Hosted by:

John Rex Endowment
712 W. North Street Raleigh, NC

JOHN REX ENDOWMENT

Facilitated by:

Carolyn Crump PhD, Rachel Page MPH & Robert Letourneau MPH

The University of North Carolina Gillings School of Global Public Health
Department of Health Behavior

UNC GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH

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May 2, 2014

A. Background

On May 2, 2014 team members from the University of North Carolina Gillings School of Global Public Health (Carolyn Crump, Rachel Page, and Robert Letourneau) facilitated the "Building to Impact: Preventing Childhood Injury" meeting hosted by the John Rex Endowment at the Marbles Kids Museum, 201 E Hargett St, Raleigh, NC.

The meeting was attended by public health professionals representing the following stakeholders: 1) Public Safety Officials (e.g. police, fire, EMS); 2) Government; 3) Non-Profit; 4) Academia/University; 5) Medical/Healthcare facility; and 6) representatives from other types of organizations. The list of participants, with contact information, is available in Appendix A.

The three goals of the meeting were to: 1) Explore and understand the leading causes of childhood injury in Wake County based on results of a recent assessment, the Wake County Childhood Injury Prevention Assessment Project; 2) Hear from keynote speaker Carolyn Fowler, PhD from Johns Hopkins University, about the importance of incorporating childhood development when considering childhood injury prevention; and 3) Participate in interactive networking sessions led by the Healthy Solutions Team to discuss ways to consider and identify opportunities to enhance the impact of childhood injury prevention, and identify resources to improve those efforts in Wake County.

For the full report, *A Profile of Wake County Childhood Injury and Injury Prevention,* prepared by the Healthy Solutions Team and the Carolina Center for Health Informatics at the University of North Carolina at Chapel Hill under contract to the John Rex Endowment see http://www.rexendowment.org/learning-resources. The John Rex Endowment also provided an overview of their 2014 Preventing Injury funding announcement.

B. Summary of Agenda

The meeting was organized into two parts: 1) Presentations and 2): Discussions. The agenda is provided in Appendix B.

Part I *8:00 am- 10:30am*

- Breakfast and Networking
- Welcome
- *A Profile of Wake County Childhood Injury and Injury Prevention*
- Keynote Address: Advancing Childhood Prevention in Wake County: Challenge or Opportunity?
- John Rex Endowment's Funding Preview and Next Steps

Part II *10:45 am- 12:30pm*

- Networking Break
- Facilitated Discussion #1 *Targeting Efforts for Impact*
- Facilitated Discussion #2 *Building Effective Networks*
- Group Discussion
- Wrap – Up/Closure

Throughout the morning, three small group discussions elicited ideas pertaining to childhood injury and violence prevention in Wake County. A note taker was assigned to each table of 6 to 8 participants to capture major themes and the guided discussion. A description of each discussion is included in Sections C, E and F of this report.

C. *A Profile of Wake County Childhood Injury and Injury Prevention* Overview

Objective: Review and discuss Wake County childhood injury data; organizations, coalitions and programmatic approaches.

Upon arrival, participants were assigned to pre-designated tables consisting of a mixture of stakeholder groups (e.g., funders, practitioners, researchers) to provide diverse perspectives regarding the overview of *A Profile of Wake County Childhood Injury and Injury Prevention*.

The first presentation shared the findings from *A Profile of Wake County Childhood Injury and Injury Prevention,* presented by Carolyn E. Crump, PhD, UNC Gillings School of Global Public Health. Slides and handouts for this presentation are provided in Appendices C and D.

The presentation was divided into two sections: 1) Overview of Wake County Childhood Injury Secondary Data; and 2) An Analysis of Organizational and Coalitions Working in Childhood Injury Prevention in Wake County. After each section participants responded to four questions: 1) What is new or interesting to you from the findings? 2) What are the gaps? 3) Does this information reflect what you know about childhood injuries in Wake County? and 4) How might you use this information? Tables 1 and 2 show a summary of participant's comments from 11 tables. Complete comments are listed in Appendix F.

Table 1. Discussion regarding Wake County Childhood Injury Secondary Data Summary (n=11 tables).

Question	*Summary Comments*
1. What is new or interesting to you from the findings?	• The majority of tables found at least one component of the information as "shocking" or "surprising" (n=7). • Several tables discussed how to identify ways to apply the information presented to their programmatic approach(es) (n=5).
2. What are the gaps?	• Several tables discussed potential limitations of data (n=6). • Some tables discussed interest in additional data sources (n=4) that were either not included or addressed in the presentation, or not available. • Some tables discussed an interest to see the data presented in greater detail (n=4).
3. Does this information reflect what you know about childhood injuries in Wake County?	• Some tables found the information presented aligned with previous experiences (n=4).
4. How might you use this information?	• Several tables identified ways to integrate the information into their current prevention work (n=6). • Some of the tables discussed application to targeting messages (n=2). • Some tables discussed how to use the information to leverage funding (n=2). • One table discussed using this information to coordinate efforts (n=1).

Table 2. Discussion regarding the Analysis of Organizational and Coalitions Working in Childhood Injury Prevention in Wake County (n=11 tables).

Question	*Summary Comments*
1. What is new or interesting to you from the findings?	• The majority of tables discussed the use of the public health frameworks (Socio-ecological Model; The 3 Es of Injury Prevention, Education, Engineering, and Enforcement; and Frieden's Health Impact Pyramid) (n=9). • Some of the tables discussed implications for policy (n=2). • Some of the tables discussed presence of falls (n=2). • Some of the tables discussed approval of current population focus (n=2).
2. What are the gaps?	• Some mentioned the need for increased collaboration among organizations (n=4). • Some of the tables discussed an interest in reviewing additional details provided in the report (n=4).
3. Does this information reflect what you know about childhood injuries in Wake County?	• Several tables discussed how the information presented on organizations and collations aligned with their previous understandings (n=3). • One table was unfamiliar with Frieden's Health Impact Pyramid (n=1).
4. How might you use this information?	• The majority of the tables discussed how to expand and/or review their current organizational approach (n=7). • Some of the tables discussed how to collaborate with additional groups (n=4). • Some of the tables discussed how to modify funding initiatives (n=3). • Some of the tables discussed how to increase diversity of activities (n=2).

D. Keynote Address: *Advancing Childhood Prevention in Wake County: Challenge or Opportunity?*

The Keynote Address '*Advancing Childhood Prevention in Wake County: Challenge or Opportunity?*' was presented by Carolyn J. Cumpsty-Fowler, PhD, MPH, from the Johns Hopkins School of Nursing and Johns Hopkins Bloomberg School of Public Health. Dr. Cumpsty-Fowler emphasized three "take home" messages related to injury prevention in Wake County: 1) childhood injuries are a problem; 2) many organizations contribute to injury prevention; and 3) there is both the capacity to prevent injuries and potential to leverage these resources to build greater capacity and impact.

Dr. Cumpsty-Fowler addressed innovate approaches to childhood injury prevention, including incorporating the developmental state of children when creating interventions, activities and/or programs. Slides for this presentation are provided in Appendix E.

E. Facilitated Discussion # 1 Targeting Efforts for Impact

Objective: Identify powerful Wake County decision makers and ways to engage decision makers.

During Part II of the event, participants discussed how to identify powerful Wake County decision makers and ways to engage those decision makers. Participants were assigned to tables comprised of a variety of organizational types (e.g. non-profit, government), and a mixture of injury topic of interest (e.g., falls, burns). Participants were assigned to tables to increase the diversity of discussions about decision makers. Different types of agencies may have varying levels of accessibility to certain types of decision makers and different decision makers may be relevant across the range of injury type. Participants identified current effective methods and potential methods for targeting efforts.

Participants at each table were given 35 minutes to discuss three questions after introducing themselves: 1) Identify decision makers who can change social and physical environments that would reduce childhood injury; 2) How do you or can you influence these decisions makers?; and 3) How can you enhance the focus of your current activities/skills to more effectively influence decision makers in the future? Table 3 shows a summary of comments from the nine tables; complete findings are listed in Appendix G.

Table 3. Summary Comments from Facilitated Discussion #1 *Targeting Efforts for Impact* (n=9 tables)

Question	*Summary Comments*
1. Identify decision makers who can change social and physical environments that would reduce childhood injury?	• The majority identified different types of governmental positions (n=27), including broad based governmental functions, e.g., federal, state, local (n=9); followed by state level (e.g., state agencies, General Assembly) (n=7). • Several tables identified schools and/or daycare systems (n=9). • Several tables identified Non-profits/business sector (n=6). • Some tables identified parents/caregivers (n=4).
2. How do you or can you influence these decisions makers?	• Collaborate and/or work with local agencies who are focused on child health (where the primary function may not be directly focused on injury prevention) (n=16) • Several tables discussed how to provide education on "how" to advocate (n=10). • Several tables discussed how to create targeted and poignant messages (n=9). • Some tables discussed how to work with new population groups (n=3). • Some tables discussed how to address environmental/social changes (n=3).
3. How can you enhance the focus of your current activities/skills to more effectively influence decision makers in the future?	• The most common response was to increase targeting specific key populations (n=12). • Several tables discussed how to incorporate data and information into activities and approach(es) (n=8). • Several tables discussed how to increase collaboration (n=6) and targeting of messaging (n=6).

