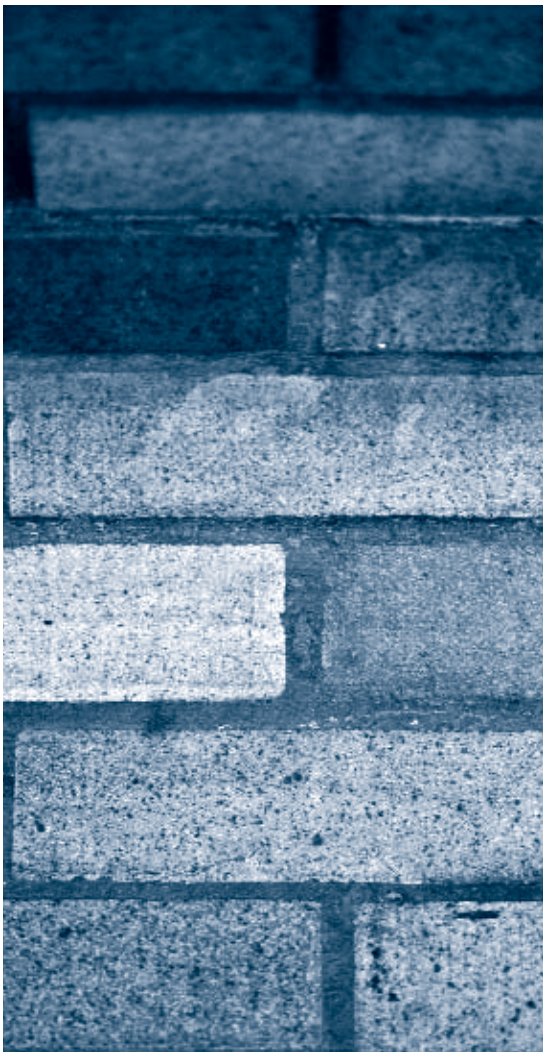


Figure 1: Six Leading Causes of Death, North Carolina

2001-2006, All Races, Both Sexes

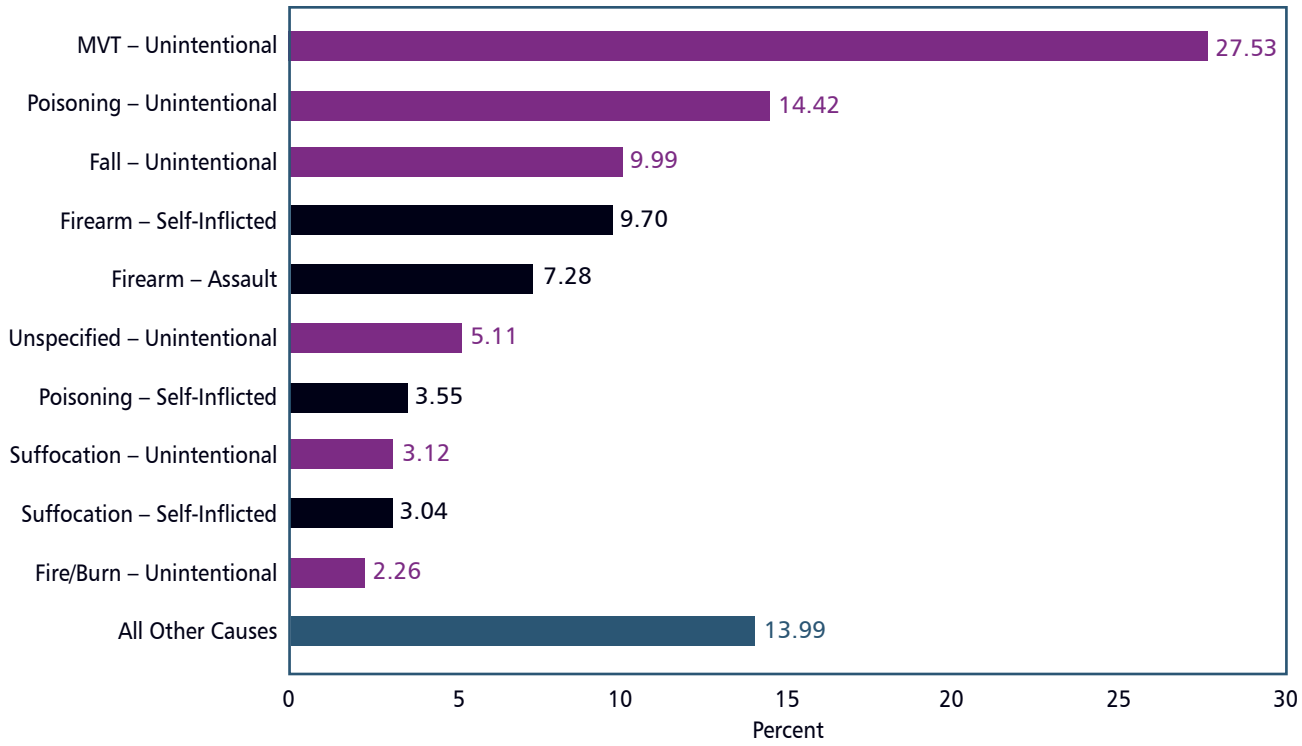
RANK	AGE GROUPS										
	>1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Short Gestation 1,195	**Unintentional Injury 294**	**Unintentional Injury 242**	**Unintentional Injury 309**	**Unintentional Injury 3,311**	**Unintentional Injury 2,964**	**Unintentional Injury 3,575**	Malignant Neoplasms 9,625	Malignant Neoplasms 18,728	Heart Disease 85,274	Heart Disease 108,633
2	Congenital Anomalies 1,083	Congenital Anomalies 86	Malignant Neoplasms 80	Malignant Neoplasms 91	**Homicide 989**	**Homicide 975**	Malignant Neoplasms 2,930	Heart Disease 7,221	Heart Disease 12,442	Malignant Neoplasms 66,505	Malignant Neoplasms 98,939
3	SIDS 587	**Homicide 66**	Congenital Anomalies 32	**Homicide 42**	**Suicide 752**	**Suicide 939**	Heart Disease 2,667	**Unintentional Injury 3,248**	Chronic Low. Respiratory Disease 2,502	Cerebro-vascular 25,874	Cerebro-vascular 30,251
4	Maternal Pregnancy Comp. 445	Malignant Neoplasms 57	Heart Disease 30	**Suicide 41**	Malignant Neoplasms 226	Malignant Neoplasms 690	**Suicide 1,330**	Cerebro-vascular 1,390	Cerebro-vascular 2,192	Chronic Low. Respiratory Disease 19,356	**Unintentional Injury 23,271**
5	Placenta Cord Membranes 269	Heart Disease 39	**Homicide 27**	Congenital Anomalies 36	Heart Disease 204	Heart Disease 620	HIV 965	**Suicide 1,252**	Diabetes Mellitus 2,174	Alzheimer's Disease 12,622	Chronic Low. Respiratory Disease 22,866
6	Bacterial Sepsis 204	Influenza & Pneumo-nia 22	Chronic Low. Respiratory Disease 10	Heart Disease 31	Congenital Anomalies 99	HIV 402	**Homicide 707**	Liver Disease 1,183	**Unintentional Injury 1,916**	Diabetes Mellitus 9,597	Diabetes Mellitus 13,522

WISQARS™ Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Both intentional and unintentional injuries make frequent appearances in the chart of leading causes of death. Unintentional injury, which includes motor vehicle crashes, poisonings, falls and fires/burns, is the number-one cause of death for people in the first four decades of life. Most startling, Figure 1 shows that injury is in the top six causes of death for all North Carolinians ages one and older. As stated by the National Academy of Sciences in the 1988 report *Injury Control*, "Injury is probably the most under-recognized major public health problem facing the nation today." There is a critical need to raise public awareness of the severity of the problem and to garner resources for prevention.

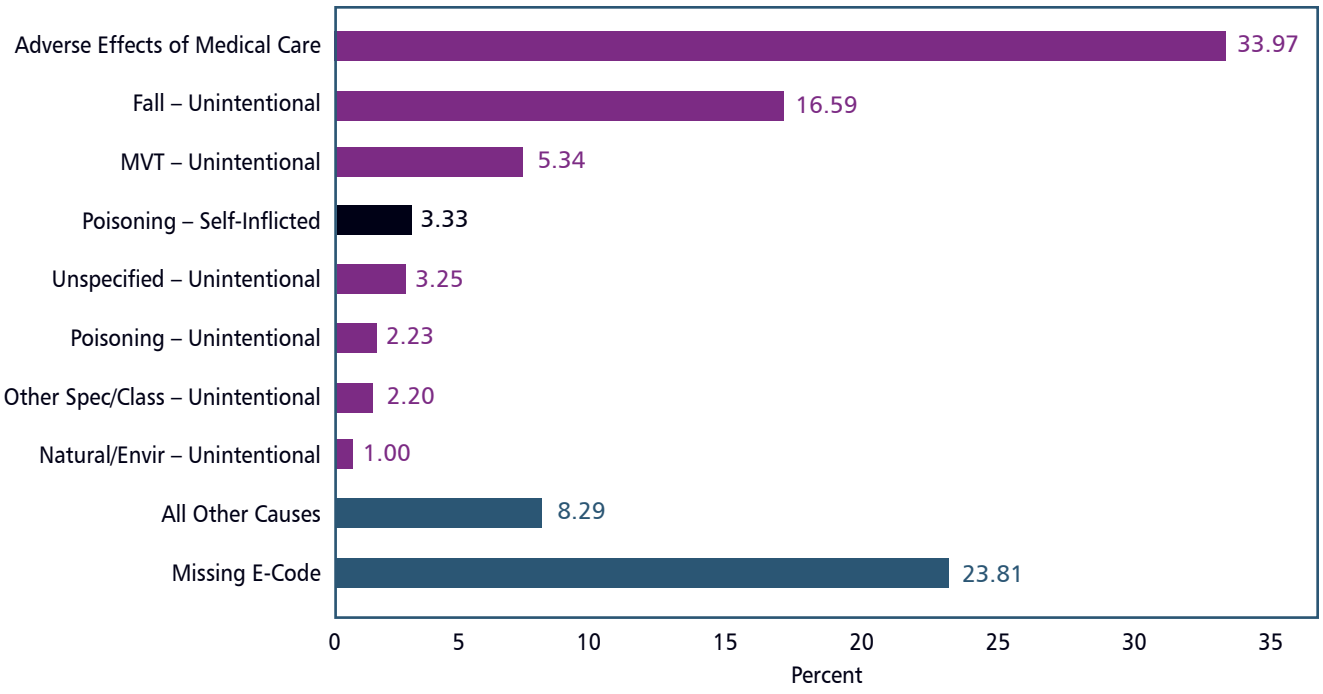
Figure 2: Percent Leading Causes of Injury Deaths, All Ages
N.C. Residents: 2007 (Total Deaths = 6,247)



Source: N.C. State Center for Health Statistics, Death file 2007; Analysis by N.C. DPH Injury and Violence Prevention Branch, Epidemiology and Surveillance Unit

Injury deaths from 2007 data are shown in Figure 2. Suicide by firearm was the fourth-leading cause of injury death, while suicide by poisoning is the seventh. Note that suicides by firearm account for a greater percentage of deaths than do homicides by firearm. The second leading cause of injury death is unintentional poisoning, which includes overdose from prescription drugs. The dramatic rise in poisoning deaths is often of surprise to many people. These death rates increased by more than 180 percent from 1999 (3.53 deaths per 100,000 population) to 2007 (9.94 deaths per 100,000 population).

