

Health Priority: Intentional and Unintentional Injuries and Violence

Objective 2: Motor Vehicle-Related Injuries and Death (Template)

Long-term (2010) Subcommittee Outcome Objectives

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

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

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

Long-term outcome objective updated as of: Sept 2004

Wisconsin Baseline	Wisconsin Sources and Year
Rate of motor vehicle crash-related deaths and serious injuries was 135 per 100,000 population in 2000.	Department of Transportation Five Year Summary of Motor Vehicle Crashes – July 2002
Rate of fatality and incapacitating injuries per hundred million vehicle miles travel was 12.6 in 2000.	Department of Transportation Five Year Summary of Motor Vehicle Crashes – July 2002
Age-adjusted overall motor vehicle death rate was 16.5 per 100,000 in 2000.	WISQARS Injury Mortality Report
In 2000, there were a total of 43,145 injury crashes, 718 of these were fatal.	Department of Transportation Drivers and Vehicles Final Year Crash Statistics (2002 crash statistics with comparison to prior years).
In 2000, there were a total of 1,657 pedestrian crashes, 50 of these were fatal.	Department of Transportation Drivers and Vehicles Final Year Crash Statistics (2002 crash statistics with comparison to prior years).
In 2000, there were a total of 9,096 alcohol-related crashes, 301 of these were fatal.	Department of Transportation Drivers and Vehicles Final Year Crash Statistics (2002 crash statistics with comparison to prior years).
36 work related deaths from motor vehicle related crashes; 30% of all work-related fatalities.	Department of Health and Family Services, 2000

Federal/National Baseline	Federal/National Sources and Year
15.6 deaths per 100,000 population (age-adjusted)	<i>Healthy People 2010</i> , November 2000, United States Department of Health and Human Services
1.6 deaths per 100 million vehicle miles traveled	<i>Healthy People 2010</i> , November 2000, United States Department of Health and Human Services
1,181 nonfatal injuries per 100,000 population were caused by motor vehicle crashes in 1998.	<i>Healthy People 2010</i> , November 2000, United States Department of Health and Human Services
69% of the total population used safety belts in 1998	<i>Healthy People 2010</i> , November 2000, United States Department of Health and Human Services
92% of motor vehicle occupants aged 4 years and under in 1998 used child restraints.	<i>Healthy People 2010</i> , November 2000, United States Department of Health and Human Services
67% of motorcycle operators and passengers used helmets in 1998.	<i>Healthy People 2010</i> , November 2000, United States Department of Health and Human Services
0.7 occupational motor-vehicle fatalities per 100,000 workers.	Worker Traffic-Related Motor Vehicle Crashes, July 1998, United States Department of Health and Human Services
5.9 alcohol related deaths per 100,000 population	<i>Healthy People 2010</i> , November 2000, United States Department of Health and Human Services
113 alcohol related injuries per 100,000 population	<i>Healthy People 2010</i> , November 2000, United States Department of Health and Human Services
33% of students in grades 9 through 12 reported in 1999 riding during the previous 30 days with a driver who had been drinking alcohol.	Youth Risk Behavioral Surveillance System, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention & Health Promotion as cited in <i>Healthy People 2010</i> , November 2000, United States Department of Health and Human Services
41 states and District of Columbia in 1998 have administrative license revocation laws for persons who drive under the influence of intoxicants.	U.S. Department of Transportation National Highway Traffic Safety Administration, as cited in <i>Healthy People 2010</i> , November 2000, United States Department of Health and Human Services

Federal/National Baseline	Federal/National Sources and Year
16 states in 1998 had legal requirements for maximum blood alcohol concentration level of 0.08% for motor vehicle drivers aged 21 years and older.	U.S. Department of Transportation National Highway Traffic Safety Administration as cited in <i>Healthy People 2010</i> , November 2000, US DHHS

