Filling the Gaps: Strategic Directions for a Safer California, 2010 – 2013

A Final Report to the National Centers for Disease Control and Prevention

California Department of Public Health
Safe and Active Communities Branch
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Safe and Active Communities Branch (SACB), California Department of Public Health

The Safe and Active Communities Branch (SACB) works to ensure that all Californians have safe places to live, work, play, and fully participate in community life without worry about violence or accidental injury. The Branch is the focal point for the California Department of Public Health's injury and violence prevention efforts, including epidemiological surveillance, program planning and consensus building, interventions, policy development, professional education and training, and public information.

The Branch focuses on primary prevention—instituting policies and interventions designed to prevent harmful events from occurring in the first place. SACB efforts work towards shifting social norms in all relevant domains—from safe and walkable neighborhoods to embracing zero tolerance for intimate partner violence.

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Chapter One: Background

Purpose

Over the last twenty years, California has built a strong and vibrant injury and violence prevention program, guided by strategic thinking in partnership with many experts, decision makers, and stakeholders across the state. The CDC-funded *Safe California* capacity-building project has provided a unique opportunity to assess current efforts and determine where the gaps are in data, policy, and practice. As a result, the recommendations set for in "Filling the Gaps: Strategic Directions for a Safer California, 2010-2013" are not all inclusive—they represent a strategic "to do" list designed to strengthen efforts in areas that need more focused attention and serve as a catalyst for new and evolving areas of injury prevention. Significantly, the *Safe California* project has been designed to complement the following seminal documents that currently help drive injury and violence prevention across California:

- Rape Prevention Education Strategic Plan *(scheduled for release in 2009)*, *www.cdph.ca.gov/programs/EPIC/Pages/default.aspx.*
- California Strategic Highway Safety Plan (2006), *www.dot.ca.gov/SHSP*
- California Statewide Policy Recommendations for the Prevention of Violence Against Women (2006), *www.cdph.ca.gov/programs/EPIC/Pages/default.aspx.*
- Universal Livability: A Dream for Tomorrow, A Plan for Today, California 2005-2010 Strategic Plan (2005), *www.cdph.ca.gov/programs/EPIC/Pages/default.aspx.*
- Preventing Falls in Older Californians: State of the Art, Archstone Foundation (2003), *www.archstone.org*
- Traffic Safety Among Older Adults: Recommendations for California (2002), *www.eldersafety.org*

Next Steps: The State Role in Implementation

The Safe and Active Communities Branch is committed to collaborating with colleagues across the state to ensure that the "Filling the Gaps" recommendations result in real actions that reduce injuries in California. As such, the Branch will monitor and facilitate implementation by providing data, as well as working with partners to coordinate and convene stakeholders, provide venues to foster community support, pursue funding, and connect with efforts in other states. It is hoped that public health stakeholders in California will use the recommendations as a catalyst for new grants, to build support for an expanded public health role in these issues, and for policy and program development.

And finally, given the ever-evolving landscape of injuries and injury prevention in California, the recommendations will be reviewed and updated annually.

Chapter One: Background

Injuries in California: A Public Health Priority

What is Injury?

Injuries are unintentional or intentional damage to the body resulting from acute exposure to mechanical, thermal, electrical, or chemical energy or from the absence of such essentials as heat or oxygen. The term "injury" has been adopted by the public health community to replace the word "accident" when describing the events that result in bodily harm. This change has been a deliberate one to draw attention to the fact that injuries are not chance occurrences—unpredictable and uncontrollable. Recent history proves that intelligent policies and practices can reduce the risk of injuries and result in lower injury rates.

Magnitude of the Problem: Across the Nation

Injuries rank as one of our most pressing health problems, yet they are probably the most under-recognized. They are the leading cause of death for persons from the first year of life to middle age and the fourth leading cause of death among persons of all ages.[i] However deaths are only a small part of the picture. In fact, injuries cause many more hospitalizations, emergency department visits, and doctor's office visits than deaths. Injuries and their consequences account for more than 10 percent of annual medical spending, approximately $260 billion each year. At least half of these costs are borne by the public.[ii,iii]

In addition to health care costs, fatal and non-fatal injuries exact a terrible personal and societal toll. They are a tremendous drain on society in terms of lost productivity and other societal impacts. In addition to the economic costs to the individual affected, this loss extends to the injured person's family, friends, and coworkers. Permanent disability resulting from an injury can affect all aspects of a survivor's existence and can disrupt, change, and dominate his or her family life forever. Even those without physical scars may be forever haunted by post-traumatic stress resulting from the injury event.