Figure 3: Percentage of Leading Causes of Injury Hospitalization, All Ages
North Carolina Residents: 2007 (Total Hospitalizations = 154,348)



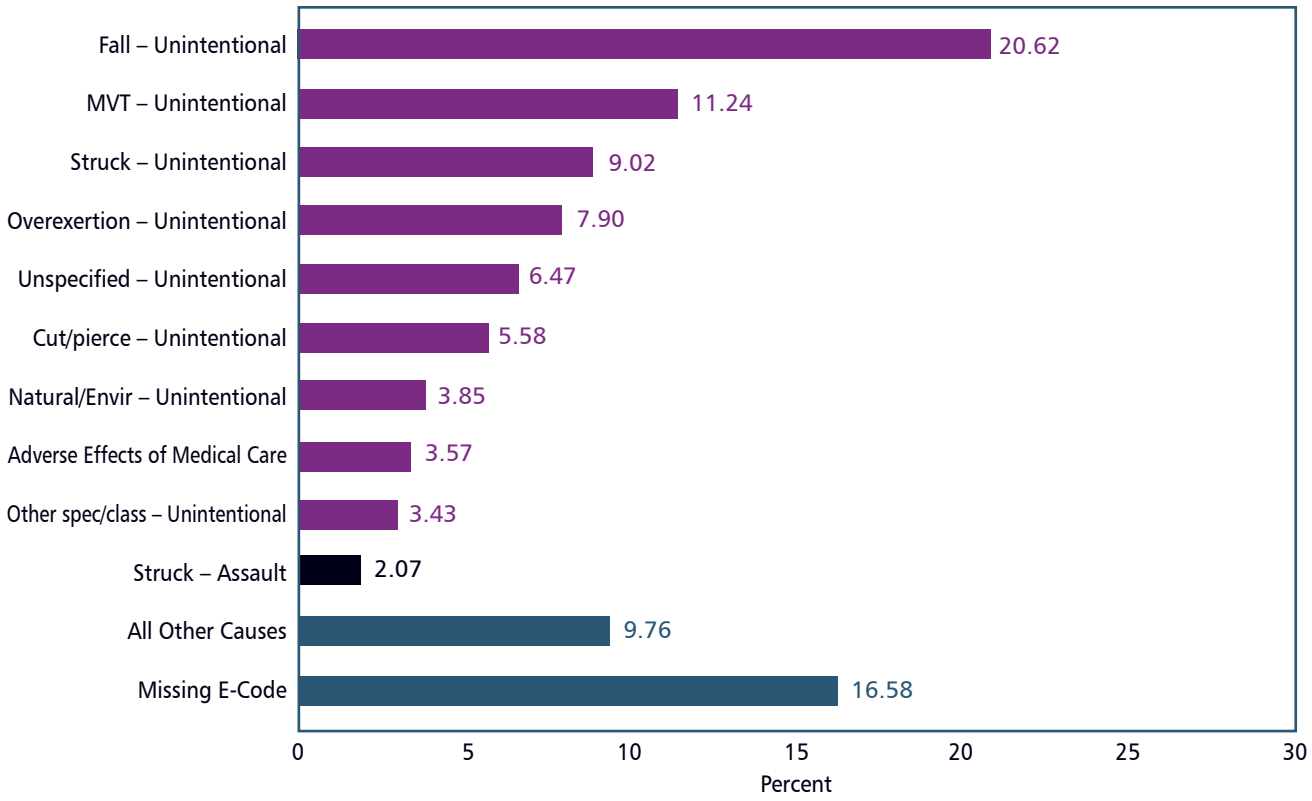
Source: N.C. State Center for Health Statistics, Death file 2007; Analysis by N.C. DPH Injury and Violence Prevention Branch, Epidemiology and Surveillance Unit

Hospitalizations for injuries in 2007 numbered over 154,000. The leading causes of these hospitalizations are outlined in Figure 3. Adverse effects of medical care, unintentional falls and motor vehicle traffic injuries make up the top three causes of injury hospitalizations. The All Other Causes category includes numerous causes of injury that individually do not account for a large percentage of injury hospitalizations, but when added together make up about 8 percent of hospitalizations caused by an injury.

The category labeled "Missing E-code" means that no external cause or mechanism and intent of injury was assigned for that hospitalization. The high number, 23.81 percent, of missing E-Codes is of concern because it makes it difficult to get an accurate picture of the injury problem. E-codes differentiate causes of a given injury, which is critical information for prevention programming. For example, E-codes indicate whether a concussion was from a motor vehicle crash, a football injury or assault by a domestic partner.

To improve E-coding in North Carolina, it is recommended that there be a mandate requiring E-coding of medical records relating to injuries and electronic capture of the E-code, modification of coding software to encourage detailed coding, adequate training of hospital personnel (especially coders and clinicians), and consideration of periodic validation of E-coding.

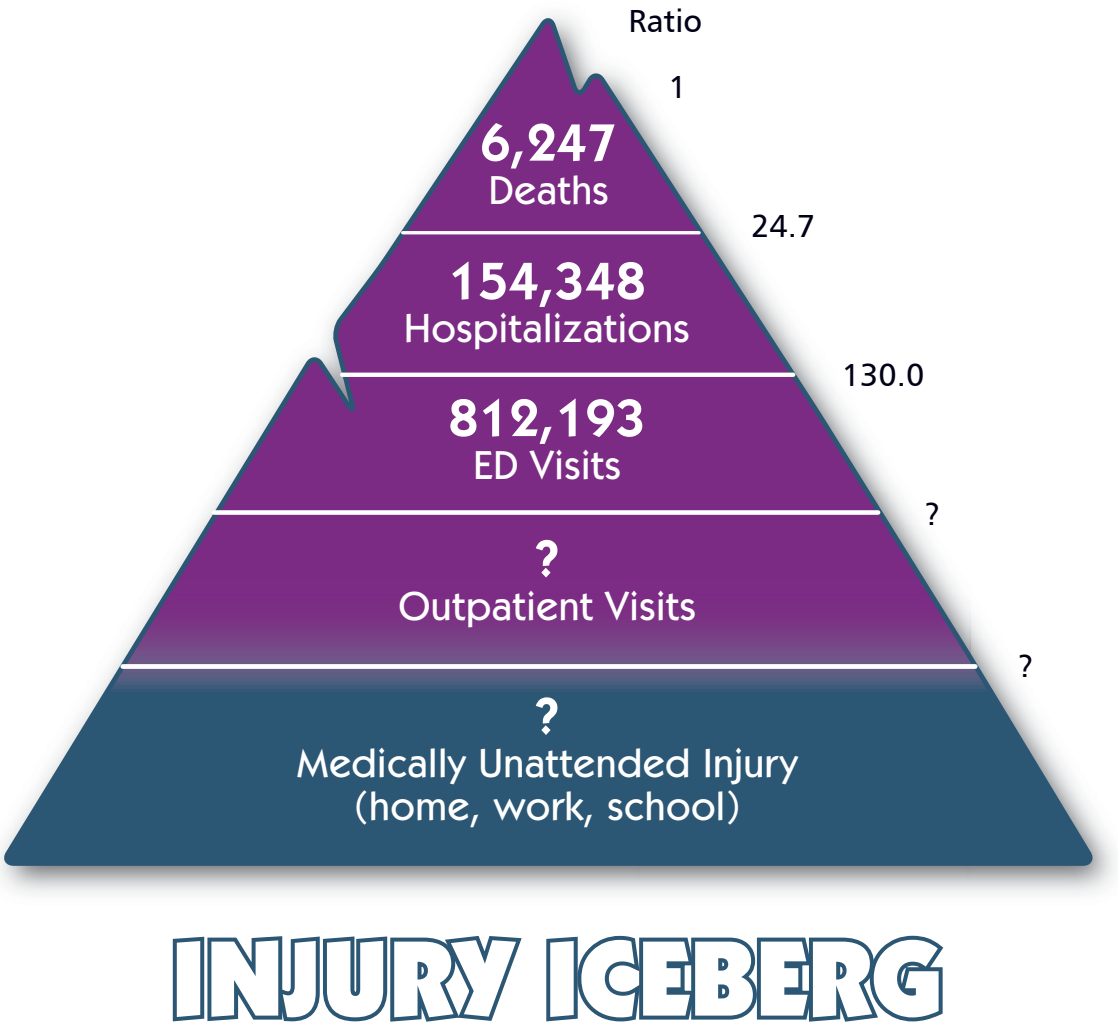
Figure 4: Percentage of Leading Causes of Injury Emergency Department Visits, All Ages
North Carolina Residents: 2007 (Total Visits = 812,193)



Source: N.C. State Center for Health Statistics, Death file 2007; Analysis by N.C. DPH Injury and Violence Prevention Branch, Epidemiology and Surveillance Unit

Among visits to the emergency department (ED) due to an injury, about one-third of injuries are caused by falls and motor vehicle crashes. The leading causes of ED visits are mostly unintentional injuries, according to 2007 data. Over 16 percent of cases are missing E-Codes in Figure 4, reinforcing the need for improved data collection methods.

Figure 5: North Carolina Injury Iceberg
North Carolina Residents: 2007

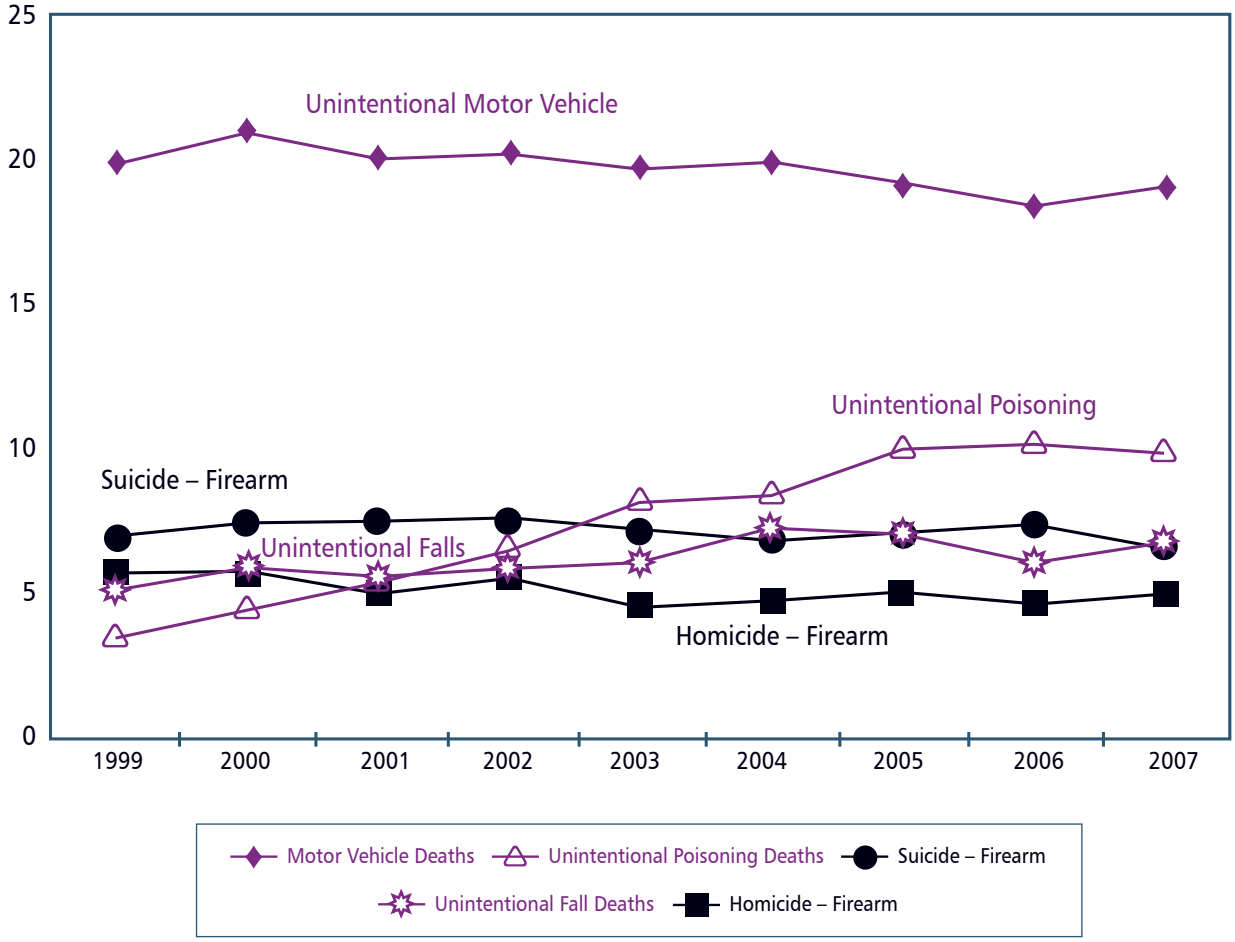


Data sources: State Center for Health Statistics, death file 2007; Hospitalizations: State Center for Health Statistics, discharge file 2006; Emergency Department visits: N.C. DETECT, ED file 2007. NC Residents. Analyses conducted by Injury Epidemiology and Surveillance Unit.

Deaths are only the tip of the iceberg when looking at the overall burden of injury. In Figure 5, the wider levels below deaths represent the large numbers of people who are injured each year as evidenced by hospitalizations, emergency department visits and outpatient visits, as well as medically unattended injuries. While many injuries are defined by mortality rates, injuries also can impair overall health, causing life-long disabilities and/or psychological effects, and preventing people from living to their full potential. There are question marks for the widest levels of the pyramid because current surveillance systems are unable to capture this information routinely; however, the numbers are estimated to be very large. Every three minutes there is a visit to a North Carolina ED because of a fall injury; however, this metric does not capture

people who fall and then visit their primary care physician or who do not seek any medical attention at all. This gap between reported ED visits and the actual number likely exists in *all categories of injury* and therefore current data represents a fraction – the tip of the iceberg – of the true burden of injury in North Carolina.