F. Facilitated Discussion # 2 Building Effective Networks

Objective: Build effective Wake County Childhood Injury Prevention networks.

During Part II of the event, participants discussed how to build effective Wake County Childhood Injury Prevention networks. Participants were assigned to tables consisting of the same injury types and a mixture of work focuses (e.g. counseling, advocacy) within injury type. Tables were created to increase the likelihood of a shared ground of current networks available within a specific injury type, as well as to identify ways to expand current networks and collaboration efforts. Participants discuss how they could be more strategic in sharing information, sharing work and sharing resources.

Participants at each table were given 35 minutes to discuss three questions after introducing themselves: 1) How can you be more strategic in your networking (sharing information)?; 2) How can we increase collaboration and partnerships (sharing work)?; and 3) What resources can we share to do our work well? Table 4 shows a summary of findings from nine tables; complete findings are listed in Appendix H.

Table 4. Summary Comments from Facilitated Discussion *# 2 Building Effective Networks* (n=9 tables)

Question	*Summary Comments*
1. How can you be more strategic in your networking (sharing information)?	• Several participants discussed expanding their current childhood injury prevention partnerships (n=14). • Several participants discussed creating new partnerships (n=7). • Some participants discussed how to expand education efforts (n=4). • Some participants discussed how to work towards environmental/social changes (n=3). • Some participants discussed expand outreach methods (n=2).
2. How can we increase collaboration and partnerships (sharing work)?	• The most common response was to expand current collaboration (n=17), including working with new partnerships (n=11). • Several participants discussed how to target messages/approaches to childhood injury prevention (n=10). • Several participants discussed how to increase communication to share resources (n=8). • Some participants discussed ways to maintain current collaboration (n=6).
3. What resources can we share to do our work well?	• The most common response was to increase transparency and communication across organizations (n=15), for example, one table commented *"We need to change the model where organizations have to compete with each other, but instead, can work together to secure funding to support a broader effort, with shared responsibilities based on where expertise lies to complete project work*." • Several participants discussed ways to incorporate data (n=7). • Several participants discussed how to increase outreach (n=4). • Several participants discussed how to use existing resources (n=2).

Appendix A. Meeting Participants

Table 5. Building to Impact: Preventing Childhood Injury May 2 Meeting Participants.

Last Name	*First*	*Organization*	*Position*	*E-mail Address*
Alfano-Sobsey	Edie	Wake County Human Services	Epidemiologist/Lab Director	edie.alfanosobsey@wakegov.com
Austin	Margaux	HopeLine, Inc.	Executive Director	director@hopeline-nc.org
Bell	Laila	NC Child	Director of Research and Data	laila@ncchild.org
Blackburn	Lauren	NCDOT	Bicycle and Pedestrian Director	lablackburn2@ncdot.gov
Bradley-Bull	Kristin	New Perspectives Consulting Group	Senior Associate	kristin@newperspectivesinc.org
Butler, MD	Linda	Rex Healthcare	Chief Medical Officer	kathy.rhodes@rexhealth.com
Circosta	Damon	A.J. Fletcher Foundation	Executive Director	damon@ajf.org
Coble	Paul	Wake County Commission	Commissioner	paulcoble@nc.rr.com
Davis	Susan	Wake County Medical Society Community Health Foundation	Executive Director	sdavis@wakedocs.org
DeRonja	Cristin	SAFEchild	Director of the SAFEchild Advocacy Center	cderonja@safechildnc.org
Dibble	Kylene	PLM Families Together	Community Engagement Coordinator	kylene@plmft.org
Drasal-Hinton	Monica	El Pueblo, Inc.	P.A.R.E. Project Coordinator	monica@elpueblo.org
Ellis	Jeana	Tammy Lynn Center	Early Childhood Intervention Services Manager	jellis@tammylynncenter.org
Farmer	Sandra	Brain Injury Association of North Carolina	Executive Director	sandra.farmer@bianc.net
Gilbert	Colisha	StepUp Ministry	Children's Program Manager	colishagilbert@gmail.com
Grogan	Curtis	Wake County Public School System	Director, Risk & Safety Management	cgrogan@wcpss.net
Hairston	Gladys	John Rex Endowment	Program Associate	gladys@rexendowment.org
Heath	Jill	Mulkey Engineers & Consultants	President and CEO	jheath@mulkeyinc.com
Hooten	Elizabeth	Glen Oaks Farm	Owner/Manager	eghooten@gmail.com
Hudgins	Elizabeth	Child Fatality Task Force	Executive Director	elizabeth.hudgins@dhhs.nc.gov
Johanson	Amanda	Holly Hill Hospital	Director of Business Development	amanda.johanson@uhsinc.com
Ledford	Sue Lynn	Wake County Human Services - PH Division	PH Division Director	sue.ledford@wakegov.com
MacLachlan	Elizabeth	NC Public Health Foundation	Executive Director	elizabeth.maclachlan@ncphf.org
Mann	Angela	Passage Home, Inc.	Youth Outreach Counselor	amann@passagehome.org
Mask, MD	Allen	Raleigh Urgent Care Center	Medical Director	doctormask@aol.com
McClain	JoAnn	Division of Adult Corrections and Juvenile Justice	Juvenile Court Counselor Supervisor	joann.mcclain@ncdps.gov
Menestres	Marjorie	SAFEchild	Executive Director	mmenestres@safechildnc.org
Merz	Sara	Advocates for Health in Action	Executive Director	smerz@wakeaha.org
Moyano-Kleckner	Sofia	Catholic Charities of the Diocese of Raleigh	Assistant Executive Director	sofia.moyano-kleckner@raldioc.org
Mugno	Deborah	Lucy Daniels Center	Director of Education/Operations	dmugno@lucydanielscenter.org
Nelson	Beth	Wake County Juvenile Crime Prevention Council (JCPC)	Chair	bnelsonlpc@gmail.com
Nelson, PhD	Deborah	John Rex Endowment	Consultant, Early Childhood	dnelson52@nc.rr.com
Newman	Debbie	Safe Kids Wake County	Coalition Coordinator	denewman@wakemed.org
Pace	Robert	Wake County Public School System	Safety Administrator	rpace@wcpss.net
Parker	Jan	Safe Kids NC	Injury Prevention Specialist	jan.parker@ncdoi.gov
Pavlis	Stephanie	Prevent Child Abuse North Carolina	Program Coordinator	spavlis@preventchildabusenc.org
Petrarca	Debra	WakeMed Health & Hospitals	Trauma Program Manager	dpetrarca@wakemed.org
Pinther	Anita	John Rex Endowment	Consultant	anita.blomme@mindspring.com

Appendix A. Meeting Participants

Table 5. Building to Impact: Preventing Childhood Injury May 2 Meeting Participants.

Last Name	*First*	*Organization*	*Position*	*E-mail Address*
Proescholdbell	Scott	NC Department of Health and Human Services	Injury Epidemiologist	scott.proescholdbell@dhhs.nc.gov
Pullen-Seufert	Nancy	UNC Highway Safety Research Center	Senior Research Associate	pullen@hsrc.unc.edu
Ragan	Krista	United Way of the Greater Triangle	Community Impact Project Manager Director	kragan@unitedwaytriangle.org
Ray	Thomas	Alice Aycock Poe Center for Health Education	Sr. Director of Educational Programming	t.ray@poehealth.org
Relos	Ruth	Partners Against Trafficking Humans in NC	Leadership Team	pathnc@mindspring.com
Rojano	Ramon	Wake County Human Services	Director	rrojano@wakegov.com
Rollins	Ann	Alice Aycock Poe Center for Health Education	Executive Director	a.rollins@poehealth.org
Rose	Margie	Partners Against Trafficking Humans in NC	Leadership Team	margierose71@gmail.com
Saloni	Cecilia	El Pueblo, Inc.	Public Safety Director	cecilia@elpueblo.org
Shirah	Kate	John Rex Endowment	Program Director	kate@rexendowment.org
Starsoneck	Leslie	NC Child	Interim Executive Director	lstarsoneck@nc.rr.com
Tolle Whiteside	Jennifer	NC Community Foundation	CEO	jtwhiteside@nccommunityfoundation.org
VanHusen	Diane	Hilltop Home	Executive Director	dvanhusen@hilltophome.org
Vaughn, MPH, CPH	Margaret	Injury and Violence Prevention Branch, NC Division of Public Health	Program Consultant	margaret.vaughn@dhhs.nc.gov
Weatherly	Shannon	Youth Thrive	Executive Director	sweatherly@unitedwaytriangle.org
White	Janice	Division of Mental Health/Developmental Disabilities/Substance Abuse Services	TBI Program Coordinator	janice.white@dhhs.nc.gov
Witt	Patricia	Partners Against Trafficking Humans in NC	Leadership Team	pathnc@mindspring.com
Wray	Carleen	National Association of Students Against Violence Everywhere (SAVE)	Executive Director	cwray@nationalsave.org
Zechmann	Michelle	Haven House Services	CEO	mzechmann@havenhousenc.org

Table 6. John Rex Endowment Staff, Speakers and UNC Healthy Solutions Team.