Magnitude of the Problem: California

Each year in California, injuries cause more than 17,000 deaths, over 75,000 people to be permanently disabled, over 250,000 nonfatal hospitalizations, and more than 2,000,000 emergency department visits.[iv,v,vi] The death toll in California from injuries is greater than that produced if a fully loaded jumbo-jet were to crash every ten days.

Chapter One: Background

Prevention is Better than Cure

Historically, the most successful public health injury and violence prevention programs combine three types of intervention strategies. These are categorized as:

- Engineering/technological interventions - changes in the design of products or of the physical environment;
- Education/behavior change interventions - the education of the population-at-large or of targeted groups or efforts to alter specific injury-related behaviors; and
- Legislative/enforcement interventions - the passage and enforcement of new laws or the increased enforcement of existing ones.

Child safety seats provide an excellent example of how these three strategies can be interwoven. In 1983, legislation was passed that required all children under four years old riding in motor vehicles be restrained in a child safety seat; it has changed over the years to reflect new knowledge about the risks to older children. The design of the seats was an engineering/technological advance known to be extremely effective when used properly. Education was an important factor in passing the legislation and remains important in encouraging parents to obtain and use seats correctly.

Another example is the "Vision Zero" traffic safety goal in Sweden and several other nations.[vii,viii] The goal is to have no deaths or serious disabling injuries that result from motor vehicle trauma. This goal does not involve the elimination of all vehicle crashes or minor traffic-related injuries. It only seeks to prevent the serious ones. The process toward this goal includes improvements to the design of automobiles, roadways, and pedestrian crossings. It also involves improvements to the efficiency of road and other transportation systems, creation of new legislation and enforcing existing laws, incentives to the public and to businesses to change needed travel patterns, and an extensive education campaign to inform the public about the goal and the reasons for the changes. The integrated process seems to be working. Although the number of minor crashes has remained about the same, serious injuries are declining. This level of success is definitely an incentive for replication elsewhere.

Effective injury prevention requires the combined efforts of experts and professionals in more than 30 distinct professional disciplines, including health, education, transportation, law, engineering, architecture, and safety sciences.[ix] Such collaboration is needed to affect legislation, regulations, and public attitudes towards injury prevention. This multidisciplinary approach is the premise upon which each of the “Filling the Gaps” recommendations has been developed.

Chapter One: Background

Report Development

In 2005, the Safe and Active Communities Branch (SACB) received a State Injury Surveillance and Program Development Core Capacity Building grant from the Centers for Disease Control and Prevention (CDC). This *Safe California* grant was to support the development and implementation of recommendations to enhance injury control capacity and strengthen program infrastructure. With its last strategic plan successfully completed in 1998, SACB was very pleased to receive funding for a new planning process to guide further expansion of California's injury and violence prevention efforts. Due to the small-scale of the grant but also the maturity of injury prevention efforts in California, SACB determined that the best strategy would be to focus on broad infrastructure needs and on injuries that merit more attention (i.e., filling in the gaps).

In April 2006, the Branch convened the first of two Injury Prevention Planning Groups (IPPG) tasked with developing the recommendations. This IPPG-1, used a more global lens concentrating on how to strengthen existing infrastructure, and consisted of 29 influential stakeholders from both within and outside the traditional injury prevention community. To launch their deliberations, IPPG-1 members reviewed the infrastructure recommendations from the recent State Technical Assessment Team (STAT) visit conducted by the State and Territorial Injury Prevention Directors Association (STIPDA). STIPDA's expert team concluded that staff and funding resources for injury prevention within CDPH were not commensurate with the injury burden and insufficient to support state-level injury prevention activities.