Figure 6: Leading Causes of Injury Death Rates per 100,000
N.C. 1999-2007

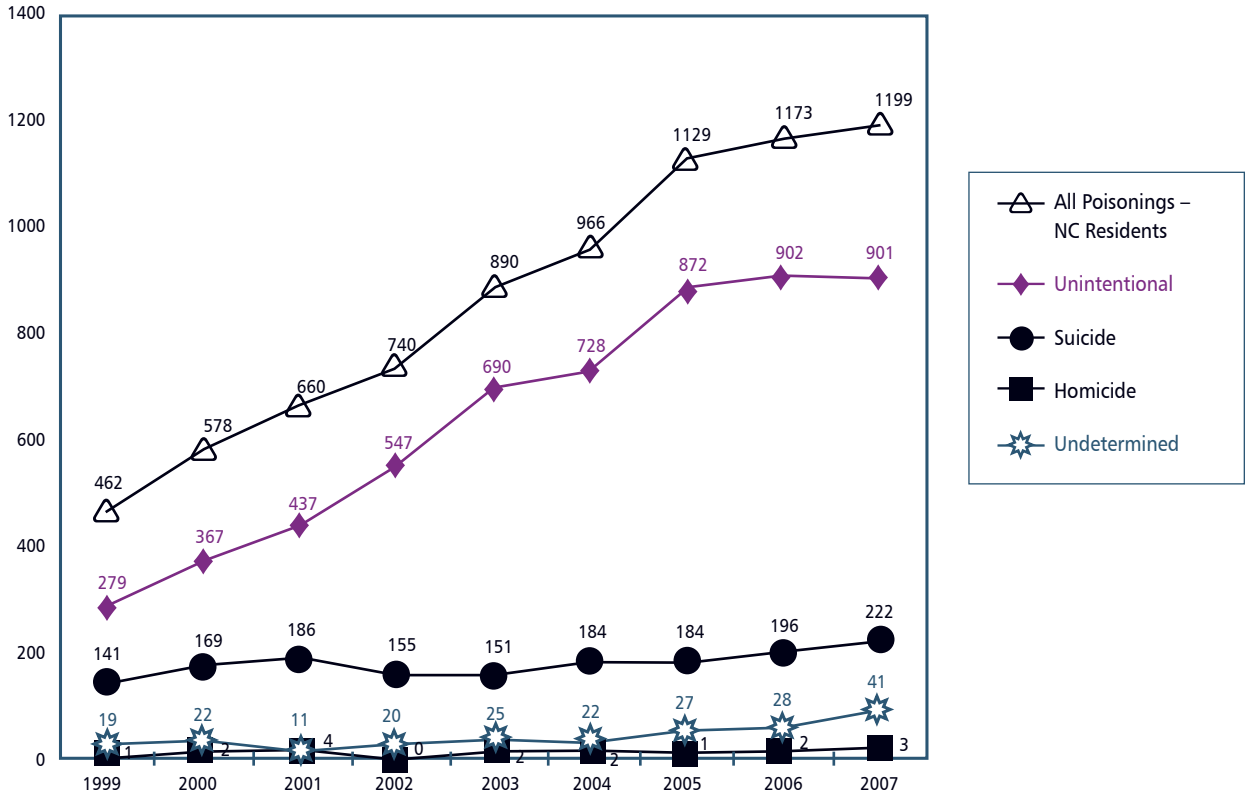


Data sources: Deaths: N.C. State Center for Health Statistics, death file 2007; Analyses conducted by Injury and Violence Prevention Branch, Epidemiology and Surveillance Unit

Trends over time for the five leading causes of injury death from 1999 to 2007 are seen in Figure 6. Unintentional poisonings and unintentional fall injuries have both seen significant increases over this time period.

While there have not been significant changes, rates of suicide, homicide and motor vehicle crashes remain unacceptably high.

Figure 7: Number of Poisoning Deaths by Intent
N.C., 1999-2007



Source: Deaths: N.C. State Center for Health Statistics, Death file 2007; Analysis by N.C. DPH Injury and Violence Prevention Branch, Epidemiology and Surveillance Unit

A seriously under-recognized and misunderstood public health issue is death from unintentional poisonings, the vast majority of which are related to prescription narcotics. Unintentional poisonings are commonly referred to as overdoses. Most of these deaths are not intentional, as can be seen in Figure 7. In 2007, 901 North Carolina residents died as a result of unintentional poisonings. Most of these deaths were related to misuse of painkillers.

Street drugs like heroin and crack cocaine were the overdose epidemics of the 1970s, '80s and '90s. In this decade, a new and growing concern is the misuse and abuse of prescription drugs. Narcotic painkillers such as methadone, oxycodones, and hydrocodones are the cause of the majority of unintentional poisoning deaths in North Carolina.[4]

Fall injuries are of particular concern for people ages 65 and older. According to 2007 data, over three-quarters of fall injury deaths occurred in that age group. Older adult fall injury deaths are only expected to worsen: projections show a "Silver Tsunami" coming to North Carolina over the next decades. In 2000, fewer than 25 of North Carolina's 100 counties had more people over the age of 65 than under the age of 18. Population projections based on July 2006 data show that in 2030 over 75 counties will have more people 65 and older than 18 and younger.

Table 1: 2030 Unintentional Fall Injury Projections for Deaths, Hospitalizations and ED Visits, N.C. Residents, Ages 65+

	2006/2007	Year 2030	% Increase
Deaths	480	947	97.3
Hospitalizations	17,579	35,569	102.3
ED Visits	44,541	87,921	97.4

The effect of this explosion in the older adult population is seen in Table 1. Significant increases are expected for deaths, hospitalizations and ED visits due to unintentional fall injuries. The 2030 count projections are based on fixed 2007 rates for fall injuries. It is expected that this rate will increase as it has for the past several years. Though these numbers, like the 97 percent increase in projected ED visits, are alarming enough, current trends tell us that these are likely conservative estimates. The true numbers will probably be even larger.[6,7,8,9]

Violence in North Carolina

Violence accounted for 1,785 resident deaths in 2006 in North Carolina. Sixty-two percent of these deaths were due to suicide and 34 percent were due to homicide. The N.C. Violent Death Reporting System (N.C. VDRS) is a CDC-funded state-wide surveillance system that collects detailed information on violent deaths that occur in the state, specifically homicide, suicide, unintentional firearm deaths, deaths from legal intervention, and those deaths where the intent could not be determined. A multi-source system, N.C. VDRS gathers information from death certificates, medical examiner reports and law enforcement reports. The collection of this information has created a better understanding of the circumstances that surround violent deaths occurring in the state. In Table 2, data from the N.C. VDRS are presented, outlining the gender, race and age group of violent death victims in the state in 2006.

Table 2: Gender, Race, and Age Group of Violent Death Victims in N.C., 2006

		Number	%	Rate	95% C.I. for Rate
Gender					
	Male	1,373	76.9	31.6	29.9 - 33.3
	Female	412	23.1	9.1	8.2 - 10.0
Hispanic					
	Hispanic	88	4.9	14.9	11.8 - 18.0
	Non-Hispanic	1,697	95.1	20.5	19.5 - 21.5
Race					
	American Indian	29	1.6	25.5	16.2 – 34.8
	Asian	12	0.7	6.8	2.9 – 10.6
	Black	440	24.7	22.5	20.4 – 24.6
	Pacific Islander	1	0.1	*	*
	White	1,297	72.7	19.6	18.5 – 20.7
	Other	4	0.2	*	
	Unknown	2	0.1	*	*
Age Group (yrs)					
	< 1	17	1.0	13.2	6.9 – 19.5
	1-4	13	0.7	2.7	1.3 – 4.1
	5-9	9	0.5	1.5	0.5 – 2.5
	10-14	14	0.8	2.4	1.2 – 3.6
	15-19	112	6.3	18.5	15.1 – 21.9
	20-24	213	11.9	34.9	30.2 – 39.6
	25-34	312	17.5	25.7	22.9 – 28.6
	35-44	356	19.9	26.9	24.1 – 29.7
	45-54	350	19.6	27.6	24.7 – 30.5
	55-64	187	10.5	19.2	16.5 – 21.9
	65-74	112	6.3	19.5	15.9 – 23.1
	75-84	64	3.6	17.5	13.2 – 21.8
	85 +	26	1.5	19.2	11.8 – 26.6
Total Deaths		**1,785**	100		

Source: N.C. Violent Death Reporting System, Annual Report 2006, N.C. DPH Injury and Violence Prevention Branch, Epidemiology and Surveillance Unit

C.I. = Confidence interval

Note: Asterisk indicates numbers were too small to calculate a rate.

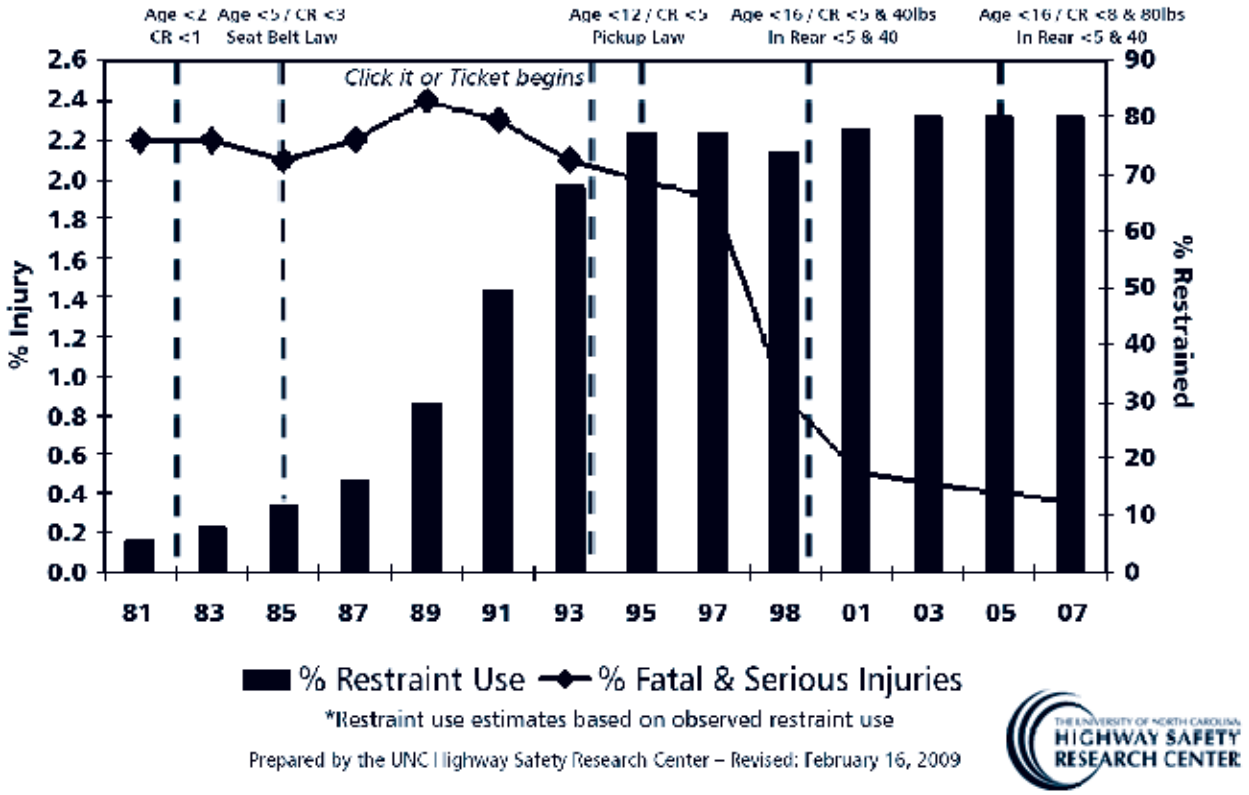
The data indicate that violent death is concentrated among certain populations.