Related USDHHS <i>Healthy People 2010</i> Objectives			
Chapter	Goal	Objective Number	Objective Statement
15-Injury Prevention	Reduce injuries, disabilities, and deaths due to unintentional injuries and violence.	15-15	Reduce deaths caused by motor vehicle crashes.
		15-16	Reduce pedestrian deaths on public roads.
		15-17	Reduce nonfatal injuries caused by motor vehicle crashes.
		15-18	Reduce nonfatal pedestrian injuries on public roads.
		15-19	Increase use of safety belts.
		15-20	Increase use of child restraints.
		15-21	Increase the proportion of motorcyclists using helmets.
		15-22	Increase the number of States and the District of Columbia that have adopted a graduated driver licensing model law.
		15-23	(Developmental) Increase use of helmets by bicyclists.
		15-24	Increase the number of States and the District of Columbia with laws requiring bicycle helmets for bicycle riders.
20 – Occupational Safety and Health	Promote the health and safety of people at work through prevention and early intervention.	20-1	Reduce deaths from work-related injuries.

Related USDHHS *Healthy People 2010* Objectives

Chapter	Goal	Objective Number	Objective Statement
		20-2	Reduce work-related injuries resulting in medical treatment, lost time from work, or restricted work activity.
26 – Substance Abuse	Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.	26-1	Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes.
		26-24	Extend administrative license revocation laws, or programs of equal effectiveness, for persons who drive under the influence of intoxicants.
		26-25	Extend legal requirements for maximum blood alcohol concentration levels of 0.08 percent for motor vehicle drivers aged 21 years and older.

Definitions

Term	Definition
Motor vehicle related deaths and injuries	<p>Defined by Wisconsin Statutes {Sec.346.70, 346.70(1)} as those occurring in a crash on a Wisconsin traffic way, involving at least one motor vehicle in transport and resulting in injury or death to any person, or damage to any property. In 2000, the reporting threshold was \$1,000 damage to any one person’s property.</p> <p>The existence and severity of injury (fatal, incapacitating, non-incapacitating, possible, or unknown defined by ANSI D.16 and ANSI D.21) is determined at the site by the reporting law enforcement officer.</p> <p>Fatalities are counted if the injured person dies within 30 days of the crash and state-level data are available approximately 3 months after the quarter in which the crash occurred.</p> <p>Incapacitating injuries are those in which the victim was transported from the scene or appeared to the reporting officer to be severely injured.</p> <p>Note: Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services, data differs slightly from the Department of Transportation data used here. Death is not limited to 30 days post crash and severity information is not quantified.</p>

Definitions	
Term	Definition
Causation	Motor vehicle deaths and serious injuries are the results of collisions in which the forces involved are extreme or in which human behavior creates additional risk of injury. Crash causation is multi-factorial, resulting from a mixture of human, environmental, and vehicle factors, each of which can be affected by multiple disciplines at state and local government and individual action.
State leadership and facilitation	The Department of Transportation, Bureau of Transportation Safety, serves as the State Highway Safety Office required by federal law for the acceptance and distribution of state and community highway safety grant funds. The Department of Natural Resources is responsible for enforcement of laws governing off-road or recreational motor vehicles. The Department of Health and Family Services is responsible for programs affecting all types of injury, and the Department of Public Instruction governs school injury. The Department of Justice trains traffic enforcement officers.
Safe community model	This is a model comprised of partnerships in a community that develop, implement, and evaluate safety strategies based upon a data-driven, inclusive, multidisciplinary and performance-based decision-making process. Studies have shown that self-directed safety programs at the local level have greater and more long-lasting effects than programs developed at the state level and delivered to the community. Models for coordinated, data-driven health and safety programs are well-known and several have been applied here. In 2000, fewer than 20 “Safe Community” coalitions were active in Wisconsin, and no standards or coordinated state program existed.
Local Programs	At the local level, the organization of programs affecting injury is similarly fragmented and may vary from county to county or in adjacent municipalities, depending upon local knowledge, political will and access to strategic resources. Since 1995, a number of Wisconsin communities have begun organizing local injury coalitions in order to make most effective use of their limited local resources.
Wisconsin’s public health system	Public health is defined as a system, a social enterprise, whose focus is on the population as a whole. The public health system seeks to extend the benefits of current knowledge in ways that will have maximum impact on the health status of the entire population (Turnock, <i>Healthiest Wisconsin 2010</i> , January 2001). The public health system is comprised of many partners that include state and local health departments, government, the public, private, nonprofit, and voluntary sectors. These partners include traditional sectors (physicians, emergency rooms) and new non-traditional sectors (faith communities).