Last Name	*First*	*Organization*	*Position*	*E-mail Address*
Cain	Kevin	John Rex Endowment	President and CEO	kevin@rexendowment.org
Crump, PhD	Carolyn E.	UNC Healthy Solutions Team	Research Associate Professor	carolyn_crump@unc.edu
Dellapenna, Jr.	Alan	NC Department of Health and Human Services	Branch Head, Injury and Violence Prevention Branch	alan.dellapenna@dhhs.nc.gov
Fowler, PhD, MPH	Carolyn	Johns Hopkins University	Assistant Professor	cfowler1@jhu.edu
Hairston	Gladys	John Rex Endowment	Program Associate	gladys@rexendowment.org
Letourneau, MPH	Robert J.	UNC Healthy Solutions Team	Research Associate	rletourn@email.unc.edu
Myhra	McAllister	John Rex Endowment	Director of Operations	mcallister@rexendowment.org
Page, MPH	Rachel	UNC Healthy Solutions Team	Research Associate	rapage@email.unc.edu
Shirah	Kate	John Rex Endowment	Program Director	kate@rexendowment.org
Waller, ScD	Anna	UNC Healthy Solutions Team	Director	anna_waller@med.unc.edu

Appendix B. Meeting Agenda.

Building To Impact: Preventing Childhood Injury
Marbles Kids Museum
Friday, May 2, 2014
-Part I-

- Breakfast and Networking
- Welcome
  Kevin Cain, President and CEO, John Rex Endowment
- *A Profile of Wake County Childhood Injury & Injury Prevention*
  Carolyn E. Crump, PhD, Research Associate Professor, Healthy Solutions Team, Department of Health Behavior, UNC Gillings School of Global Public Health, The University of North Carolina
- Introduction of Keynote Speaker
  Alan Dellapenna, Jr. MPH, Branch Head, Injury and Violence Prevention Branch, NC Department of Health and Human Services
- *Keynote Address - Advancing Childhood Prevention in Wake County: Challenge or Opportunity?*
  Carolyn J. Cumpsty-Fowler, PhD, MPH, Assistant Professor and Evaluation Coordinator, Johns Hopkins School of Nursing
  Assistant Professor Health Policy and Management, Johns Hopkins Bloomberg School of Public Health
- John Rex Endowment's Funding Preview and Next Steps
  Kate Shirah MPH, Program Director, John Rex Endowment
- Networking Break *(approx. 10:30am)*
  Participants who are not staying for Part II are asked to exit through the courtyard doors.

-Part II-

- Facilitated Discussion Overview
  UNC Healthy Solutions Team
- Facilitated Discussion #1 – Targeting Efforts for Impact
  UNC Healthy Solutions Team

  Facilitated Discussion #2 – Building Effective Networks
  UNC Healthy Solutions Team
- Group Discussion
  UNC Healthy Solutions Team
- Close (approx. 12:30pm)
  Kevin Cain, President and CEO, John Rex Endowment

A PROFILE OF WAKE COUNTY CHILDHOOD INJURY &

INJURY PREVENTION

MAY 2014

Assessment Project Methods and Results

Carolyn E. Crump, PhD
Research Associate Professor
UNC at Chapel Hill Gillings School of Global Public Health

Data Analysis
Carolina Center for Health Informatics
Anna Waller, ScD
Steven Lippmann, MSPH
Amy Ising, MSIS

Profile Analysis
Healthy Solutions Team
Rachel Page, MPH
Robert Letourneau, MPH

Purpose

Assess childhood injury and violence **burden** and **prevention activities** in Wake County.

1. Summarize Childhood Injury Data.
2. Profile Organizations Addressing Injury Prevention.
3. Compare Injury Data and Injury Prevention activities.

Approach for Presentation

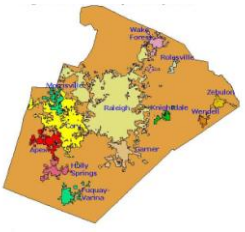
Part I
1. Burden Data Summary

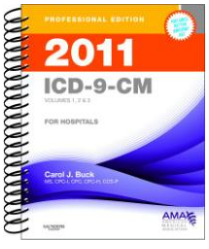
Part II
2. Organization Profile Summary

a. Orientation to methods and results

b. Small Group discussion

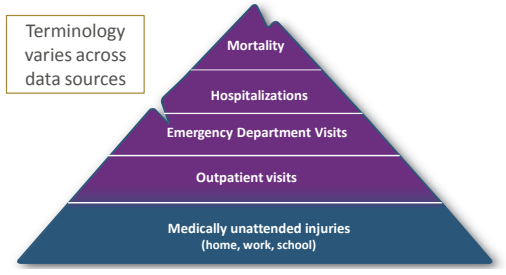
Part I: Summary of Wake County Childhood Injury Data





Injury Iceberg: Mortality Data

Terminology varies across data sources



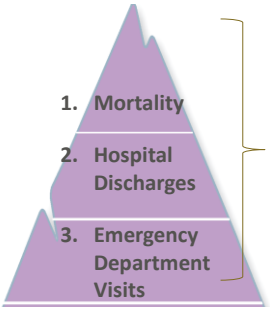
Secondary Data Collection

Three types of data were analyzed for children age 0-17 in Wake County.

	Data Source	Years	N
1.	Mortality	2006-2011	124
2.	Hospital Discharges	2006-2011	3,007
3.	Emergency Department Visits	2006-2012	138,047

Additional data summarized in report
- Poison Control Center Calls 2006-2012
- Emergency Medical Services Responses 2009-2012

Leading Injury Causes Wake County, NC Age 0-17 Between 2006-2012



1. MVC Traffic-Occupant
2. Assault
3. MVC Traffic-Pedestrian
4. Self-Inflicted/Self-Harm
5. Falls
6. Unintentional Suffocation
7. Burns
8. Struck By or Against
9. Natural/Environmental Factors
10. Bicycle Injury/Crashes

Main Results from Secondary Data….

Table 1. Leading injuries/events for mortality, hospital discharge, and emergency department data.

Rank	Mortality (2006-2011) N = 124			Hospital Discharge (2006-2011) N = 3,007			ED Visits (2006-2012) N = 138,047		
	Mortality Injury Causes	#	%	*Hospital Discharge Injury Causes*	#	%	*ED Visit Injury Causes*	#	%
1	MVC -Occupant	20	16.1	Falls	646	21.5	Falls	36,833	26.7
2	Assault	16	12.9	MVC Traffic-All	309	10.3	Struck By or Against	25,766	18.7
3	MVC -Pedestrian	15	12.1	Self-Inflicted/Self-Harm	272	9.0	MVC Traffic-Occupant	9,953	7.2
4	Self-Inflicted/Self-Harm	14	11.3	Burns	203	6.8	Natural/Environmental Factors	7,250	5.3
5	Unintentional Suffocation/Choking/ Breathing Threat	11	8.9	Assault	165	5.5	Bicycle injury/ crashes	2,994	2.2

Leading Injury Causes in Wake County, NC Age 0-17 Between 2006-2012

Injury Cause	*Top Five Injury Causes by Source*		
	Mortality	*Hospitalization*	*ED Visits*
1. MVC -Occupant	X	X	X
2. Assault	X	X	
3. MVC -Pedestrian	X	X	X
4. Self-Inflicted/Self-Harm	X	X	
5. Falls		X	X
6. Unintentional Suffocation	X		
7. Burns		X	
8. Struck By or Against			X
9. Natural/Environmental Factors			X
10. Bicycle injury/ crashes			X

Emergency Department Data by Age Group

Table 2. Percentage by age group for each leading cause of injury from ED visit data for Wake County Children, ages 0-17 years, 2006-2012 (row percentages are reported).

	N	*0 years*	*1-4 years*	*5-9 years*	*10-14 years*	*15-17 years*
Motor Vehicle Crashes (traffic) – Occupants	10,017	5.0	17.4	21.7	23.7	**32.3**
Assault/Physical Violence	2,044	2.6	4.5	8.7	**30.6**	**53.4**
Motor Vehicle Crashes (traffic) - Pedestrians	314	0	16.2	20.4	**29.6**	**33.8**
Self Inflicted/Self Harm	840	0	---	---	**29.7**	**69.3**
Falls	36,837	5.4	**35.7**	**27.5**	**22.4**	9.0
Suffocation	66	**40.2**	**35.6**	---	---	---
Burns, including fire and scalds	1,521	8.7	**50.2**	17.3	13.0	10.9
Struck by or against	25,766	1.6	21.0	23.5	**32.9**	21.0
Natural/Environmental Factors (e.g. weather related, insect bites)	7,250	3.0	**34.5**	**28.2**	21.4	12.8
Bicycle injury/crashes (NOT involving a motor vehicle)	3,019	0	12.5	**41.4**	**36.8**	9.3

Emergency Department Injury Data by Age Group

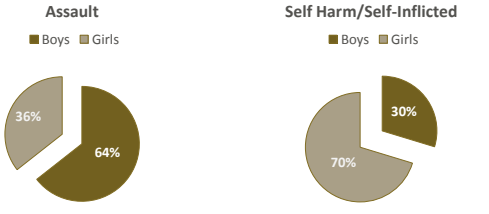
Table 3. Leading causes[a] of injury within age group (2006-2012).