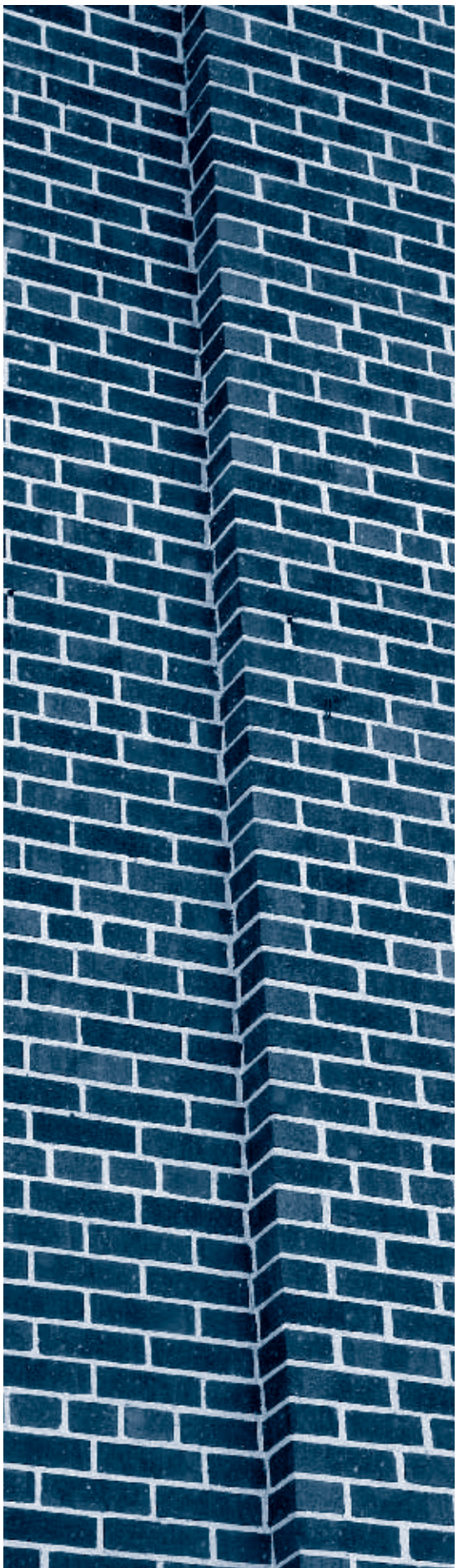
- Men are three times more likely to die a violent death than women.
- Violent death rates are highest among American Indians and African Americans.
- People between the ages of 20 and 24 experience the highest rate of violent death.
- Infants (under age 1) have the highest rate of violent death among all children under 15.

Policy Interventions and Reducing the Burden of Injury

Policy at the state, local or organizational level can be a very effective tool for preventing injuries and saving lives. Policies, such as requiring childproof tops on pill bottles and cigarettes to be self-extinguishing, have prevented many poisonings and burn injuries. Other well known examples of injury prevention policy successes include child passenger restraint and Graduated Drivers License (GDL) system policies. Injuries in children ages 0 to 15 related to motor vehicle crashes have seen sharp declines since the enactment of child restraint laws starting in the early 1980s. Analysis by the University of North Carolina Highway Safety Research Center shows the steady increase in observed restraint use corresponds with the decline in injury rates in children (Figure 8).

Figure 8: Estimated Restraint Use* and Injury Rates for Children Ages 0-15 in North Carolina Crashes
1980-2007





Motor vehicle crashes are the leading cause of death among teenagers. A combination of inexperience and the natural impulsiveness of the adolescent years contribute to this increased risk of being involved in a crash. An effective intervention to address this problem is the GDL system that went into effect in North Carolina on December 1, 1997. From 1996 to 1999, fatal 16-year-old driver crashes declined 57 percent. Crashes at night were 43 percent less likely, and daytime crashes decreased by 20 percent. Follow-up analyses of crash data through 2005 indicate that the crash rate has remained at this much lower level, with no evidence of any erosion of the benefits of this new approach to licensing.[10]

GOALS, OBJECTIVES, ACTION ITEMS AND EVALUATION MEASURES

This section of the document addresses the "how to" of *Building for Strength*. The six goals of this plan delineate specific objectives and action steps. Action steps are only included in the full version of the plan, available at www.injuryfreenc.ncdhhs.gov. Dates for completion and who is responsible for the work are also described.

The evaluation measures for each goal have two components: 1) a progress check evaluation that focuses on process measures to track progress towards achieving the stated objectives; and 2) an overarching measure that asks, "So what's the bottom line?" is asked. Currently there are not sufficient resources to do a complete evaluation of whether the bottom line measure is met. The inclusion of these measures is meant to encourage a focus on working towards the desired impact of this plan, which is ultimately to prevent serious injury and the resulting death and disability.

Goal 1: Data and Surveillance

Increase the use of injury and violence data through a comprehensive, coordinated injury surveillance system that is accurate, readily available and sustainable, and that is used to guide injury and violence prevention programs and policies at the local, regional and state level.

WHEN	Objective A	WHO
9/2009	Convene the Data Goal Team for the State Strategic Plan to address gaps in existing data and data systems.	Data Goal Team (DGT)

WHEN	Action Items	WHO
6/2009	1. Identify partners to participate on the Data Goal Team, such as Action For Children, Law Enforcement, State Bureau of Investigation, Maternal and Child Health, the Governor's Highway Safety Program, the Office of the Chief Medical Examiner, the State Center for Health Statistics, Trauma RACs, Safe Kids, the Office of Healthy Carolinians, the North Carolina Office on Disability and Health, the Office of Juvenile Justice and Delinquency Prevention, Office of State Fire Marshal. Identify other partners by emailing stakeholders list from April 27 Strategic Planning Meeting.	DGT
7/2009	2. Send out a save-the-date invitation to identified data stakeholders for a September 2009 meeting.	DGT
8/2009	3. Work to plan a data stakeholders meeting.	DGT

9/2009	4. Hold meeting of Data Goal Team. Participants will come to the meeting with a one-page summary of their programs and available data.	DGT
9/2009	5. Assign meeting participants task of developing a list of data sources that includes relevant information about the data sources to be determined by the Data Goal Team.	DGT
9/2009	6. At meeting, develop subcommittees to handle special projects, the first being creation of the data inventory.	DGT

WHEN	Objective B	WHO
8/2010	Conduct an assessment of existing data sources that contain injury and violence prevention information, and create a data source list to post on the DPH IVPB website. The assessment will outline data source information, such as who compiles and analyzes the data and when new data are available each year. The assessment will identify data needs not met by existing sources.	DGT

WHEN	Action Items	WHO
12/2009	1. Review existing data resource list from the DPH IVPB to develop a tool and process for injury and violence prevention data resource collection.	DGT
3/2010	2. Submit data resources inventory to N.C. DPH Public Affairs Office for review and approval.	DGT
8/2010	3. Compile the data resources inventory and disseminate list to stake-holders group.	DGT

WHEN	Objective C	WHO
3/2011	Complete a Data Goal Team report with plans for closing data gaps, and methods for utilizing existing data to guide injury and violence prevention programs and policies at the state, regional, and local levels.	DGT

WHEN	Action Items	WHO
12/2010	1. Evaluate data resource list to determine existing gaps in data and conduct focus groups to better understand needs in the five priority risk areas.	DGT
2/2011	2. Analyze information from focus groups and create a report with recommendations on data needs in these areas.	DGT
3/2011	3. Submit draft State of Injury and Violence Prevention Data report for review to the IVP-SAC.	DGT, IVP-SAC

WHEN	Objective D	WHO
3/2012	Collaborate with the Coordination and Constituency Goal Team to determine how to best use data at the state and local level.	DGT

WHEN	Action Items	WHO
12/2011	1. Evaluate data resource list to determine existing gaps in data and conduct focus groups to better understand needs in five priority risk areas.	DGT
2/2012	2. Analyze information from focus groups and create a report with recommendations on data needs in these areas.	DGT
3/2012	3. Submit draft North Carolina Community Injury and Violence Prevention Data Uses and Needs report for review to the IVP-SAC	DGT, IVP-SAC

Progress Check Evaluation Measures: Goal 1

1
WHEN: 8/2010

WHAT: Data inventory document is created and posted to web.

WHO: DGT

2
WHEN: 2/2012

WHAT: Report is created with recommendations on data needs in these areas.

WHO: DGT

3
WHEN: 3/2012

WHAT: North Carolina Community Injury and Violence Prevention Data Uses and Needs report has been submitted for review to the IVP-SAC.

WHO: DGT

So What's the Bottom Line?

WHEN: By 12/2014

WHAT: Decisions about prevention programs and policies at the local, regional and state level are driven by data that are used to write grants, justify policy recommendations and make programming decisions.

WHO: DGT, IVP-SAC

Goal 2: Research and Evaluation

Foster efforts to conduct useful injury and violence research and evaluation, and foster efforts to disseminate findings to promote innovation and promising practices.

WHEN	Objective E	WHO
8/2009-12/2014	Enhance the quantity and quality of injury and violence research and program evaluation.	Research and Evaluation Goal Team

WHEN	Action Items	WHO
Ongoing	1. Facilitate the cataloging of topics, funding, data, evaluation instruments, and investigators, including: ■ Information on investigator areas of expertise and interest; ■ Validation information and source links for evaluation instruments; ■ Topic-tagged existing research.	IPRC
1/2010	2. Obtain a facilitator to connect researchers, funders, topics, instruments, and data.	IPRC

Ongoing	3. Lead the training of researchers and seek out projects from academic and non-academic settings. Seek out students from academic settings and match projects and students. Implement or find best practices; applied research or evaluation for LHD project.	IPRC
By 2014	4. Hold a N.C. conference on injury research	IVPB, IPRC, AHEC
By 12/2014	5. Work with the N.C. Medical Society to produce an issue of the N.C. Medical Society Journal on injury.	The State Trauma Advisory Council (STAC) Research Chair in partnership with IPRC
Ongoing	6. Promote research about injury and violence prevention to inform gaps in legislation or policy.	Child Fatality Task Force (CFTF), IVP-SAC
Ongoing	7. Work to integrate research and program evaluation work across other disciplines, including trauma, chronic disease, labor, disability, agriculture, and maternal child and health.	DPH, IVP-SAC

WHEN	Objective F	WHO
8/2009-12/2014	Use research and evaluation for program and policy development and improvement.	Research and Evaluation Goal Team

WHEN	Action Items	WHO
12/2010	1. Develop criteria for promising programs using CDC and other national guidance.	IPRC and IVPB Programs Unit
Beginning 6/2010 ongoing through 2014	2. Develop a clearinghouse of interventions, including the evaluation of those interventions. Facilitate the utilization of this clearinghouse by program implementers and policy developers.	IPRC and IVPB Programs Unit, Highway Safety Research Center (HSRC), and the Institute on Aging
Ongoing	3. Prioritize areas of injury for which programs should be implemented and/or policy developed.	IVPB

Ongoing	4. Catalog dissemination tools to determine the best methods for disseminating information on research and evaluation to those who will translate the information into practice.	IVPB and Health Promotion and Disease Prevention (HPDP) (with permission of agency head)
Ongoing once developed.	5. Promote utilization of catalog of instruments.	IPRC, IVPB

WHEN	Objective G	WHO
8/2009-12/2014	North Carolina Foundations and other organizations with an interest in injury and violence prevention should fund preventive interventions, evaluation, and research in areas that benefit IVP including those interventions considered to be promising practices and those with limited evidence. Priority should be given to research and program implementation that crosses multiple disciplines, settings, and topics.	Research and Evaluation Goal Team

WHEN	Action Items	WHO
6/2011	1. Organize efforts to find common solutions to maximize efficiency of funding. For example, research and primary prevention program implementation in family violence should cross multiple types of family violence, including domestic violence, care giver abuse child maltreatment, and bullying prevention.	IVP-SAC, MCH programs, Research and Evaluation Goal Team (REGT)
12/2012 and ongoing	2. Host a meeting of foundations to talk about IVP and the relationship to the foundations, and present an award to the Foundation with the greatest funding/ impact in injury at both the local and state levels.	DPH and IVP-SAC Team

Progress Check Evaluation Measures: Goal 2

1

WHEN: 7/2010

WHAT: Catalog of current injury and violence prevention activities is created.

WHO: REGT

2

WHEN: 12/2012

WHAT: A meeting of foundations that fund initiatives that address injury and violence prevention has been held.

WHO: REGT

3

WHEN: 12/2012

WHAT: A foundation that is an outstanding champion of injury and violence prevention has been recognized with an award.

WHO: REGT

4

WHEN: 12/2014

WHAT: One evaluation of an injury and violence prevention intervention that integrates work from a non-injury field has been conducted.

WHO: REGT

5

WHEN: 12/2014

WHAT: Three examples of interventions that utilized evidence-based or best practice information are documented.

WHO: REGT

6

WHEN: 12/2014

WHAT: A brief guide on best practices for disseminating research to practice has been developed.

WHO: REGT

7

WHEN: 12/2014

WHAT: Conference focusing on injury and violence prevention research has been held.

WHO: REGT and IVP-SAC

8

WHEN: 12/2014

WHAT: An issue of the N.C. Medical Society Journal on injury and violence prevention has been published.

WHO: REGT

9

WHEN: 12/2014

WHAT: A clearinghouse of injury and violence prevention interventions has been developed and disseminated to stakeholders.

WHO: REGT

So What's the Bottom Line?

WHEN: 12/2014

WHAT: Prevention programs developed and implemented within the state are based on evidence of successful outcomes.

WHO: IVP-SAC

Goal 3: Messaging, Policy and Environmental Change

Develop strong, vocal community support for injury and violence prevention and the creation of safe, accessible environments by reframing unintentional injuries and violence as unacceptable and by promoting policies that support prevention of injury and violence.