In November 2006, the Branch convened IPPG-2, a second group of 23 state and local injury prevention experts, to determine which specific injury areas merited attention. Since this process sought to "fill gaps" in California's injury and violence prevention efforts, an injury area had to be deemed as "underworked" to be included. This selection process was informed by a Branch survey completed by over 120 members of California's Injury Prevention Network (CIPN) to ensure broad stakeholder input into potential injury topic areas for the report. Following the selection of injury areas, 39 additional members with technical expertise were brought in to participate on five IPPG-2 workgroups. These workgroups developed their recommendations through a process that included reviewing data, existing reports and programs, gaps, and promising practices. The workgroups emphasized culturally competent recommendations that considered the unique and diverse populations in our state. In addition, to be included in the report, recommendations had to be:

- supported by the literature's best practices and by California data;
- achievable within the 3-year timeframe of the report;
- an appropriate and important role for public health at the state level;
- achievable with existing resources or resources that are readily available within the plan's duration;
- supportable by issue stakeholders.

Recommendations were then vetted with the CIPN and other key stakeholders. This outside review provided broad feedback from California's large and diverse injury prevention community. Finally, the

IPPG-2 workgroups developed a detailed Action Plan for each of their recommendations (found in a supplementary document on SACB's website). For a complete list of IPPG-1 and IPPG-2 Members, please see Appendix C. For more information on the California Injury Prevention Network, please visit the website at: *www.injurypreventionnetwork.org.*

Injury Prevention and Control Infrastructure Recommendations

The recommendations in this section address injury prevention and control infrastructure needs both statewide and within the California Department of Public Health (CDPH). The goal of these broad recommendations is to improve the safety and health of all Californians by establishing sustainable funding and resources for comprehensive statewide injury and violence prevention activities.

Statewide Recommendations

A. Support and strengthen the public voices advocating for injury and violence prevention as a critical, funded public health function at the state and local levels.

A-1. Increase recognition that injuries are pervasive in the lives of all Californians and preventable, and that there is a need for wide-ranging prevention efforts.

A-2. Build and strengthen constituencies and foster leadership in diverse communities throughout California to advocate for sustainable funding and resources for injury and violence prevention activities at local and state levels.

A-3. Focus public demand for safer, healthier communities on increasing injury and violence prevention efforts that are commensurate with the emotional, physical, and economic burden of injuries and violence, as well as California's rapidly shifting demographics.

B. Strengthen alliances to ensure that injury and violence prevention are integrated as key components in other efforts to address major public health and safety issues.

B-1. Connect injury control with violence and other health, social, environmental, and economic issues, such as physical activity and obesity prevention, aging, disability, poverty, and emergency preparedness.

B-2. Promote integration of injury and violence prevention efforts into broader public health programs and initiatives.

B-3. Create and support opportunities for connecting injury and violence prevention advocates with other public health advocates such as those who champion chronic disease prevention.

State Level Recommendations (within CDPH)

C. Position injury and violence prevention as a prominent and necessary public health function within the CDPH.

C-1. Convey that injury and violence prevention plays a critical role in achieving the CDPH's health and safety goals.

C-2. Pursue statutory language for the Department to have injury and violence prevention as a core function.

C-3. Work to infuse injury and violence prevention into existing and emerging CDPH program areas, such as the "universal livability" and tobacco tax initiatives.

D. Facilitate capacity building for injury and violence prevention programming and research efforts at the local and state levels.

D-1. Provide the opportunity for learning and collaboration among advocates in the injury and violence prevention field through statewide conferences, teleconferences, and professional development opportunities.

D-2. Foster relationships among existing and emerging injury and violence prevention efforts such as pedestrian safety and senior fall prevention.

D-3. Expand the major sources of data on injury and violence, their risks and protective factors, and increase access to, and usefulness of these data.

D-4. Provide resources and information to support local programming and applied research efforts.

Chapter Three: Injury Priority Areas

Injury Priority Areas

"Filling the Gaps" seeks to strengthen existing efforts that require additional focus, as well as, to expand into emerging injury prevention issues. To fulfill this goal, five emergent and underserved injury areas have been selected: older adult falls; older adult poisoning due to medication errors; motor vehicle occupant injuries (ages 14 to 20); pedestrian safety, walkability, and universal livability; and child maltreatment.