Rationale:

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

vehicle crash injury totaled over \$50 million and the total estimated economic cost of deaths and incapacitating injuries from motor vehicle crashes was over \$1 billion.

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

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

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

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

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

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

Fewer persons aged 70 years and older are licensed to drive, compared to younger persons, and they drive fewer miles per licensed driver. Persons in this older age group, however, have higher rates of fatal crashes per mile driven, per 100,000 persons, and per licensed driver than any other group except young drivers (aged 16 to 24 years).

Pedestrians account for about 13 percent of motor vehicle deaths. The problem of pedestrian deaths and injuries is worse among young children and older adults. Children are more likely to be injured, while older adults are more likely to die in pedestrian crashes.

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

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

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

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

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

Outcomes:

Short-term Outcome Objectives (2002-2004)

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

- State-level coordination of injury, programs, and resources are institutionalized within the Division of Public Health, Bureau of EMS and Injury Prevention.
- State agencies, such as the Department of Transportation and Department of Health and Family Services, share strategic resources by means of institutionalized injury program coordination.
- A statewide injury prevention coordinating group facilitated by the Division of Public Health, Bureau of EMS and Injury Prevention distributes “best practices” of coordinated community action as developed in the Safe Communities Model.
- Participating agencies, federal, state, and local, permit grant funds to be used for a wide variety of program strategies proven to be effective.
- The statewide injury coordinating group coordinates the development and distribution of motor vehicle injury data in a user-friendly format related to other injury data.
- Local coordinated injury coalitions (utilizing the Safe Communities model) are organized in 10 more communities across the state (5 per year x 2 years).
- Coalition building and maintenance skills are improved at both state and local levels.
- Data collection and analysis skills are improved at both state and local levels.
- Increase to 30 communities that have effective injury coalitions in place. [Note: Current status reflects that as of the year 2000, twenty communities have effective injury coalitions in place. Project an increase of five new effective injury coalitions in place each year for two years.]

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

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

- *Other:* Training; assessment; outreach; community program assistance; technical support; and data collection and analysis.

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

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

Participants/Reach:

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

High-risk populations Identified: With crash data by age, gender, location, outcome. Identified with other data for ethnic groups.

Medium-term Outcome Objectives (2005-2007)

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

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

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

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

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

Long-term Outcome Objectives (2008-2010)

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

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

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

Activities include:

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

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

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

Evaluation and Measurement

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

Crosswalk to Other Health and System Priorities in Healthiest Wisconsin 2010

Alcohol and Other Substance Use and Addiction: Many motor vehicle related crashes and deaths involve alcohol and addictive substances.

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

Integrated Electronic Data and Information Systems: Comprehensive data and information that are linked and analyzed are critical to the prevention and control of injuries and deaths due to motor

vehicle and related crashes. It is important to remember that data development in new areas, such as pre-hospital and emergency room data, are equally important.

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

Significant Linkages to Wisconsin's 12 Essential Public Health Services

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

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

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

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

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

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

Connection to the Three Overarching Goals of Healthiest Wisconsin 2010

Protect and promote health for all: Integrate electronic data and information systems connecting Department of Transportation, Department of Health and Family Services, and Department of Justice data, integrate highway safety into community health improvement processes and plans, integrate

state-level highway safety activities across disciplines, and coordinate these with local level cross-discipline activities.

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

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

Key Interventions and/or Strategies Planned:

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

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