WHEN	Objective H	WHO
4/2009-6/2011	Work with the National Center for Injury Prevention and Control at the Centers for Disease Control, The Children's Safety Network, social marketing professionals in the N.C. DPH, and universities to reframe traditional prevention messages into messages that will better inform the public and public health professionals that injuries and violence are preventable.	The Policy and Social Messaging and other Environmental Changes Goal Team (PSMEC)

WHEN	Action Items	WHO
12/2009	1. Identify priority injury and violence prevention areas where messages need to be developed or disseminated by consulting the Injury and Violence Prevention State Advisory Council (IVP-SAC).	PSMEC
2/2010	2. Review currently used prevention messages for the identified priority areas from national, state and local materials.	PSMEC
3/2010	3. Determine effectiveness of predominate currently used messages by reviewing messaging campaign evaluations when available and/or collecting the expert opinion of professionals in the injury and violence prevention field.	PSMEC
3/2010	4. Review prevention messages that are inclusive of persons with disabilities and incorporate ideas as appropriate.	PSMEC
3/2010	5. Review how state and national media present injury and violence prevention messages.	PSMEC
6/2010	6. Create repository of effective (determined by evidence-based or expert opinion) messages and make available on the DPH, IVPB website and other websites as appropriate.	PSMEC, IVPB
6/2011	7. Ensure injury and violence prevention stakeholders share common prevention messages, tailored to each injury or violence issue area, based on recommendations developed with state and national partners, to be used in communications with the public.	PSMEC

7/2011	8. Coordinate with the Training Goal Team to include the effective message repository in training materials they develop and disseminate.	PSMEC
12/2011	9. Tailor message content and method of dissemination (radio, web, etc.) for specific populations including policymakers.	PSMEC

WHEN	Objective I	WHO
6/2010	Identify at least eight champions and opinion leaders from throughout the state to assist with dissemination of the idea that individuals working in different injury and violence prevention topic areas are part of a larger collective that is the field of injury and violence prevention. Champions will support county-level key stakeholders and provide guidance in bringing message to counties in a dynamic fashion.	PSMEC and Coordination and Constituency Goal Team

WHEN	Action Items	WHO
6/2009 and ongoing	1. Support efforts to fund eight Regional Injury Prevention Coordinators and one State Injury Prevention Manager and the efforts of the Coordination and Constituency Goal Team to identify injury prevention champions throughout the state.	PSMEC, IVP-SAC
Ongoing	2. When coordinators or champions are identified, utilize these individuals to connect existing local injury and violence prevention networks through formal and informal communication and sharing of resources such as toolkits and training opportunities. Existing networks include: Governor's Highway Safety Program, Trauma Regional Advisory Councils, Safe Kids, N.C. Coalition Against Domestic Violence, N.C. Coalition Against Sexual Assault, Victims with Disabilities Task Force, Prevent Child Abuse N.C., County Gang Prevention Task Forces, local health departments, Maternal and Child Health programs and others working throughout the state.	PSMEC
Ongoing	3. When coordinators or champions are in place, work with the Coordination and Constituency Goal team to organize these individuals to promote injury and violence prevention as a field, and identify subject matter experts in specific areas, i.e. motor vehicle crash or falls prevention to use messages developed in Objective H.	PSMEC

WHEN	Objective J	WHO
8/2010	Assist in the development of a three-year substantive policy agenda for North Carolina Injury and Violence Prevention.	PSMEC

WHEN	Action Items	WHO
12/2009	1. Review and compile the policy agendas from injury and violence prevention partners at the national level, such as STIPDA, AMCHP, and CDC, as well as agendas from other states. Also include agendas from in-state organizations such as Governor's Highway Safety Program, North Carolina Coalition against Sexual Assault, Mothers Against Drunk Driving, North Carolina DPH and others as appropriate. *Current injury and violence prevention policy initiatives supported by the PSMEC and the IVP-SAC include:* ■ Instituting an evidence-based driver's education program in North Carolina ■ Instituting a safety training program for moped operators ■ Instituting graduated fines for speeding violations *Preliminary N.C. IOM recommendations supported by the PSMEC and the IVP-SAC include:* ■ Strengthening rear seat occupant seat belt law by making it a primary seat belt use law ■ Increasing seat belt law fines for violations ■ Increasing license restoration fee for DWI offenders from $100 to $125 to support DPH's efforts in the Booze It & Lose it program. ■ Instituting a training requirement for all people who operate a motorcycle ■ Changing current motorcycle permit provisions to correct loopholes	PSMEC
12/2009	2. Review the Institute of Medicine's recommendations related to injury and violence prevention and incorporate into the substantive policy agenda for injury and violence prevention as appropriate.	PSMEC
1/2010	3. Support and participate as needed in a study commission to review the fine structure for traffic violations.	PSMEC, GHSP

2/2010	4. Select priority policy items from the compiled policy agendas of injury and violence prevention stakeholders.	IVP-SAC, PSMEC
Begin by 9/2010	5. Encourage injury and violence prevention champions to identify state legislators with an interest in injury and violence prevention.	IVP-SAC, PSMEC
7/2010	6. Identify priority policy agenda items to develop issue-specific fact sheets.	IVP-SAC, PSMEC
8/2009-9/2010 and continuing	7. Increase communications with local injury and violence prevention partners throughout the state regarding policy priorities to encourage statewide advocacy and support for the agenda.	IVP-SAC, PSMEC
6/2010 and continuing	8. Educate and cultivate relationships with injury and violence prevention champions to enable them to effectively support the injury and violence prevention policy agenda.	IVP-SAC, PSMEC

Progress Check Evaluation Measures: Goal 3

1
WHEN: 12/2009

WHAT: Information about current and prospective substantive policy agenda items is created and disseminated to all Goal Team members and their partners.

WHO: PSMEC, IVP-SAC

2
WHEN: 2/2010

WHAT: A three-year Substantive Policy Agenda for Injury and Violence Prevention is created, incorporating agenda items and recommendations from injury and violence prevention partners and the Institute of Medicine.

WHO: PSMEC

3
WHEN: 7/2010

WHAT: Issue-specific fact sheets are developed for priority policy agenda items and distributed to legislators, champions and other advocates.

WHO: PSMEC

4
WHEN: 12/2010

WHAT: At least eight injury and violence prevention champions are identified and are working to promote common prevention messages across the field and cultivate relationships with legislators to promote the Substantive Policy Agenda for Injury and Violence Prevention.

WHO: PSMEC and Coordination and Constituency Goal Team

5
WHEN: 6/2011

WHAT: The IVP-SAC uses and promotes common prevention messages for priority prevention areas across the field.

WHO: IVP-SAC, PSMEC

So What's the Bottom Line?

WHEN: 12/2014

WHAT: Injury and Violence Prevention stakeholders in N.C. are viewed as a strong, cohesive group that collectively and effectively advocates for injury and violence prevention policies.

WHO: IVP-SAC

Goal 4: Saving Lives

Reduce the rate of morbidity caused by injury and violence by 15 percent, thus also reducing injury and violence related mortality, by implementing prioritized, data-driven strategies and programs, policies, and innovative and tested practices.*

From March 2009 to December 2014, address the three leading causes of unintentional injuries and the two leading causes of intentional injuries to strategically reduce the overall rate of injury morbidity by 15 percent. Data from 2007 shows the leading causes of unintentional injuries are **motor vehicle crashes, **poisonings**, and **falls**. The leading causes of intentional injuries (violence are **suicide** and **assault/homicide**.*

WHEN	Objective K: Motor Vehicle Crashes	WHO
7/2009-12/2014	Work to reduce N.C. fatalities and serious injuries (defined by DMV form A type injuries) from motor vehicle crashes to a rate of 1.0 for fatalities per 100,000 VMT and a rate of 1.0 per 100,000 VMT for serious injuries. The average fatality rate per 100,000 VMT from 2004-2008 was 1.53.	Governor's Highway Safety Program (GHSP), Motor Vehicle Crash Goal Team (MVCGT), Safe Kids

WHEN	Action Items	WHO
7/2010	1. Identify in a written summary existing and needed efforts in N.C. related to motor vehicle crash prevention initiatives on: ■ Reducing driver speeding ■ Increasing use of passenger restraints ■ Strengthening language in child passenger safety law to increase enforceability of the law ■ Reducing motor vehicle related pedestrian injuries and fatalities ■ Reducing driving while intoxicated ■ Increasing safety of motorcycle riders.	MVCGT

7/2010	2. Review the N.C. Institute of Medicine's final recommendations and the PSMEC Goal Team's recommendations for policy related to preventing injuries and fatalities from motor vehicle collisions. 2009 preliminary recommendations include: ■ Instituting an evidence-based driver education program in North Carolina ■ Instituting a safety training program for moped operators ■ Instituting graduated fines for speeding violations ■ Enacting a primary seat belt use law for rear seat occupants ■ Increasing belt law fines ■ Increasing license restoration fee for DWI offenders from $100 to $125 to support DPH's efforts in the Booze It & Lose it program. ■ Instituting a training requirement for all people who operate a motorcycle ■ Changing current motorcycle permit provisions to correct loopholes	MVCGT
8/2010	3. Select 3 to 5 priority policy issues to pursue.	MVCGT, PSMEC, IVP-SAC
12/2009-12/2014	4. Convene existing or new (as needed) group of motor vehicle crash prevention stakeholders at least twice a year to review progress of current prevention initiatives, review data to identify emerging issues in MVC injury and fatality, and plan for ways to support current initiatives and initiate new efforts as needed.	GHSP, MVCGT

Progress Check Evaluation Measures Goal 4: Motor Vehicle Crashes

1
WHEN: 7/2010

WHAT: A written document is available that outlines existing and needed efforts in N.C. to reduce motor vehicle crashes and the resulting injuries that are attributed to driver speeding, unrestrained passengers, driver intoxication and environmental hazards.

WHO: GHSP, MVCGT and PSMEC

2
WHEN: 8/2010

WHAT: 3 to 5 priority policy issues have been identified to present to MVC stakeholders in existing or newly formed groups.

WHO: MVCGT and PSMEC

3
WHEN: 12/2010-12/2014

WHAT: Action steps to address priorities have been written or the policy change is achieved.

WHO: MVCGT and PSMEC

WHEN	Objective L: Falls	WHO
Ongoing	Continue work to achieve the priority areas identified by the N.C. Falls Prevention Coalition workgroups.	N.C. Falls Prevention Coalition (NCFPC)

WHEN	Action Items	WHO
By 01/2010	1. Create a N.C. Falls Prevention Coalition website with links to all appropriate groups, contact information for members and links to falls prevention resources, tools and best practices.	NCFPC: Infrastructure Development and Maintenance work group
By 12/2010 and ongoing as needed	2. Conduct an environmental scan to identify community awareness and education resources that are currently available, and organizational interests and capabilities for falls prevention.	NCFPC: Community Awareness and Education work group, Coordination and Constituency Goal Team, Training and Workforce Development Goal Team, DPH IVPB
By 12/2010 and ongoing as needed	3. Develop an algorithm that spells out primary, secondary and tertiary screening tools, risk assessment tools and interventions for preventing falls in at risk groups.	NCFPC: Risk Assessment and Behavioral Intervention work group
9/15 and 9/16, 2009	4. Feature falls prevention at the Healthy Aging Network's "Promoting Environmental and Policy Change to Support Healthy Aging" conference.	NCFPC: Advocacy for Supportive Policies and Environments

WHEN	Objective M: Falls	WHO
Beginning 8/2009 - 2/2010	Implement the policy planning initiative as outlinedby the opportunity grant from the National Association of Chronic Disease Directors.	University of North Carolina Institute on Aging (IOA), Carolinas Geriatric Education Center (CGEC), DHHS Division of Aging and Adult Services (DAAS) and DPH

WHEN	Action Items	WHO
8/2009-02/2010	1. Use available epidemiological data, program data and policy data to determine three to five critical areas for falls prevention policy development.	NCFPC, IOA, CGEC, DAAS, DPH
8/2009 and ongoing	2. Develop strategies to integrate falls prevention programming and policies within the state's broader health promotion programming and policies for older adults (65 and older).	NCFPC, IOA, CGEC, DAAS, DPH
8/2009 and ongoing	3. Continue development of three to five local Falls Prevention Coalitions, building on groups currently working in Charlotte, Greensboro, Greenville and Asheville.	NCFPC, IOA, CGEC, DAAS, DPH

Progress Check Evaluation Measures Goal 4: Falls

1
WHEN: 01/2010

WHAT: The website for the NCFPC is created.

WHO: N.C. Falls Prevention Coalition (NCFPC)

2
WHEN: 12/2010

WHAT: Initial compilation of currently available community awareness and education resources, planned resources and organizational interests and capabilities for falls prevention is created.