Age in Years	*N*	*Leading Causes*	*%*
0	4,488	Falls MVC- Occupant Struck By/Against	44% 11% 9%
1-4	33,541	Falls Struck By/Against Natural/Environmental	39% 16% 8%
5-9	28,622	Falls Struck By/Against MVC – Occupant	35% 21% 8%
10-14	31,532	Struck-by/Against Falls MVC-Occupant	27% 26% 8%
15-17	21,352	Struck-by/Against Falls MVC-Occupant	25% 16% 15%

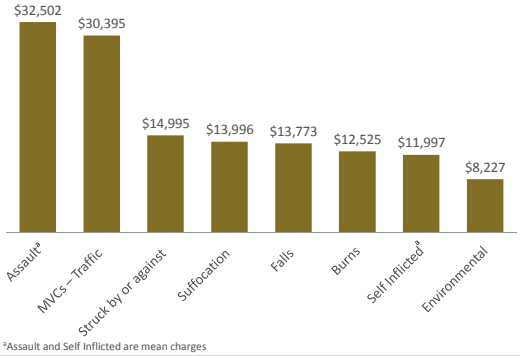
[a]*Not mutually exclusive*

Emergency Department Injury Data by Sex (2006-2012)

1. Boys higher for almost all unintentional injury causes of ED visits
2. Injuries vary by sex for intentional injury causes.



Hospital Discharge Median and Mean Charges (2006-2011)



[a]Assault and Self Inflicted are mean charges

A Profile of Wake County Injury & Injury Data Summary Handout

Handout # 2 is a summary of the three sources of data used in the report.

Part II. Profile of Wake County Organizations Addressing Childhood Health and Safety

Organizations and Coalitions Profile

Table 4. Response Rate for Wake County Survey

Survey	*Invited to participate*	*Completed*	*Response Rate*
Organizations	154	110	71%
Coalitions	18	15	83%

Methods: Organizations and Coalitions Profile

Question Categories	Types of Questions (n=27)
A. Demographics and Outreach	1. Number of Employees 2. Organization Type 3. Geographical Area 4. Populations Served 5. Targeted Groups
B. Injury Prevention Focus	1. Importance of Childhood Health and Safety 2. Organizational Work Focus 3. Intentional and Unintentional Injury Causes 4. IVP Programs and Activities
C. Organizational Resources	1. Data Sources 2. Funding Sources 3. Interest in Capacity Building Activities 4. Self-rated Organizational Capacity

Results: A - Demographics and Outreach

Organizations

1. # Employees	Half of organizations were small, with <10 full-time employees	50%
2. Organization Type[a]	Most Non – profit	74%
3. Geographical Area[a]	Most Wake County	70%
4. Populations Served[a]	Targeted the following populations • Low income • African-American • Hispanic	 72% 52% 51%
5. Targeted Groups[a]	Most targeted the following groups • Children • Parents/Caregivers	 85% 78%

[a]Not mutually exclusive.

Results: B - Injury Prevention Focus

Organizations (n=107)

Majority of organizations (88%) indicated that childhood injury and/or violence prevention was "somewhat" or "extremely" important.

Table 5. Category of Injury focus of organizations.

Injury Type	*N*	*%*
Both Intentional and Unintentional	56	52%
Intentional Only	33	31%
Unintentional Only	12	11%
Neither	6	6%

Results: B - Injury Prevention Focus

Organizations working in Intentional Injury (n=89)

Table 6. Organizations with focus on intentional injury.[a]

Injury Type	*N*	*%*
Child Abuse/ Maltreatment (physical, sexual, emotional)	71	80%
Assault/Physical Violence	62	70%
Bullying	61	69%
Sexual Violence (e.g. assault, rape)	51	57%
Self Inflicted/Self Harm	50	56%
Human trafficking	17	19%
Other	17	19%

[a]*Not mutually exclusive.*

Results: B - Injury Prevention Focus

Organizations working in Unintentional Injury (n=68)

Table 7. Organizations with focus on unintentional injury.[a]

Injury Type	*N*	*%*
All Motor Vehicles	44	65%
Poisoning/overdose	27	40%
Bicycle injury/crashes (NOT involving a motor vehicle)	25	37%
Falls	25	37%
Environmental Factors (e.g. weather related)	24	35%
Firearm	20	29%
Other	19	28%
Drowning/submersion	17	25%
Burns, including fire and scalds	15	22%
Suffocation	12	18%
Animal bites	11	16%

[a]*Categories are not mutually exclusive.*

Results: C - Organizational Resources

Organizations

1. Data Sources	• National level data	66%
	• North Carolina state level data	71%
	• Wake County level data	57%
2. Funding Sources	• Private donors	43%
	• NC funding Sources (e.g. Foundations)	36%
	• NC Department of Health and Human Services	26 %
3. Capacity Building Activities	• Receiving childhood injury resources	81%
	• Networking with Wake County stakeholders	77%
	• Participate grant funding information sessions	76%
	• Receiving Wake County data reports	76%

Methods: C - Organizational Resources

Self-Reported Capacity -- Organizations

Ability to *Identify:*

- Evidence-based Practices
- Wake County Childhood Data
- Wake County IVP Funding
- Wake County IVP Networks

Ability to *Integrate:*

- Evidence-based Practices
- Wake County Childhood Data
- Wake County IVP Funding
- Wake County IVP Networks

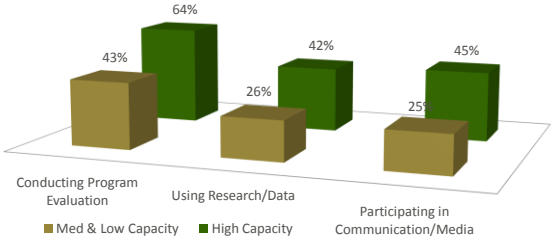
Organizational Capacity Index

Participating organizations were divided into three equal categories based on a frequency distribution of self-rated capacity (N~33).

Capacity Index Level	*Scale* *low (8)- high (32)*
High	≥ 25
Medium	<25 and ≥21
Low	<21

Results: C - Organizational Resources

Self-Reported Capacity – Organizations



Results: C - Organizational Resources

Leading Injury Cause Tiers by Capacity

Table 8. Average Capacity for Organizations Working to Prevent Injuries by Leading Injury Cause Tiers.

Leading Injury Cause Tiers	*All Organizations* *N = 110*	*High Capacity* *N =33*	*Medium Capacity* *N = 33*	*Low Capacity* *N = 32*	*Coalitions* *N=15*
Tier I 1. MVC Traffic-Occupant 2. Assault a. Assault/Physical Violence b. Child Abuse/ Maltreatment (physical, sexual, emotional) c. Sexual Violence (e.g. assault, rape) 3. MVC Traffic-Pedestrian 4. Self-Inflicted/ Self-Harm	46.7%	57.2%	38.3%	45.3%	36.7%
Tier II 5. Falls 6. Unintentional Suffocation 7. Burns 8. Struck By or Against 9. Natural/Environmental Factors a. Animal bites 10. Bicycle Injury/Crashes	17.2%	21.0%	21.5%	11.0%	17.9%

Results: A - Demographics and Outreach

Coalitions Working in Wake County (n=8, 53%)

1.	**# Members**	Large networks (50+ members)	63%
2.	**Populations Served**	Most coalitions reported targeting • African-American • Hispanic • Low-Income • Urban	
3.	**Targeted Groups**	Most targeted the following groups	
		• Policy Makers/Decision Makers	100%
		• Public Safety (e.g. police, fire)	88%
		• Parents/Caregivers	88%
		• Medical Professionals	75%

Results: B - Injury Prevention Focus

Coalitions Working in Wake County (n=8)

The majority of coalitions (76%) indicated that childhood injury and/or violence prevention was "somewhat" or "extremely" important.

Table 9. Category of injury focus.

Injury Type	*N*	*%*
Both Intentional and Unintentional	1	12%
Intentional Only	2	25%
Unintentional Only	4	51%
Neither	1	12%
Total	**8**	**100%**

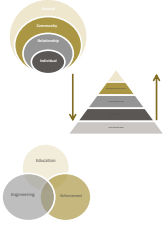
Part III: Program Descriptors & Estimated Program Impact

Methods: Program Descriptors

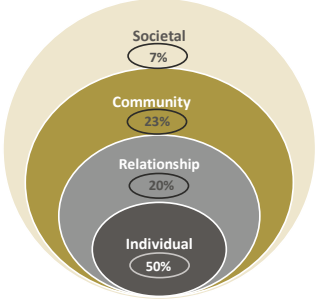
'Top 5' Programs submitted we coded for:

N = 243 Programs

1. Socio-Ecological Framework
   (Dahlberg, L., Krug, EG., Mercy J., Zwi A., & Lozano R., 2002)
2. Frieden's Health Impact Pyramid
   (Frieden, 2010)
3. The Three Es of Injury Prevention (education, enforcement, engineering)
   (CDC, 2012)

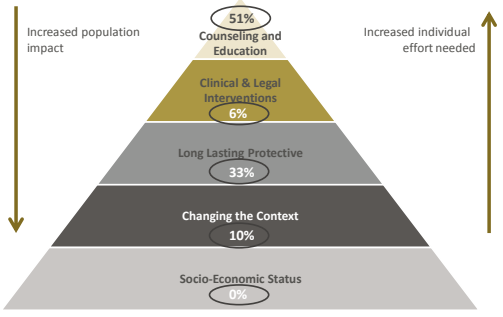


Wake County Childhood Injury Prevention Programs by the Socio-Ecological Framework