Older Adult Falls

Goal: Build state and local capacity to reduce fall-related injuries and deaths among older adults.

Safe California 2010 Objective: Reduce fatal fall injury rate for adults 65 years and over to 32.9 per 100,000 population.

Safe California 2010 Objective: Reduce nonfatal hip fracture (ICD-9 CM 820) rate for male adults 65 years and over to 296.3 per 100,000 population.

Safe California 2010 Objective: Reduce nonfatal hip fracture (ICD-9 CM 820) rate for female adults 65 years and over to 578.9 per 100,000 population.

Falls among older adults are a major cause of injury in California, leading to lengthy hospital stays, long-term care admission, and, all too frequently, to a spiral of events that ends in death.[x] Falls are also a frequent cause of traumatic brain injury and hip fractures in seniors, both of which can lead to long-term disability. In 2007, over 1,400 Californians age 65 and older were killed as the result of a fall and there were almost 68,000 nonfatal hospitalizations due to falls in this age group.[xi,xii] These non-fatal fall injuries cost Californians approximately $2.4 billion each year in direct medical costs.[xiii]

The following recommendations were developed with consideration for the

Archstone Foundation's *Preventing Falls Among Older Californians: State of the Art* (2003) and the Fall Prevention of Excellence's *Statewide Strategy for Action* (2007). More information on these reports can be found at: *www.stopfalls.org*.

Recommendations (See Supplementary Document for Action Plan)

E. SACB should work with the Office of Statewide Health Planning and Development (OSHPD) to establish state capacity to track older adult falls by capturing more data on fall risks and improving the quality and connection between discrete sources of information, including emergency medical services, emergency departments, acute care hospitals, rehabilitation, and long-term care.

F. SACB, in conjunction with other governmental and professional associations, should explore the potential for health care provider reimbursement for fall prevention activities via the promotion and use of the ICD-9 code for "history of falls or risk of falls" (V15.88).

G. SACB should establish, in conjunction with its state partners, an executive-level state task force or coalition to provide leadership and coordination of older adult fall prevention and implement statewide policy initiatives.

H. SACB, in collaboration with the Fall Prevention Center of Excellence (FPCE) and the StopFalls Network, should build the capacity of local public health departments to support partnerships and sustainable fall prevention programs.

I. SACB should work with state and county health care associations and the FPCE to improve the ability of health care providers to conduct fall risk assessment and prevention.

J. SACB should increase older adult access to fall prevention services by working with state partners to integrate fall prevention into state and local public health, aging programs, and caregiver training programs.

K. SACB should work with the California Council on Gerontology and Geriatrics (CCGG) to incorporate order adult fall prevention curricula into academic programs in institutions of higher education.

Recommended Key Partners

California Department of Aging; California Council on Gerontology and Geriatrics; Caregiver Resource Centers; Emergency Medical Services Authority; Fall Prevention Center of Excellence; Office of Statewide Health Planning and Development; StopFalls Network.

Older Adult Poisoning Due to Medication Errors

Goal: Reduce medication errors and misuse among older adults.

Safe California 2010 Objective: Reduce nonfatal accidental poisoning due to medication errors (ICD-9-CM E850.x – E858.x) rate for adults 65 and over to 18.3 per 100,000 population.

Safe California 2010 Objective: Reduce fatal accidental poisoning due to medication errors (ICD-10 X40-X44) rate for adults 65 and over to 2.7 per 100,000 population.

Older adult poisoning due to medication errors is a rapidly emerging public health problem. Such poisoning injuries result when one or more medications are prescribed or used inappropriately. This is also frequently called a "medication error." Medication errors include "any preventable event occurring in the medication-use process, including prescribing, transcribing, dispending, using, and monitoring, that results in inappropriate medication use or patient harm."[xiv] Unfortunately, most injury surveillance systems cannot completely differentiate medication errors from abuse, but research on poisoning surveillance is underway.