WHO: NCFPC

3
WHEN: 12/2010

WHAT: Algorithm that spells out primary, secondary and tertiary screening tools, risk assessment tools and interventions for preventing falls in at risk groups is developed.

WHO: NCFPC

4
WHEN: On 9/15 and 9/16 2009

WHAT: Falls prevention information is presented at Healthy Aging Network's "Promoting Environmental and Policy Change to Support Healthy Aging" conference.

WHO: NCFPC

5

WHEN: By 12/2012

WHAT: Greater capacity for supporting and developing policy around falls prevention is developed, as evidenced by support for policies based on data and strong and active local and statewide falls prevention coalitions.

WHO: NCFPC

6

WHEN: By 12/2014

WHAT: The emergency department visit rate for unintentional fall injuries has been reduced by 15%. The baseline for rate will be the two-three years prior to the initiation of this plan, 2006--2008. The end rates will be based on 2014 -2016 data. Rate 2006: 1496.3, 2007: 1848.0 (per 100,000 population)

WHO: NCFPC

WHEN	Objective N: Unintentional Poisonings	WHO
10/2009-10/2012	Ensure unintentional poisoning deaths are studied by an existing task force with membership from agencies involved in reducing rates such as Public Health, Division of Mental Health, Substance Abuse Services, Developmental Disabilities, Office of the Chief Medical Examiner, Poison Control Center, law enforcement, etc. Study to include monitoring of rates and trends, identifying additional data that needs to be collected, national responses to problem, promising practices or evidence-based approaches to reducing rates and evaluation of existing community intervention projects such as Project Lazarus in Wilkes County.	Unintentional Poisonings Goal Team (UPGT)

WHEN	Action Items	WHO
10/2009	1. Identify and appoint members of the task force mentioned above through support from the DPH IVPB.	UPGT, IVPB
4/2010	2. Establish a central repository, created by the task force, for local, state and national data regarding unintentional poisoning morbidity and mortality, intervention programs and evaluations related to unintentional poisonings morbidity and mortality	UPGT, N.C. Unintentional Poisonings Task Force (NCUPTF)
10/2010	3. Make the data from the Controlled Substances Reporting System available for examination by pertinent public health authorities and medical examiners.	UPGT, NCUPTF, PSMEC
10/2010	4. Identify additional data points to be collected and data sets requiring on-going maintenance or increased support.	UPGT, NCUPTF

10/2011	5. Design and obtain support for studies on: ■ survivors of unintentional poisonings to determine etiologic factors and social correlates ■ impact of public access to real-time call center triage (e.g. services provided by the Carolinas Poison Center) to provide early intervention for adverse drug events and to avert unnecessary emergency department visits ■ impact of regulations (e.g. FDA risk evaluation and mitigation strategies) on unintentional poisoning-related morbidity and mortality	UPGT, NCUPTF
10/2012	6. Improve data coding by educating professional coders, physicians, nurse practitioners, physician assistants, emergency medical services and other providers on proper coding of final diagnoses (ICD-9/ICD-10 codes) and E-codes.	UPGT, NCUPTF

WHEN	Objective O: Unintentional Poisonings	WHO
12/2009-6/2014	Increase education and awareness around unintentional poisonings of 1) health care providers and pharmacists, 2) consumers, 3) public policymakers.	UPGT, NCUPTF

WHEN	Action Items	WHO
Begin by 12/2009	1. Facilitate and support social interactions between community groups to promote the development of locally-oriented interventions to prevent unintentional morbidity and mortality.	UPGT, NCUPTF
10/2010	2. Develop educational tools to prevent, identify and treat unintentional poisonings with specific populations in mind: ■ Physicians and other health care providers ■ Care givers (formal and informal, such as patient's family)	UPGT, NCUPTF
10/2011	3. Explore non-education tools such as regulation and coalitions with local stakeholders (e.g., pharmaceutical companies in N.C.) to inform the national policy debate about mortality and morbidity from unintentional poisoning and efforts within N.C. to address the problem.	UPGT, PSMEC, NCUPTF, IVP-SAC

Progress Check Evaluation Measures Goal 4: Unintentional Poisoning

1
WHEN: 12/2009

WHAT: N.C. Unintentional Poisonings Task Force is meeting to address rates and trends, additional data that needs to be collected, national responses to problem, promising practices and evidence-based approaches to reduce rates, and the evaluation of existing community intervention projects.

WHO: UPGT, NCUPTF

2
WHEN: 10/2011

WHAT: The N.C. Unintentional Poisoning Task Force has designed needed studies of the problem and identified possible funding sources for the studies.

WHO: UPGT, NCUPTF

3
WHEN: 10/2011

WHAT: Written plan is available that addresses training professionals involved in ICD-9/ICD-10 codes and E-Codes to improve proper coding of final diagnoses.

WHO: UPGT, NCUPTF

4
WHEN: 6/2014

WHAT: Educational tools on unintentional poisonings that teach how to prevent, identify, and treat unintentional poisonings are being identified, funded, developed and disseminated.

WHO: UPGT, NCUPTF

WHEN	Objective P: Violence/Assault	WHO
10/2009-12/2014	Use N.C. Violent Death Reporting System (VDRS) data to identify and assist six communities with high rates of violence or significant disparities in violence rates to implement evidence-based or best practice prevention programs.	IVPB, N.C. VDRS Board Leadership and Evaluation Team

WHEN	Action Items	WHO
2009-2013	1. Begin identifying communities in 2009 using available data; sixth community to be identified by 2013.	NCVDRS, VAGT
Within six months of the identification of a community	2. Complete a community assessment to determine community needs and assets. This assessment will identify existing resources such as current programs and potential partners.	NCVDRS, VAGT
Within six months of community assessment completion	3. Using data from the community assessment, review evidence-based strategies that address the issues the community is facing and make recommendations for appropriate interventions.	NCVDRS, VAGT

Within nine months of assessment completion	4. If evidence-based practices for a community's issues are available, ensure the community is knowledgeable of the practices and provide technical assistance to help them select the practices that best fit the community.	NCVDRS, VAGT
Ongoing	5. Provide ongoing technical assistance for implementation and evaluation of the chosen strategy	NCVDRS, VAGT

WHEN	Objective Q: Violence/Assault	WHO
12/2014	Establish a non-fatal violence data collection system that captures and links morbidity information from multiple sources to inform programs, practices, policies, and evaluation.	IVPB, IVP-SAC, Data Goal Team (DGT), organizations housing relevant databases and filed actuaries

WHEN	Action Items	WHO
1/2011	1. Assess existing non-fatal data sources, including morbidity and risk and protective factors.	Violence/Assault Goal Team (VAGT), DGT, IVPB
3/2011	2. Analyze data sources to identify gaps.	VAGT, DGT
5/2011	3. Create a report to the IVP-SAC and DGT that identifies existing and needed data.	VAGT, DGT
5/2011	4. Recommend partners to convene in order to better capture and to link the multiple sources of data that exist.	VAGT

WHEN	Objective R: Violence/Assault	WHO
12/2011	Identify the resources needed to complete development and access key violence prevention partners to establish a common definition of terms including identifying forms of violence to inform policies, practices, and programs at the state and local levels.	VAGT, IVP-SAC

WHEN	Action Items	WHO
By 3/2010	1. Identify key partners and stakeholders.	VAGT

7/2010	2. Convene meeting of stakeholders to review the purpose of the group and to clarify specific goals and objectives.	VAGT, DGT
7/2010	3. Review current terminology and collaborate to produce common definitions of terms.	VAGT, DGT
8/2010	4. Seek broad input on terms and proposed definitions.	VAGT, DGT
12/2010 and ongoing	5. Work with partners/other agencies to gain consensus on use of terms and definitions.	VAGT, DGT

Progress Check Evaluation Measures Goal 4: Violence/Assault

1
WHEN: 12/2010

WHAT: Common definitions of violence terms are established.

WHO: VAGT, DGT

2
WHEN: 12/2014

WHAT: At least six N.C. communities have evidence-based or best practice violence prevention interventions implemented.

WHO: VAGT, NCVDRS

3
WHEN: 12/2014

WHAT: A non-fatal violence database that links morbidity information from multiple sources is created.

WHO: VAGT, DGT

WHEN	Objective S: Suicide	WHO
10/2009-8/2011	Use Garrett Lee Smith funds from the Substance Abuse, Mental Health Services Administration (SAMHSA) to implement suicide prevention training for Child and Family Support Teams and school-based and school-linked professionals including: ■ Two-day ASIST gatekeeper training for 175 Child and Family Support Team individuals and school health center staff, and ■ One-half day SafeTALK gatekeeper training for 275 other school staff in systems across the state.	IVPB, Youth Suicide Prevention Program Partners

WHEN	Action Items	WHO
01/2010	1. Train at least 175 Child and Family Support Team and school health center staff individuals in two-day ASIST gatekeeper training.	IVPB, Youth Suicide Prevention Program Partners

05/2010	2. Train at least 275 statewide school administrative, professional and support staff in one-half day SafeTALK gatekeeper training.	IVPB, Youth Suicide Prevention Program Partners
12/2010	3. Apply for ongoing funding from SAMHSA (if available), as well as other funding sources such as the Department of Juvenile Justice and Delinquency Prevention. Evaluation results will be used to inform application and program activities.	IVPB, Youth Suicide Prevention Program Partners

WHEN	Objective T: Suicide	WHO
10/2009-8/2011	Implement a Youth Suicide Prevention Program using Garrett Lee Smith funds from the SAMHSA including the development of a statewide communications campaign targeting youth.	IVPB, Youth Suicide Prevention Program Partners

WHEN	Action Items	WHO
8/2009	1. Conduct 9 focus groups with youth (72 total) to guide the development of media materials.	N.C. Mental Health Association (MHA)
10/2009	2. Partner with a media vendor to develop content for campaign materials using the results of the youth focus groups.	NCMHA
1/2010	3. MHA and selected media vendor will release campaign materials to all schools with trained ASIST and SafeTALK staff statewide.	NCMHA

WHEN	Objective U: Suicide	WHO
9/2011	Initiate the planning for and creation of Community Trauma Response Teams and Local Outreach to Suicide Survivors (LOSS) groups in selected communities by: ■ Identifying community-based suicide prevention and intervention stakeholders, ■ Assessing needed resources, and ■ Seeking funding.	North Carolina Youth Suicide Prevention Task force (NCYSPTF), NCMHA

WHEN	Action Items	WHO
1/2010	1. Identify a group of stakeholders interested in developing the network.	NCYSPTF
1/2010	2. Work with stakeholders to achieve objective such as law enforcement, survivor groups, community and for-profit mental health providers, faith communities, interested others, Mental Health Association, N.C. Office on Disability and Health, and the Youth Suicide Prevention Task Force.	NCYSPTF
1/2010	3. Identify coverage area for teams.	NCYSPTF
1/2011	4. Arrange the trainings in the state and train the teams using the identified model.	NCYSPTF and AHECs
6/2011	5. Promote this initiative through partners including first responders and law enforcement and local suicide prevention coalitions.	MHA
6/2012	6. Investigate potential insurance coverage through an individual's coverage or the state.	NCYSPTF
6/2012	7. Investigate private foundation funding.	NCYSPTF
6/2012	8. Investigate the American Foundation for Suicide Prevention (AFSP) or other prevention organizations such as the Triangle Consortium for Suicide Prevention (TCSP) for funding opportunities.	North Carolina Youth Suicide Prevention Task force

WHEN	Objective V: Suicide	WHO
9/2009-2014	Develop a collaboration plan with N.C. Veterans Affairs staff to support existing efforts of military to prevent suicide within the military and among military families and civilian communities.	NCGV, MHA, NCYSPTF

WHEN	Action Items	WHO
8/2009	1. Work with Veterans Affairs Hospitals to increase awareness of community resources.	MHA, Suicide Goal Team (SGT)
12/2009	2. Investigate current efforts and possible collaboration with the N.C. Coalition Against Domestic Violence.	NCGV, (SGT)

Progress Check Evaluation Measures Goal 4: Suicide

1

WHEN: 8/2011

WHAT: Youth suicide prevention campaign is implemented across the state and evaluation of impact has begun.

WHO: IVPB, Youth Suicide Prevention Program Partners, MHA

2

WHEN: 8/2011

WHAT: Over 170 school-based child and family support teams and school health center staff have been trained using ASIST and over 250 individuals have received SafeTALK training.

WHO: IVPB, Youth Suicide Prevention Program Partners, MHA

3

WHEN: 9/2011

WHAT: Media guidelines for messaging and best practices for dissemination from the American Association of Suicidology are consistently used by the Garrett Lee Smith Grant Team.

WHO: IVPB, Youth Suicide Prevention Program Partners

4

WHEN: 9/2011

WHAT: A training model that will create a network of community trauma response teams is identified.