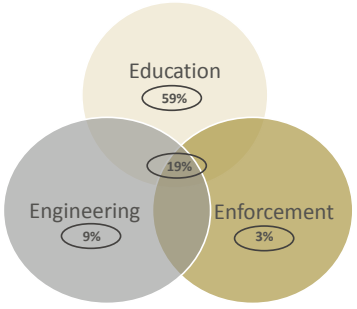
(Dahlberg, L., Krug, EG., Mercy J., Zwi A., & Lozano R. 2002)

Wake County Childhood Injury Prevention Programs by Frieden's Health Impact Pyramid



(Frieden 2010)

Wake County Childhood Injury Prevention Programs by The 3E's of Injury Prevention



Methods: Estimated Program Impact

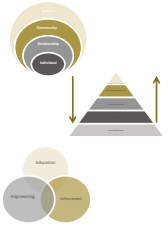
Estimated program impact index was created by summing the codes for three public health frameworks:

1.Socio-ecological Framework(1-4)

2.Frieden's Health Impact Pyramid (1-5)

3.The 3E's of Injury Prevention (1-4)

Highest rating possible is 13.

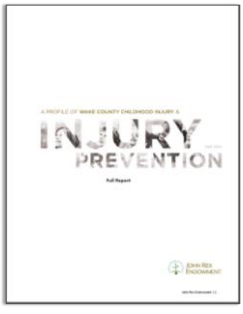


Results: Estimated Program Impact Index by Injury Focus and Capacity Level

Table 10. Average program impact index by injury intent and organization capacity level, range low (3) to high (13).

Injury Type	*All Programs N= 243*	*High Capacity N=110*	*Med Capacity N= 75*	*Low Capacity N=46*
Intentional Only	4.5	4.6	4.3	4.6
Unintentional Only	6.6	8.3	4.4	5.6
Both Intentional and Unintentional	6.9	8.1	6.5	5.8
All programs	**5.8**	**6.3**	**5.5**	**5.6**

Access to report: A Profile of Wake County Childhood Injury & Injury Prevention May 2014



The full final report will be available on the John Rex Endowment's website.

http://www.rexendowment.org/

References

- Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2012). *National Action Plan for Child Injury Prevention*. Atlanta, GA: CDC, NCIPC.
- Dahlberg, L., Krug, EG., Mercy J., Zwi A., & Lozano R. (2002). Violence-a global public health problem. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization; 1–56.
- Frieden, T. (2010). A framework for public health action: the health impact pyramid. *American Journal of Public Health.* Vol 100(4): 590-595, doi: 10.2105/AJPH.2009.185652.

Appendix D. Wake County Injury and Violence Secondary Data by Source

Table 7. Wake County Injury and Violence Secondary Data by source.

Injury Event	***Mortality*** *2006-2011 N=124*	***Hospital Discharges*** *2006-2011 N=3,007*	***Emergency Department Visits*** *2006-2012 N=138,047*
Intentional Injury	**30**	**437**	**2,893**
1. Assault/Physical Violence	**16**	**165**	**2,044**
a. Struck (fight, brawl, blunt/thrown object)	*0*	*22*	*1,002*
b. Cutting or piercing instrument	*1*	*16*	*99*
c. Abuse of child or adult (emotional, physical, or sexual)	*5*	*Not available[b]*	*152*
d. Firearms or explosives	*4*	*20*	*92*
e. Human bite	*0*	*Not available[b]*	*75*
f. Rape	*0*	*Not available[b]*	*87*
2. Self Inflicted/Self Harm	**14**	**272**	849
a. Poisoning	*0*	*195*	*605*
b. Cutting or piercing instrument	*0*	*35*	*172*
c. Suffocation (Hanging)	*10*	*[b]*	*22*
d. Firearms or explosives	*4*	*0*	*[c]*
Unintentional Injury	**93**	**2,320**	**116,378**
3. Motor Vehicle Crashes[a]	**61**	**309**	**10,974**
a. Cars/trucks/buses (occupants)	***20***	*Not available[b]*	***9,953***
i. Passenger	*15*	*Not available[b]*	*8,046*
ii. Driver	*5*	*Not available[b]*	*1,893*
b. Pedestrian	***15***	*Not available[b]*	*310*
c. Bicyclist	*1*	*Not available[b]*	*142*
d. Motorcyclist	*0*	*Not available[b]*	*178*
e. Other specified	*1*	*Not available[b]*	*62*
4. Poisoning/overdose	3	157	2,142
5. Bicycle injury/crashes (NOT involving a motor vehicle)	0	*Not available[b]*	**3,007**
6. Falls	1	**646**	**36,833**
a. Slipping, tripping, stumbling	*0*	*Not available[b]*	*6,776*
b. Fall striking against other object	*0*	*Not available[b]*	*5,252*
c. From playground equipment	*0*	*Not available[b]*	*3,091*
d. From one level to another	*0*	*Not available[b]*	*2,854*
e. On or from stairs/steps	*0*	*Not available[b]*	*2,345*
f. From bed	*0*	*Not available[b]*	*2,077*
7. Natural/Environmental Factors	6	144	**7,250**
a. Venomous and non-venomous arthropods	*0*	*Not available[b]*	*3,675*
b. Dog bite	*0*	*Not available[b]*	*1,948*
c. Bite/other injury caused by animals	*0*	*Not available[b]*	*601*
d. Excessive heat/cold, exposure to weather/storms	*5*	*Not available[b]*	*294*
8. Firearm	3	*[b]*	73
9. Drowning/submersion	4	17	114
10. Burns, including fire and scalds	4	**203**	1,516
11. Suffocation/Choking/Breathing Threat	**11**	46	87
12. Struck by or against	0	162	**25,766**
a. Other struck against with/without fall	*0*	*Not available[b]*	*10,978*
b. In sports	*0*	*Not available[b]*	*8,942*
c. By Other stationary object	*0*	*Not available[b]*	*2,304*
d. By Furniture	*0*	*Not available[b]*	*2,131*
e. By falling object	*0*	*Not available[b]*	*1,304*
Undetermined Intent of Injury	**1**	**56**	**235**

[a] For mortality data, all MVC deaths were combined since there were few that clearly coded traffic vs. non-traffic. Most all that were specified were traffic with some coded as non-traffic.

[b] Sub-mechanism data for hospital discharges were not available to the research team, but may be available through a data request to the Injury and Violence Prevention Branch at the NC DPH.

[c] Data use agreements require that frequencies of 1-9 be masked.

Advancing childhood injury prevention in Wake County: challenge or opportunity?

Carolyn Cumpsty-Fowler, PhD, MPH
Johns Hopkins University

Tree of Life (Stained Glass) Artist: Naomi Maddux

[Injury prevention] is what we, as a society, do collectively to assure [the physical and social environmental] conditions in which people can be [safe and] healthy.

Adapted from: Institute of Medicine.(1988).The Future of Public Health. Washington, DC: National Academy Press, p. 41.

JOHN REX ENDOWMENT

"We're focused on taking the right steps now; creating healthier environments where children can thrive."

Kevin Cain, President and CEO

My "take-home" from childhood injury prevention in Wake County profile:

1. Childhood injuries are a problem
2. Many organizations are involved in activities related to IP
3. There is capacity to prevent injuries; there is the potential to leverage these resources to build greater capacity and impact.

Identifying a problem is important ..

..but this is only useful if identification initiates a sequence of careful, considered actions.

The actions we initiate to make change are influenced by our perspective

The Child Injury Prevention Strategy Challenge

Moving to preventive perspective that is informed by an understanding of - and respect for – child development

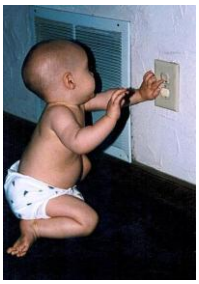
Childhood injury exhibits strong developmental trends:

These have implications for our intervention decision making

What Is the Child's World?

That depends on when you ask the question!

A child discovers their world ..



by exploring it

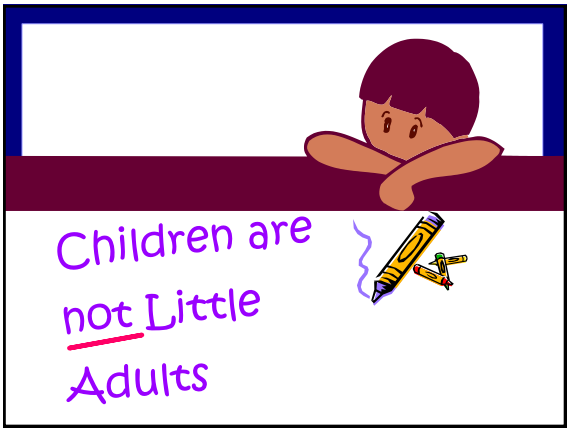
I think, at a child's birth, if a mother could ask a fairy godmother to endow it with the most useful gift, that gift should be curiosity.