According to the California Medication Errors Panel, medication errors "cause harm" to 150,000 Californians annually and cost an estimated $17.7 billion.[xv] In 2007, there were almost 3,100 hospitalizations and 43 persons died due to medication errors among Californians age 65 or older.[xvi,xvii]

Recommendations (See Supplementary Document for Action Plan)

L. SACB should work with the California Poison Control System (CPCS) and OSHPD to enhance understanding of older adult poisoning due to medication errors by linking, analyzing, and disseminating data from hospitals, emergency departments, community clinics, vital statistics, and the CPCS.

M. SACB should, in collaboration with state agencies and associations, support the establishment of older adult poisoning due to medication errors as a major public health problem and work to integrate solutions into state and local public health departments.

N. SACB should collaborate with professional health care associations and other partners to improve health care provider capacity to prevent older adult poisoning due to medical errors.

O. SACB should collaborate with CPCS to increase older adult and caregiver awareness of older adult poisoning due to medication errors by developing culturally sensitive, consumer-focused educational campaigns.

Recommended Key Partners

California Department of Aging; California health care associations; California Poison Control System; California Public Health Association – North; California Public Health Nurses Association; Office of Statewide Health Planning and Development; Southern California Public Health Association.

Chapter Three: Injury Priority Areas

Motor Vehicle Occupant Injuries, Ages 14 to 20

Goal: To enhance systems that support safe decision making by teen and young adult drivers and motor vehicle occupants.

Safe California 2010 Objective: Reduce motor vehicle occupants killed for ages 14-20 to 5.7 per 100,000 population.

Motor vehicle crashes are the leading cause of death and nonfatal injury hospitalizations among California youth ages 14 through 20.[xviii, xix] In 2007, 447 California youth were killed, and there were almost 3,500 nonfatal injuries among motor vehicle occupants in this age group.[xx, xxi] All too often, these injuries and deaths are caused by immaturity and limited driving experience that lead to risk-taking behind the wheel. Issues range from drinking and driving to distracted use of cell phones.[xxii] In fact, nationally in 2004, driver error accounted for 78 percent of fatal crashes among 16-year-olds.[xxiii]

Graduated driver licensing (GDL) laws have been shown to be one of the most effective ways to reduce motor vehicle crashes, injuries, and deaths to teens. A 2006 national evaluation of GDL programs and crashes found that comprehensive GDL programs reduce 16-year-old drivers' fatal crash involvement rates by approximately 20%.[xxiv] While California has one of the strongest GDL laws in the nation, significant enhancements need to be made to its regulations and enforcement, as well as education for parents, in order to increase its effectiveness and further reduce needless crash deaths among California youth.

The following recommendations were developed with consideration for the California Department of Transportation's Strategic Highway Safety Implementation Plan (SHSIP). Where possible, the recommendations support the public health role in implementing recommendations in SHSIP's Challenge Area 6, "Reduce Young Driver Crashes." More information on the SHSIP is available at: *www.dot.ca.gov/hq/traffops/survey/SHSP/*.

Recommendations (See Supplementary Document for Action Plan)

P. SACB should establish a system that allows for comprehensive analysis of teen and young adult crash data and make such data accessible to injury prevention researchers.

Q. SACB should work with stakeholders to enhance the effectiveness and enforcement of graduated drivers licensing (GDL) laws in reducing teen and young adult motor vehicle occupant injuries.

R. SACB should promote the effective integration of developmentally

appropriate driver and motor vehicle occupant risk reduction strategies into high school curricula and school policies.

S. SACB, in partnership with state and local agencies, should research and develop a two-part social norm campaign, one part for parents and another for teens and young adults, to enhance adherence to GDL laws and improve teen and young adult driving and vehicle occupant safety behaviors.

T. SACB, in conjunction with its partners, should promote implementation and evaluation of promising parent education and involvement programs such as Start Smart that encourage parents to adopt and maintain restrictions on teen and young adult driving post-GDL, especially during the first year of licensure.

Recommended Key Partners

California Highway Patrol, California Office of Traffic Safety; California Department of Motor Vehicles; Automobile Club of Southern California; California State Automobile Association; Center for Youth Development, University of California, Davis; California Parent Teacher Association; Personal Insurance Federation; School Health Connections and Healthy Start, California Department of Education; Safe Transportation Research and Education Center, University of California, Berkeley.