WHO: IVPB, Youth Suicide Prevention Program Partners

5

WHEN: 12/2014

WHAT: A relationship between civilian suicide prevention partners and military and Veterans Affairs staff working to prevent suicide is established.

WHO: MHA, NCGV

So What's the Bottom Line?

This bottom line measure applies to all of Goal 4's objectives.

WHEN: 12/2014

WHAT: The rate of morbidity from all causes of injury and violence is reduced by 15 percent, thus also reducing injury-and-violence-related mortality.

WHO: IVP-SAC

Goal 5: Building the Injury Prevention Community

Increase coordination among injury and violence prevention partners at the local, regional and state level to create a more efficient system and a broader, stronger constituency.

WHEN	Objective W	WHO
9/2009	Create a preliminary database of injury and violence prevention stakeholders in N.C. at the local and state level with the who, what, when and where for each stakeholder compiled in an electronic resource list to be developed and updated annually, and made accessible to the public.	IVPB, Coordination and Constituency Goal Team (CCGT)

WHEN	Action Items	WHO
By 9/2009 and Ongoing	1. Gather existing lists of injury prevention networks such as Safe Kids Coordinators, Regional Trauma Councils, etc.	IVPB, CCGT
By 2/2010 and Ongoing	2. Research non-public health/non-traditional potential partners who are involved in injury and violence prevention, such as state, regional and local committees and task forces, community-based groups and nonprofits.	IVPB, CCGT
By 12/2009	3. Design and post web-based list of IVP partners with support from DPH IT staff if needed.	IVPB, CCGT
Starting 12/2009 and ongoing	4. Work with other injury and violence prevention offices with large constituency groups to have a link to the database on their websites.	IVPB, CCGT
Starting 12/2009 and ongoing	5. Assign a staff person from the IVPB to work on maintenance of the website including keeping data current.	IVPB, CCGT

WHEN	Objective X	WHO
2009-2014	Use multiple sources such as Healthy Carolinians Partnerships' Community Health Assessment data, Safe Kids needs assessments, MCH Title V Needs assessment, and Trauma RACs to identify local injury and violence prevention needs. Utilize these networks and others that may be identified to provide appropriate information, training, and data to communities to address identified needs.	Coordination and Constituency Goal Team (CCGT)

WHEN	Action Items	WHO
Beginning in 2009 and repeating in 2011 and 2013	1. Compile existing primary data on injury and violence prevention needs from known sources such as Healthy Carolinians Partnerships' Community Health Assessments, Safe Kids needs assessments, and trauma RAC data every two years.	CCGT
8/2009	2. Review results of state survey sent to all known injury and violence-related agencies in spring 2009.	IVPB, CCGT
12/2009	3. Review and compile data collected from all sources.	IVPB, CCGT
12/2009	4. Identify injury and violence prevention community needs, gaps, and strengths.	IVPB, CCGT

WHEN	Objective Y	WHO
8/2009	Create six Goal Teams with the leadership of each team making up an advisory council to be appointed by the State Health Director including representatives from the field of injury and violence prevention in program development, research and evaluation, data collection and analysis, policy, fund/resource development, social marketing, and training and professional development. This group will guide implementation of this plan, address special projects, be used as a resource, and provide future direction for the growth of the injury and violence prevention field in N.C.	State Health Director, CCGT, IVPB

WHEN	Action Items	WHO
5/2009	1. Compile green ½ sheets from April 27, 2009 meeting and begin determining leadership and membership of seven Goal Teams.	IVPB
1/2010	2. Develop a reporting mechanism to measure progress of Goal Teams communicating through leadership of each Team.	IVP-SAC, CCGT
Ongoing	3. Manage team meetings, including logistics, setting agendas and outcomes with each team meeting at least four times per year. Meetings may be held using phone conferencing or other technology-based resources.	IVP-SAC, CCGT
12/2009 and every 6 months	4. Track progress towards achieving goals and objectives in the plan.	IVP-SAC, CCGT
12/2009	5. Create a written timeline for achieving goals and objectives set out in this plan.	IVP-SAC, CCGT

WHEN	Objective Z	WHO
02/2010	Compile a preliminary toolkit that will be regularly updated and made available to the members of the communication web and others through the DPH's IVPB website. Information will include self-assessment tool for injury and violence prevention competencies, training opportunities, funding resources, policy initiatives, and agency resources.	IVPB, CCGT

WHEN	Action Items	WHO
02/2010	1. Develop web-based toolkit to facilitate sharing of information.	IVPB, CCGT
10/2009	2. Use database referred to in objective Z to gather existing lists of injury prevention networks such as Safe Kids Coordinators, Regional Trauma Councils, local health department injury and violence prevention professionals, etc.	IVPB, CCGT

12/2009	3. Research non-public health/non-traditional potential partners who are involved in injury and violence prevention, such as state, regional and local committees and task forces, community-based groups and nonprofits.	IVPB, CCGT
6/2010	4. Coordinate regional efforts to enter information into web-based toolkit.	IVPB, CCGT
6/2010	5. Communicate to other agencies their responsibility to contribute information into web-based toolkit.	IVPB, CCGT
6/2010	6. Set-up links from other agencies' websites to this information so it is more easily accessed.	IVPB, CCGT

WHEN	Objective AA	WHO
10/2009	Begin developing an injury and violence prevention stakeholder communication web/infrastructure by using the stakeholder roster to identify at least one key injury and violence prevention leader per county beginning with areas that have existing injury professionals and initiatives. Contacts in counties without current resources or injury programs will be added by 2014.	CCGT

WHEN	Action Items	WHO
12/2009	1. Create an "Opportunities and Commitments" sheet for identifying one key, passionate injury prevention leader per county.	CCGT
12/2009	2. Identify injury and violence prevention "key leaders" in each county.	CCGT
12/2009	3. Review "key leaders" information and identify gaps in counties without key leaders.	CCGT
12/2010	4. Connect county-level leaders with eight champions to encourage connections.	CCGT

WHEN	Objective BB	WHO
8/2012	Work with the Training and Workforce Development Goal Team to determine the feasibility of hosting an injury and violence prevention symposium in North Carolina to provide further opportunities for professional networking, garner attention for significant injury and violence prevention issues in N.C., and provide a professional development opportunity to stakeholders and others involved in injury and violence prevention work.	CCGT, IVPB, the IVP-SAC and other key injury prevention groups, Training and Workforce Development Goal Team (TWGT)

WHEN	Action Items	WHO
12/2009	1. Review past conferences held at the national level such as STIPDA's conference and state injury conferences such as Safe Kids to obtain guidance on topics useful to a general injury prevention audience.	CCGT, IVPB, the IVP-SAC, other key injury prevention groups, TWGT
5/2010	2. Incorporate injury and/or violence prevention topics and workshops into existing conferences (i.e., Healthy Carolinians, Safe Kids, etc.)	CCGT, IVPB, the IVP-SAC, other key injury prevention groups, TWGT
5/2010	3. Promote existing conferences and trainings.	CCGT, IVPB, the IVP-SAC, other key injury prevention groups, TWGT
6/2011	4. Develop webinar trainings and/or translate existing trainings to webinar format.	CCGT, IVPB, the IVP-SAC, other key injury prevention groups, TWGT
6/2011	5. Work with the Area Health Education Centers to create an "N.C. Injury and Violence Prevention" certificate program with CEs and CEUs or other appropriate professional development credits.	CCGT, IVPB, the IVP-SAC, other key injury prevention groups, TWGT
8/2012	6. Work with the Area Health Education Centers to create an "N.C. Injury and Violence Prevention" certificate program with CEs and CEUs or other appropriate professional development credits.	CCGT, IVPB, the IVP-SAC, other key injury prevention groups, TWGT

Progress Check Evaluation Measures: Goal 5

1

WHEN: 10/2009

WHAT: N.C. Injury and Violence Prevention State Advisory Council is established with six operating goal teams meeting and implementing the goals, objectives, and actions steps of the State Injury and Violence Prevention Strategic five-year plan. The Council has a minimum of 15 members including the leadership of each Goal Team and meets face-to-face or by phone conference at least four times per year.

WHO: CCGT

2

WHEN: 6/2010

WHAT: A data base of injury and violence prevention professionals' contact information and areas of expertise is available on the IVPB, DPH website. The database is reviewed for accuracy every six months and utilized by professionals in the field regularly.

WHO: CCGT

3

WHEN: 12/2009-12/2014

WHAT: A list of key IVP leaders with one identified in at least 50 counties is available and these leaders are sharing key information with constituents in their counties. Counties without IVP leadership are identified as counties to target for support between December 2009 and December 2014 until leadership is available and identified in each county.

WHO: CCGT

4

WHEN: 02/2010

WHAT: An injury and violence prevention toolkit is available to professionals in the field through the IVPB, DPH website with materials based on the statewide needs assessments referenced in Goal 6, Obj. DD.

WHO: CCGT

5

WHEN: 8/2012

WHAT: A recommendation is available regarding having a Statewide IVP Conference in N.C.

WHO: CCGT

So What's the Bottom Line?

WHEN: 12/2014

WHAT: A strong injury and violence prevention movement exists in N.C. illustrated by strong local and state-level injury prevention programs that are evidence-based and have documented outcomes.

WHO: IVP-SAC

Goal 6: Workforce Development

Develop a statewide injury and violence prevention workforce that meets core injury and violence prevention competencies as outlined by the National Training Initiative for Injury and Violence Prevention (NTI) and the State and Territorial Injury Prevention Directors Association (STIPDA).

WHEN	Objective CC	WHO
6/2010	Survey injury and violence prevention professionals throughout N.C. to assess training needs. Disseminate summary findings.	Training and Workforce Development Goal Team (TWGT), UNC Injury Prevention Research Center (IPRC)

WHEN	Action Items	WHO
9/2009–10/2009	1. Review current and past training needs assessment tools that were used and results from their use. Use self assessment tool that includes the nine core competencies for injury and violence prevention professionals that was developed in the Summer of 2009 ■ IPRC collects the needs assessment tools for Injury prevention for last 36 months and reviews ■ IPRC disseminates needs assessment tools to groups for review and selection of tool that will be used to survey IVP professionals in North Carolina ■ Group convenes for final discussion about which tool to use by October 1, 2009. At this meeting, the parameters for the tool will be set, the variables used will be reviewed and decisions about the use of quantitative vs. qualitative measures will be made.	The TWGT is lead, with partners including the IVBP, the IPRC, the office of emergency medical service (OEMS) and Area Health Education Centers (AHEC).
11/2009 ■ Decision made about tool by 11/2009 ■ Determine if review needed and revise by 11/2009	2. Identify training needs assessment tools specific to N.C.	TWGT is the lead with partners including IVPB, IPRC, OEMS and AHEC

11/2009	3. Identify audience for the needs assessment. ■ Review all prior audiences for the needs assessment ■ Review all stakeholders ■ Identify groups that have not yet participated in a needs assessment regarding core competencies in injury and violence prevention ■ Select pilot group for needs assessment ■ Notify the selected group of the pilot survey	IPRC is the lead with partners IVPB, OEMS and AHEC with guidance from DGT and the Research and Evaluation Goal Team (REGT)
12/2009	4. Identify method of delivery of the needs assessment tool.	IPRC is the lead with partners including the IVPB, OEMS, AHEC with guidance from the DGT and the REGT
1/2010	5. Review and revise needs assessment tool based on comments from the TWGT.	IPRC is the lead in partnership with TWGT
1/2010	6. Implement the pilot study with selected groups.	IPRC is the lead, with partners IVPB, REGT, Trauma RACs and TWGT
2/2010	7. Evaluate results of the pilot study.	IPRC is the lead, with partners IVPB, REGT, Trauma RACs and TWGT
3/2010	8. Review and revise the needs assessment tool based on the results of the pilot study.	IPRC is the lead, with partners IVPB, REGT, Trauma RACs and TWGT
3/2010-5/2010	9. Use revised needs assessment tool to conduct assessment of injury and violence prevention professionals throughout N.C.	IVPB in partnership with IPRC
6/2010	10. Compile and disseminate results of needs assessment to the IVP-SAC.	IPRC is the lead in partnership with TWGT

WHEN	Objective DD	WHO
6/2010	Study training survey results to identify gaps in training opportunities, to develop new or existing trainings to meet needs, and identify resources that may be used to increase training opportunities.	IPRC in partnership with TWGT