Eleanor Roosevelt

Curiosity: Gift or Risk Factor?

I have no special talent. I am only passionately curious.

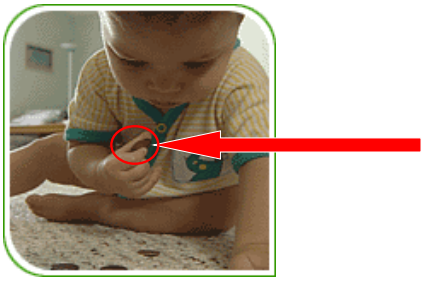
Albert Einstein



Curiosity: Gift or Risk Factor?

Our answer will influence our intervention choices

What will this curious infant do next?



What should we do to protect him?

The "obvious" injury prevention answer: separate the child from the risk factor

But at what developmental cost?

We need Substitution not Separation

Curiosity is Essential

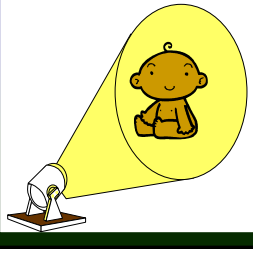
Exploration is much more than fun

Play is the WORK of Children!

FACT:
No child deserves to be injured ..
No matter how he or she behaves.

We will never prevent injuries by blaming, labeling or isolating kids!

Adequate review of injury risk factors includes both intrinsic and extrinsic risk factors:



- Developmental level
- Pre-existing conditions
  - physical/cognitive/etc.
- Physical environment
- Social environment
  - Individual/family level
  - Community
  - Systems
- Injury patterns and outcomes
- Exposure

Causes of death and injury in infants

INFANTS:

Sleep-environment-related death!

Choking, Motor Vehicle Occupant, Drowning, House Fires, Falls, Poisoning, Abuse & Homicide

Our Prevention Challenges:

- Safe environments
- Informed and alert caretakers
- Rapidly changing ability and behaviors

Causes of death and injury in toddlers

TODDLERS:

Motor Vehicle Occupant, Drowning, Fire, Suffocation & Choking, Pedestrian, Falls, Poisoning

Our Prevention Challenges:

- The Great Explorers!
- Safe environments for the increasingly mobile and fearless
- Sudden fatigue

Causes of death and injury in elementary school age children

ELEMENTARY SCHOOL AGE

Motor Vehicle Occupant, Drowning, Fire, Suffocation & Choking, Falls, Bike, Pedestrian, Poisoning

Our Prevention Challenges:

- Mismatched physical and cognitive abilities
  - Especially when in groups
- Adults **over**-estimate their abilities
- Adults **under**-estimate their developmental needs

Causes of death and injury in teenagers

PRE-TEENS & TEENS

Motor Vehicle Occupant and Driver, Pedestrian, Drowning, Falls

Suicide & Homicide

Our Prevention Challenges:

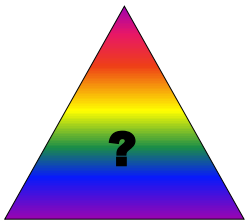
- Major physical, cognitive, social, and emotional transitions (high risk)
- Exponential increase in independent mobility and exposure to risk factors
- Adults under-estimate their physical and developmental needs

If we want to understand childhood injury, we must understand environment

For better or worse, children are in constant interaction with their environment.

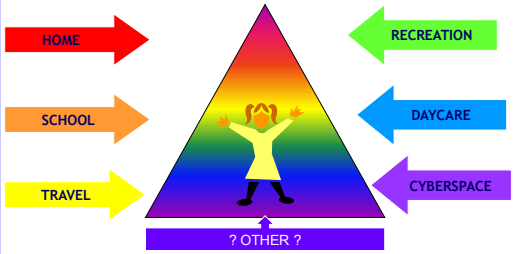
Lead ingestion risk photograph: www.healthyhomescollaborative.org

So, what environments comprise the child's world?



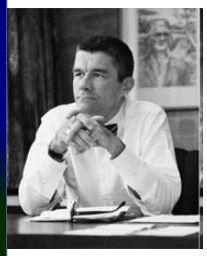
They are Physical AND Social!

Do We Know What's Going On?



There Are So Many Ever-Changing Pieces

Our Environmental Guide: William (Bill) Haddon, Jr., MD



Dr. Bill Haddon, 1926-1985

- First "Highway Safety Chief"
  - National Highway Traffic Safety Administration
- Headed Insurance Institute for Highway Safety
- Developed a Framework for Understanding Key Determinants of Injury:

The **"Haddon Matrix"** (1972)

Phases of Injury Prevention

Pre-Event
Reducing the number of events with the potential to cause injury.

Event
Reducing the number & primary severity of injuries that occur.

Post-Event
Preventing secondary insults; improving the final outcome.

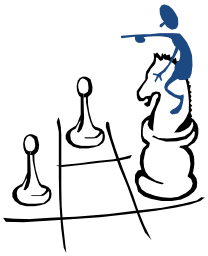
Haddon Matrix: **Child Pedestrian Injury** (simplified)	Human (Individual)	Agent & Carrier	Environment: Physical	Environment: Social
Pre-Event	Age*, Size, Behavior, Experience, Supervision, Alcohol, Fatigue	Speed, Size, Braking & Maneuvering ability	Visibility, Congestion, Road Design, Surface	Traffic control, child care regs. & facilities, driver training and licensure
Event	Size, clothing, (protective gear)	Force, direction & number of impacts	Impact surface(s), fixed objects, other vehicles	Road and environmental design policies; maintenance
Post-Event	Pre-existing conditions, EMS care & rehabilitation	Additional vehicle impacts; entrapment; fire	Urban/rural; proximity to medical care; weather, etc.	Provision of care; financial, legal & social resources

Haddon Matrix: **Child Pedestrian Injury**	Human (Individual)	Agent & Carrier	Environment: Physical	Environment: Social
Pre-Event	Age*, Size, Behavior, Experience, Supervision, Alcohol, Fatigue	Speed, Size, Braking & Maneuvering ability	Visibility, Congestion, Road Design, Surface	Traffic control, child care regs. & facilities, driver training and licensure
Event	Size, clothing, (protective gear)	Force, direction & number of impacts	Impact surface(s), fixed objects, other vehicles	Road and environmental design policies; maintenance
Post-Event	Pre-existing conditions, EMS care & rehabilitation	Additional vehicle impacts; entrapment; fire	Urban/rural; proximity to medical care; weather, etc.	Provision of care; financial, legal & social resources

Where should we act?

Haddon Matrix: next steps

Not all associated factors are Causal or Key

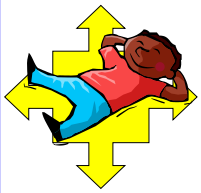


- Which factors are controllable?
  - What about the child pedestrian's behavior?
  - or EMS response time?
- Will changing these change the outcome?
  - What do you think?

Haddon Matrix: **Child Pedestrian Injury**	Human (Individual)	Agent & Carrier	Environment	
			Physical	Social
Pre-Event	Age*, Size, **Behavior**, Experience, Supervision, Alcohol, Fatigue	Speed, Size, Braking & Maneuvering ability	Visibility, Congestion, Road Design, Surface	Traffic control, child care regs. & facilities, driver training and licensure
Event	Size, clothing, (protective gear)	Force, direction& number of impacts	Impact surface(s), fixed objects, other vehicles	Road and environmental design policies; maintenance
Post-Event	Pre-existing conditions, EMS care & rehabilitation	Additional vehicle impacts; entrapment; fire	Urban/rural; proximity to medical care; weather, etc.	Provision of care; financial, legal & social resources

A child sees the world differently, and that world is ever-changing.

The Child's View



The World's View

Key Prevention Concept #1

We cannot change a child's age and his/her development-related limitations.

We must look beyond these and identify **modifiable** variables

Key Prevention Concept #2

First, Do No Harm

1. Our interventions may introduce new risk
   - Changing one part of a complex puzzle may generate other problems
2. We must remain vigilant for unintended negative consequences

How Can We Really Protect Children?

A Focus on Discreet Programmatic Areas May Limit Our Reach

- Illness Paradigm, vs.
- Wellness (Thriving) Paradigm

- Individual Focus, vs.
- Population-based Focus

- The consequences of narrow focus are of strategic and ethical importance.

Perspective

What is this?

How about this?

… or this?

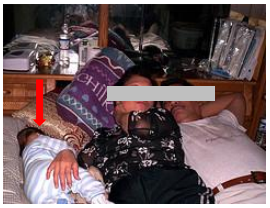
Now we get the full picture!

… or did we?

Elephants know children must be protected within their environments ---

-- not isolated from them

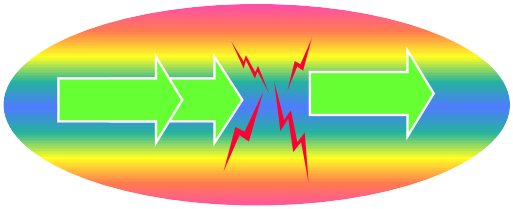
Do we?



Injury prevention is about more than reducing deaths and injuries ..

.. it's about protecting a child's fundamental need to live, sleep, explore, learn, grow, thrive and reach his/her full potential in a safe and healthy environment

Childhood injury problems occur in a complex environmental context. Prevention programs succeed ONLY if they identify and address critical (key) factors



What Are We Doing & Why?