Chapter Three: Injury Priority Areas

Pedestrian Safety, Walkability, and Universal Livability

Goal: To create a pedestrian friendly environment.

Safe California 2010 Objective: Reduce pedestrian deaths rate to 1.7 per 100,000 population.

Safe California 2010 Objective: Reduce pedestrian injury rate to 8.5 per 100,000 population.

Motivating Californians to walk (and ride bicycles) for transportation and recreation is challenging if they do not feel safe. In 2007, over 830 pedestrians were killed in California and in 2006 more than 4,300 were hospitalized with nonfatal injuries.[xxv,xxvi] Treat and release emergency department visits in California exceed 18,000 persons.[xxvii] These totals hint at the great societal costs associated with severe pedestrian injuries. For example, the lifetime costs paid by the public sector for aftercare for a child who suffers permanent brain damage as a result of an automobile collision can total $4.5 million. Factors contributing to high pedestrian morbidity include inattentive driver behavior and lack of awareness as to what pedestrian rights include, unsafe structures that make up the built environment (e.g., wide, fast, multi-lane roadways), and dangerous pedestrian behavior (e.g., children darting out into the street and pedestrian intoxication).

Pedestrian injuries and other health risks, such as obesity, violence, and unhealthy air pollution, can be reduced for the long-term by creating walkable communities and built environments that provide safe, universal pedestrian access. "Walkable" communities are those in which pedestrian travel is readily available as a safe, connected, accessible, and pleasant mode of transport.[xxviii] Likewise, communities that are universally livable allow every individual to function within their community by providing adequate and appropriate access to transportation, safe and walkable areas, safe biking routes, and access to healthy and nutritious foods.

The following recommendations were developed with consideration for the California Department of Transportation's Strategic Highway Safety Plan (SHSIP). Where possible, the recommendations support the recommendations in SHSP's Challenge Area 8, "Make Walking and Street Crossing Safer." More information on the SHSIP is available at: *www.dot.ca.gov/hq/traffops/survey/SHSP/.*

Recommendations (See Supplementary Document for Action Plan)

U. SACB should work with its federal, state, and local partners to strengthen capacity to collect state, county, and local level pedestrian data (e.g., number of pedestrians or "counts") to better inform pedestrian safety policies and programs.

V. SACB should compile, synthesize, and disseminate data and research on pedestrian safety and the built environment to promote improvements and policy development at the local level.

W. SACB, in conjunction with its partners, should build organizational capacity of local public health departments to engage in land use and transportation planning and pedestrian safety programs by identifying funding streams, as well as the provision of training and technical assistance on safe built environments for pedestrians.

X. SACB should facilitate policies that promote pedestrian safety and modifications to the built environment for safe, universal pedestrian access.

Recommended Key Partners

California Conference of Local Health Officers; California Department of Transportation; California Office of Traffic Safety; SACB's California Center for Physical Activity as well as other CDPH nutrition/physical activity programs; Center for Civic Partnerships; Local Government Commission; Prevention Institute.

Chapter Three: Injury Priority Areas

Child Maltreatment

Goal: To enhance statewide capacity to reduce child maltreatment and neglect.

Safe California 2010 Objective: Reduce the rate of child maltreatment deaths to 1.7 per 100,000 population.

Child maltreatment refers to any act or failure to act on the part of a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child. It includes physical, sexual, and emotional abuse, neglect, and endangerment.[xxix]

Child maltreatment is a significant public health problem in terms of its magnitude, severity, and societal costs. In 2008, almost 500,000 children were referred to Child Protective Services.[xxx] Of those, over 97,100 children have substantiated claims of child maltreatment, including almost 66,000 children age 10 and younger. These official numbers represent only the tip of the iceberg of parenting problems and child adversity.