WHEN	Action Items	WHO
6/2010	1. Evaluate results of the needs assessment tool and prepare a report that includes identification of gaps.	REGT is the lead in partnership with the IVPB and IPRC
9/2010	2. Identify partners that can implement trainings that address the needs that were identified in the report. Trainings will also address workforce development needs that will help achieve the goals outlined in the statewide plan for injury and violence prevention.	TWGT in partnership with Trauma RACs
4/2011-10/2011	3. Create training plan/establish budget. ■ Convene IPRC/AHEC ■ Review results of survey with stakeholders; discuss newly developed core competencies for injury and violence prevention professionals and curriculum available that is based on increasing the competencies. ■ Use information from this discussion to build the training plan.	TWGT is the lead in partnership with Trauma RACs, DPI, LE, The Division of AA, OSFM and JPB, Justice Academy, STAC, AHEC
10/2009 and ongoing	4. Utilize and identify nine core competencies for injury and violence prevention professionals to build the training plan. ■ Formulate a financial plan	TWGT
1/2010	5. Release the plan to stakeholders	TWGT in partnership with IVPB

WHEN	Objective EE	WHO
In 2010 and 2012	Offer an injury prevention track at a selected conference, with possible venues including Healthy Carolinians, N.C. Public Health Association, N.C. Society Of Public Health Educators, the Cooperative Extension Family and Youth Summit, or the N.C. School Community Health Association so that professionals can receive education that will assist with competency development.	IVPB, IPRC and TWGT

WHEN	Action Items	WHO
6/2010	1. Review results of the training needs assessment for injury and violence prevention professionals to make decisions on where to hold trainings and what content should be presented.	REGT is the lead in partnership with the IVPB, IPRC
9/2010	2. Create a plan to implement recommended trainings for injury and violence prevention professionals at one or more statewide conference.	REGT is the lead in partnership with the IVPB, IPRC
3/2012	3. Review results of the training needs assessment for health care professionals to make decisions on where to hold trainings and what content should be presented.	REGT is the lead in partnership with the IVPB, IPRC
3/2013	4. Create a plan to implement recommended trainings for health care professionals at one or more statewide conference.	REGT is the lead in partnership with the IVPB, IPRC

WHEN	Objective FF	WHO
12/2011	Enhance the training of health care professionals (including physicians, nurses, allied health, and other health care practitioners) in evidence-based strategies to prevent motor vehicle crash injury, unintentional poisoning/drug overdose, falls, family violence, and general injury. Trainings should be expanded into academic and clinical settings, residency programs, or other continuing education programs.	AHEC in partnership with the UNC IPRC, the DPI, health professional schools, and health professional organizations

WHEN	Action Items	WHO
10/2010	1. Assess current/past tools for health care providers and results. Use self assessment of 9 core competencies created in summer of 2009. ■ IPRC collects the needs assessment tools for Injury prevention for last 36 months and reviews ■ IPRC disseminates needs assessment tools to groups ■ Group convenes for final discussion–October, 2010 to set parameters, review variables, quantitative vs. qualitative	The TWGT is lead, with partners including the IVBP, the IPRC, the office of emergency medical service (OEMS) and AHEC.
11/2010 ■ Decision made about tool by 11/2010 ■ Determine if review needed and revise by 11/2010	2. Identify tools specific to N.C. for health care providers ■ If review needed, include non-traditional stakeholders.	TWGT is the lead with partners including IVPB, IPRC, OEMS and AHEC
1/2011	3. Identify health care provider audience for needs assessment. ■ Review all prior audiences for the needs assessment ■ Review all stakeholders ■ Identify groups that have not yet participated in a needs assessment regarding core competencies in injury and violence prevention ■ Select pilot group for needs assessment ■ Notify the selected group of the pilot survey	IPRC is the lead with partners IVPB, OEMS and AHEC with guidance from DGT and the Research and Evaluation Goal Team (REGT)
2/2011	4. Identify method of delivery of needs assessment tool for health care providers.	IPRC is the lead with partners including the IVPB, OEMS, AHEC with guidance from the DGT and the REGT
4/2011	5. Plan needs assessment tool for health care providers review/revise.	IPRC is the lead in partnership with TWGT

5/2011-6/2011	6. Implement pilot study.	IPRC is the lead, with partners IVPB, REGT, Trauma RACs and TWGT
7/2011	7. Evaluate results.	IPRC is the lead, with partners IVPB, REGT, Trauma RACs and TWGT
8/2011	8. Review and revise the needs assessment tool.	IPRC is the lead, with partners IVPB, REGT, Trauma RACs and TWGT
9/2011-11/2011	9. Deliver the needs assessment tool.	IVPB in partnership with IPRC

Progress Check Evaluation Measures: Goal 6

1

WHEN: 6/2010

WHAT: A written summary of N.C. IVP professionals' training needs that includes gaps in existing trainings and plans for the development of new trainings is available.

WHO: TWGT, IVPB, IPRC

3

WHEN: 1/2012

WHAT: A written summary of N.C. health care professionals' and students' training needs that includes gaps in existing trainings and plans for the development of new trainings is available.

WHO: TWGT, IVPB, IPRC

2

WHEN: 9/2012

WHAT: An injury prevention track is offered to educators, health providers, social workers, community health partnerships and other human service professionals at one or more statewide conferences.

WHO: TWGT, IVPB, IPRC, AHEC

4

WHEN: 6/2012

WHAT: An injury prevention track is offered to health care professionals at one or more statewide conferences.

WHO: TWGT, IVPB, IPRC

So What's the Bottom Line?

WHEN: 12/2014

WHAT:

N.C. has a documented system to educate healthcare providers in injury prevention strategies to use during patient visits.

Seventy percent of registered injury and violence prevention stakeholders (registered in the state database) have achieved at least eighty percent of injury prevention professional competencies as outlined by the National Training Institute's and STIPDA's Injury and Violence Prevention Core Competencies.

WHO: IVP-SAC

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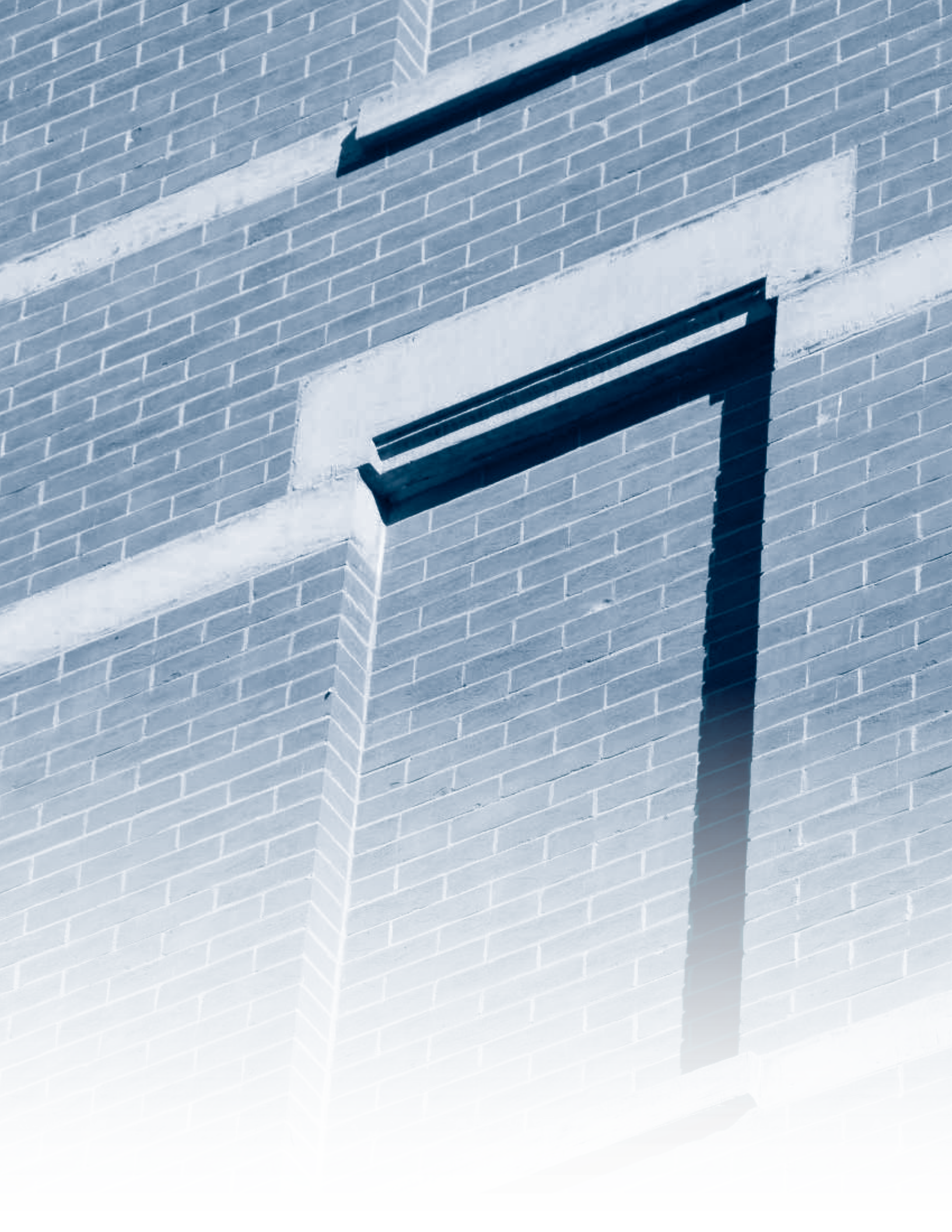

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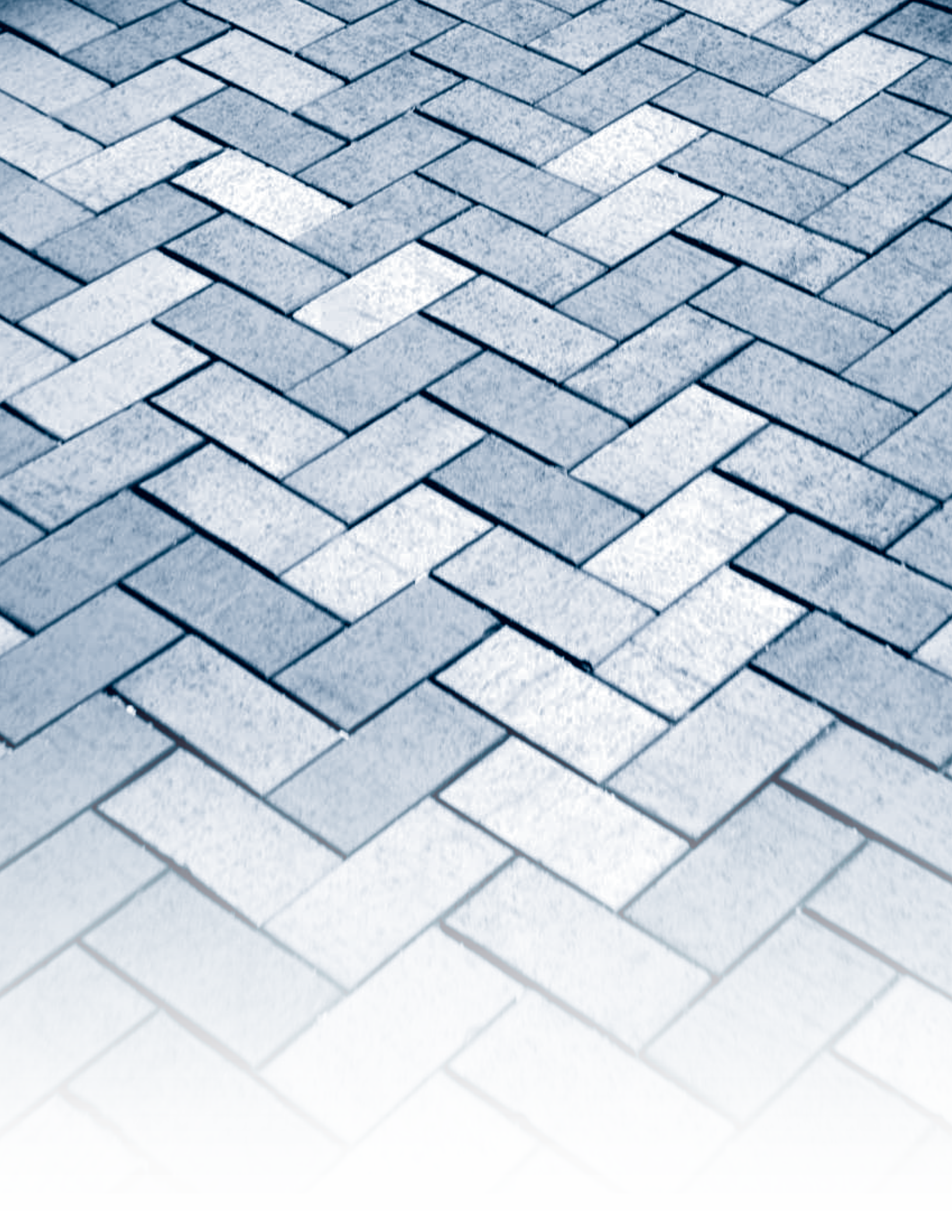

North Carolina
Injury & Violence
PREVENTION Branch

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