How can we enhance injury prevention program impact in Wake County through strategic decision making?

Mission Critical – Informed Beginnings

If the first button of one's coat is wrongly buttoned, all the rest will be crooked.

Giordano Bruno (1548-1600)

Educational programs are necessary but not sufficient to achieve injury prevention

Knowledge + Attitudes + Beliefs +

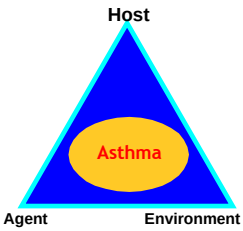
Skills + Resources

Only Sometimes = Behavior Change

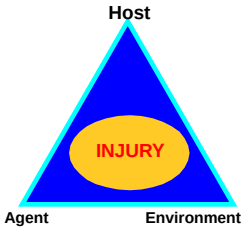
One pound of learning requires ten pounds of common sense to apply it.

Persian Proverb

Public health has long recognized the influence of environmental conditions on health



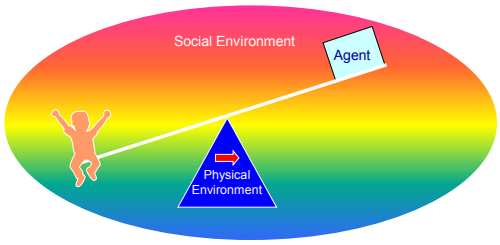
Injury is no different than disease. We must aim for action to achieve environmental (ecological) change



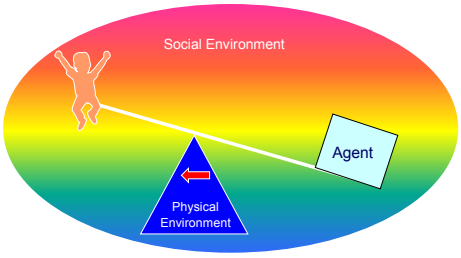
Re-Thinking the Epidemiologic Triangle

Concept: Ecological Balance

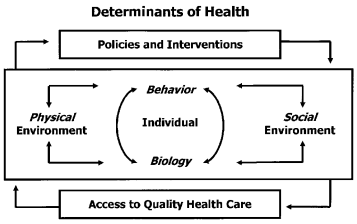
"Negative ecological balance"



Our Goal: "Positive ecological balance"

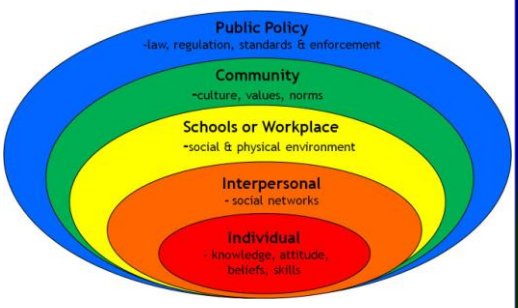


Whatever the child health/injury challenge, we must modify multiple health determinants



Source: U.S. Department of Health and Human Services, Health People 2010

We cannot ignore Social-Ecological influences



Graphic - Carolyn Cumpsty Fowler - adapted from the Social-Ecological Model

Injury Prevention Involves Multiple, Layered Strategies

Education

Engineering

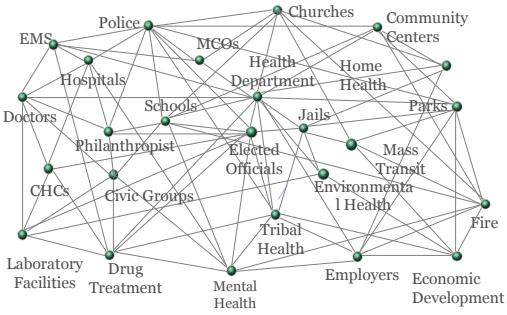
Enforcement

Economic incentives

Intervention effects are not likely to occur/be demonstrated if:

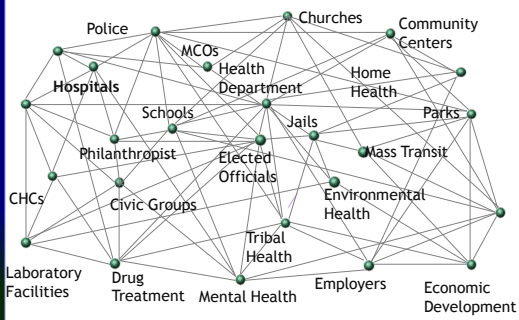
- the underlying [diagnostic] assumptions are wrong
- the program does not affect intervening variables
- the program/activity is not implemented adequately
- the changes are not measurable
- the changes are not sustained

"It takes a village" to protect children



All Injury Prevention Achievement Has Required:

- Coordinated
- Comprehensive
- Organized Community Effort



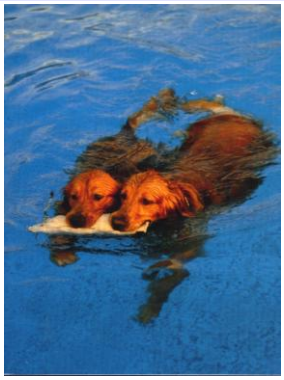
This is the injury prevention safety net!

Modifiable barriers to the implementation of effective injury prevention programs

- Overly broad problem definition
- Incomplete diagnosis
- Unrealistic goals
- Poorly defined objectives
- Inadequate implementation planning
- Working in a vacuum
- Turf wars
- Planning gaps
- Cruise control and tunnel vision
- Absent or inadequate evaluation

What Do We Need for Success?

- Skilled, experienced people
- An evidence base + critical reasoning
- Well-established & evaluated processes
- Resources & infrastructure
- Team work
- Ability to prioritize
- **Comprehensive monitoring & evaluation**



You don't have to tackle the whole problem by yourself..or do the whole program by yourself.

How do you expand and integrate your level(s) of influence in Wake County (and beyond)

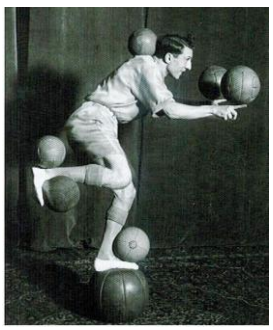
- Influencing policy and legislation
- Changing organizational practices
- Fostering coalitions and networks
- Educating providers
- Promoting community education
- Strengthening individual knowledge and skills

The Spectrum of Prevention

We need to look at our familiar picture through a new frame – the "outsider's"

Picture: Wikimedia Images (labeled as public domain)

Are potential allies simply too busy with the obvious priorities of their work … or is there something else happening?



The Dangers of Disassociation

If I am going to care about something enough to respond positively, it must be:

Credible
Actionable
Relevant
Engaging

If I feel disassociated I can't care

Whose language are we speaking?

"If you talk to a man in a language he understands, that goes to his head. If you talk to him in his language, that goes to his heart."

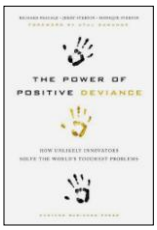
--Nelson Mandela

"We are all faced with a series of great opportunities brilliantly disguised as impossible situations."

Charles R. Swindoll

Jerry Sternin

Learn from the positive deviants!



www.positivedeviance.org

"Positive Deviance is based on the observation that in every community there are certain individuals or groups whose uncommon behaviors and strategies enable them to find better solutions to problems than their peers, while having access to the same resources and facing similar or worse challenges.

The Positive Deviance approach is an asset-based, problem-solving, and community-driven approach that enables the community to discover these successful behaviors and strategies and develop a plan of action to promote their adoption by all concerned."

Source: The Positive Deviance Initiative

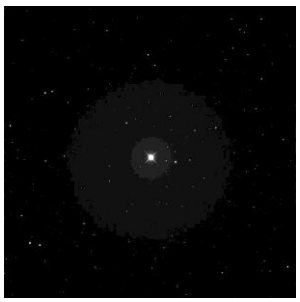
Learning to Avoid T.B.U. Temptation

- "True but useless"
- Conventional Wisdom is Neither!

One questioning strategy provides the foundation for EVERY effective positive deviance change initiative

The Somersault Question

The Scarcity to Bright Spot Shift:



- Find your bright spots
- "Amplify positive deviance"

Tree of Life (Stained Glass) Artist: Naomi Maddux

What would you attempt together in Wake County if you knew you could not fail to create a safe and healthy community in which children could thrive?

For Everything You Do to Keep Children Safe!

Carolyn Cumpsty-Fowler, PhD, MPH
cfowler1@jhu.edu
443-287-0541

Appendix F. Summary of 'A Profile of Wake County Childhood Injury and Injury Prevention' Discussion at 11 Tables

A. Overview of Wake County Childhood Injury Secondary Data

1. What is new or interesting to you from the findings?

Surprising/Shocking (n=7 comments)

1. Interesting that assault is so high. Surprised that it's reported as much as it is since the Emergency Room seems to be the place people "rush to"
2. Sad and shocking
3. Self-harm for females is alarming
4. Self-inflicted surprised so high [another person said it seemed low to them]
5. Some of it shocking (e.g., Self-inflicted injuries high among girls)
6. Surprised at number of deaths by falls *[no deaths but high]*
7. Surprising number of falls.