Exposure to any form of child maltreatment is an Adverse, Childhood Experience (ACE) often leading to both immediate and enduring negative consequences. In addition to serious physical injury or death, maltreated children may face emotional difficulties, social maladjustment, and school underperformance. Consequences in adolescence include delinquency, substance abuse, suicide risk, and school failure.[xxxi] Longer term effects of childhood maltreatment include increased risks for mental illness (e.g., depression), obesity, criminal behavior, and parenting difficulties. As the number of adverse childhood experiences accumulates, the negative physical and mental impacts expand exponentially, including increasing risks for chronic heart, lung and cancer diseases.[xxxii] This makes preventing child maltreatment even more critical to the public's health and well-being.

Recommendations (See Supplementary Document for Action Plan)

Y. SACB should work with state and local Child Death Review Teams (CDRTs) and other key partners to develop and promote the use of standardized public health surveillance definitions for child abuse and neglect for CDRTs.

Z. SACB should compile and disseminate information and research on the overlapping relationships among unintentional injuries, child maltreatment, substance abuse, and adverse childhood experiences to strengthen collaborations among prevention stakeholders at the state and local level.

AA. SACB should facilitate the implementation of policies and protocols to increase the quality and availability of training for mandated reporters, including awareness of local resources for training.

BB. SACB should work with state partners and professional associations to reduce fundamental risk factors for child maltreatment by increasing universal screening for perinatal substance use, parent education, and father involvement in order to reduce fundamental risk factors to child maltreatment.

CC. SACB should work with state and local partners to create unified, consistent, and evidence-based primary prevention child maltreatment messages for use in state and local media and social marketing campaigns.

DD. SACB should promote, in collaboration with its partners, the statewide implementation of evidence-based family strengthening programs (e.g., home visitation, family resource centers, and effective parenting curriculum).

Recommended Key Partners

American Academy of Pediatrics; American College of Obstetrics and Gynecology; California Department of Alcohol and Drug Programs; California Department of Education; California Department of Social Services; Center for Injury Prevention Policy and Practice, Kids' Plates Program, San Diego State University; Child Abuse Prevention Councils (CAPCs); Contra Costa Child Abuse Prevention Council; County Alcohol and Other Drug Administrators; County Child Death Review Teams (CDRT); CDRT and CAPC Regional Coordinators; First Five State and County Commissions; Maternal, Child and Adolescent Health Branch, California Department of Public Health; Prevent Child Abuse California; State Child Death Review Council.

Appendix A: Glossary

Adverse drug event – Any injury due to medication.[xxxiii]

Adverse childhood experience – Exposure to physical, sexual and emotional abuse, neglect, and other household dysfunctions (e.g., parental substance abuse, mental illness, intimate partner violence) before age 18.

Built environment – The totality of all buildings, spaces, and products that are created, or modified, by people. It includes homes, schools, workplaces, parks/recreation areas, greenways, business areas, and transportation systems. It includes land-use planning and policies that impact our communities in urban, rural and suburban areas.[xxxiv]

Child maltreatment – Any act or series of acts of commission or omission by a parent or other caregiver that result in harm, potential for harm, or threat of harm to a child. Includes physical and sexual abuse, neglect, and endangerment.[xxxv]

Complete Streets – Streets designed and operated to enable safe access for all users. Pedestrians, bicyclists, motorists and transit riders of all ages and abilities must be able to safely move along and across a complete street.[xxxvi]

Medication error – Any preventable event occurring in the medication-use process, including prescribing, transcribing, dispending, using, and monitoring, that results in inappropriate medication use or patient harm.[xxxvii]

Medication reconciliation – Comparison of the medications a person is taking in one care setting with those being provided in another setting.

Pedestrian – Any person on foot or who is using means of conveyance propelled by human power (e.g. wheelchair, mobility aid), other than bicycle.[xxxviii]

Universal livability – A vision that allows every individual to function as a full citizen within their community by providing adequate and appropriate access to transportation, safe and walkable areas, safe biking routes, and access to healthy and nutritious foods.

Walkability – The extent to which walking is readily available as a safe, connected, accessible, and pleasant mode of transport.

Appendix B: California Injury Prevention Planning Groups

We greatly appreciate the individual and collective contributions to this report by our Planning Group Members, Consultants, and staff.

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Endnotes

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