Programmatic Implications (n=5 comments)

1. Gender disparities—adolescent girls and self-harm
2. MVC [Motor Vehicle Crashes] dangerous at all ages
3. Brain injuries come from every category
4. Almost every incident listed has the potential to lead to a brain injury
5. The ability to target an intervention

Questions/Additional Thoughts (n=4 comments)

1. Are falls actually falls, or are they parents' excuses for assaulting kids?
2. Can falls be prevented?
3. The chart—assault, violence averages (differences between child and adults?)
4. Why is MVC {Motor Vehicle Crash] so high compared to falls?

Align with previous experiences (n=2 comments)

1. Parents often don't have time to prevent falls (while at work, etc.)
2. Developmentally, the findings make sense.

Sharing information with policy makers (n=1 comment)

1. Rankings weren't surprising, but wondering how aware the general population and policymakers are of these rankings and how to get them interested/excited about injury prev.

Depth of data used (n=1 comment)

1. The process of how they gathered info—not just focused on deaths

2. Describe any gaps you have noticed.

Limitations of Data (n=6 comments)

1. The potential for "under-reporting" of accidents (if sought care outside of Emergency Room)
2. Another reporting system besides hospital records should be studied
3. Bullying not mentioned
4. There isn't a space for brain injury
5. Trouble with hospital coding?
6. What does self-harm include?

2. Describe any gaps you have noticed. (continued)

Interested in Additional Data Sources (n=4 comments)

1. There is a lack of services for Spanish-speaking populations (not necessarily a gap in this data)
2. Funding gaps
3. Alcohol-related incidents (for falls and driving; police reports could be the data source and reports may be online; could also find from medical examiners)
4. Human trafficking of teenage girls not noted as an injury

Interested in Greater Detail in Data (n=4 comments)

1. What are the different "layers" of MVC [Motor Vehicle Crash]—by parts of interstate? By times of day?
2. Would like to tease out MVC—nature of speed, bicycle, teens driving, etc.
3. Wondering if looked at social determinants/disparities in addition to age and gender (e.g., Race, income, etc.)
4. It could be good to do more in-depth review of circumstances on child-passenger seat specifics.

Questions/Additional Thoughts (n=3 comments)

1. Who are committing the assaults? Other children? Adults?
2. Very little info out there on what to do for concussions in very young children (not necessarily a gap in this data)
3. Kids aren't wearing helmets on dangerous activities

3. Does this information reflect what you know about childhood injuries in Wake County?

Align with previous experiences (n=4 comments)

1. This data not very surprising because of the work
2. Yes, generally
3. Yes
4. [Yes, especially MVC] because I've seen more fatalities here [in Wake Co.]; I never witnessed a rear-end collision until I moved here

Surprising (n=1 comment)

1. Fall numbers were surprising. This data is not implemented enough by public health groups

Other (n=1 comment)

1. Self-inflicted may be lower than actual because of a lack of beds available

4. How might you use this information?

Conduct Work/Prevention (n=6 comments)

1. To help with interventions, education
2. To continue our work
3. Talking about (assault and in-home accident) issues with families before they arrive
4. For prevention agencies that may find this information useful ([Child Protective Services], etc.)
5. [Share with] parents
6. For parental education around falls

4. **How might you use this information?** (continued)

Target Messaging (n=2 comments)

1. Teaching first responders to ask the right questions (especially with assaults)
2. Inform policymakers and parents of this info, so they can make better decisions on policies and advocacy

Leverage Funding (n=2 comments)

1. For grant applications
2. To get more funding

Coordinate Efforts (n=1 comment)

1. To find out more about who is doing what on all these issues, especially self-harm

B. An Analysis of Organizational and Coalitions Working in Childhood Injury Prevention in Wake County

1. What is new or interesting to you from the findings?

Application of Public Health Models to Activities (n= 9 comments)

1. Frieden's Pyramid—how little is being done at the socio-economic level and how much is being done at the individual level (SEF model)
2. A lot of organizations (too many?) working at the individual level, the hardest and least impactful
3. 3 Es chart—change in equipment or environment
4. Glad to see high percentage of programs that focus on education (3 Es)
5. The inequality of the 3 Es—education is such a high percentage
6. The health pyramid
7. Wake County Human Services socio-economic impact
8. Coalitions are doing more system-level work; what organizations are in coalitions?
9. It seems most are heavy on education and individual level, but looks like there is an opportunity for collaboration to advocate for specific population-wide steps to prevent at a county level, state level for legislation changes. (e.g., MVC, Motor Vehicle Crash)

Implications for Policy (n=2 comments)

1. Instead of "health in all" policies, maybe "health and safety in all" policies
2. How it impacts policy on the global scale

Presence of Falls (n=2 comments)

1. Falls are tier 2, but I think it's more of a problem
2. Falls aren't inevitable, we can help and prevent

Population Focus (n=2 comments)

1. Supports early childhood focuses
2. Good to see support for/focus on parents

Making New Connections/Connecting the Dots (n=1 comment)

1. Didn't realize so many organizations in Wake County are addressing childhood injury

Unequal Distribution of Activities (n=1 comment)

1. A lot of organizations focusing on MVC

1. What is new or interesting to you from the findings? (continued)

Other (n=3 comments)

1. The aspect of community interactions
2. The criteria for high capacity (rating on eight different things)
3. Human trafficking as a form of bullying

2. Describe any gaps you have noticed.

Increased Collaboration (n=4 comments)

1. More rallying together
2. Socio-economic-level work is lacking in our county (but is an opportunity for growth)
3. How much coordination is going on now
4. Where do organizations fall in their ability to network?

Interests in Additional Details in Report (n=4 comments)

1. Falls broken down into subsets
2. Impacts on programs—individual versus large scale
3. Not sure how common prevention methods are in schools (e.g., For bullying)
4. Dating practices and relation to home roles?

Working with Parents and Children (n=2 comments)

1. Programs that focus on both parent and child
2. Gaps between parents and education

Other (n=3 comments)

1. Hard to know if any organizations were missing since not listed specifically
2. A lot about motor vehicle safety, not a lot about gates/safety (Parents are going to buy food before they buy a gate or fence)
3. What would the ideal distribution be in the model [community]?

3. Does this information reflect what you know about childhood injury prevention activities in Wake County?

Aligned with Previous Knowledge (n=3 comments)

1. Yes, because of lot of times, funders will fund individual level work because it's easier to gauge and attribute outcomes to the funding
2. [Yes] Safety education for parents of newborns not required in Wake County.
3. [Yes] because we get in silos and don't see the bigger picture

Other (n=3 comments)

1. Table was unfamiliar with Frieden's Pyramid
2. Surprised falls are more of an issue; surprised it's tier 2
3. Negative exposure/examples lead to negative outcomes (just like with diabetes)

4. How might you use this information?

Expand/Review Current Approach (n=7 comments)

1. Work with individuals and on a system-level
2. To move from conducting events to running programs or doing both

4. How might you use this information? (continued)

Expand/Review Current Approach (n=7 comments; continued)

3. Look at changing existing programs to a wider community aspect
4. Educate on a global/larger population scale as mentioned in presentation
5. Need to focus more on policies in schools
6. Educate parents to do more
7. For each category, it will be helpful to break it down and look at our programming and prevention mechanisms

Collaborate with Additional Groups (n=4 comments)

1. Identify groups already reaching population(s) and find ways to work together. (e.g., [YMCA]—taking on "Darkness to Light"
2. Would be interested to see what organizations were represented in the full report—could be a great opportunity to collaborate and fill gaps
3. Changing societal norms and stigmas: making sure neighbors and the community know to report abuse/abnormal circumstances
4. How to operationalize small organizations to really do more, to build capacity, to address frameworks

Modifications of Funding Initiatives (n=3 comments)

1. To fund advocacy
2. To explain to funders that we don't have "regular data" that funders are requiring now
3. Maybe provide capacity building for funders as well, if they are funding more individual work instead of system-level strategies

Increase Diversity of Activities (n=2 comments)

1. Want to see more diversity in where agencies are putting their efforts
2. More diversity in how we operationalize the work we do and how we use funding to leverage greater impact

Appendix G. Summary of Facilitated Discussion # 1 Targeting Efforts for Impact

Objective: To identify powerful Wake County decision makers. Identify ways to engage decision makers.
Breakout Groups: Break groups were formed with MIXED organizational type (e.g. non-profit, government) and MIXED injury event participants.

1. Identify decision makers who can change social and physical environments that would reduce childhood injury.

Government (n=9 comments)

1. Legislators—the people who can get in touch with them, lobbyists
2. Legislators
3. Federal, state, local, community
4. Government, Commissioners, Board of Education
5. Health Departments
6. Elected officials, public health leaders, law enforcement, Emergency Medical Services leadership
7. Chamber of Commerce
8. Homebuilder's Association and housing authorities
9. Planning Department

State Level Government (n=6 comments)

1. State agencies (e.g., Department of Mental Health/Development Disabilities/Substance Abuse Services & Department of Social Services & Department of Public Health & Department of Public Instruction)
2. General Assembly Legislators
3. State government departments
4. Department of Public Instruction (DPI)
5. NC Division of Parks & Recreation
6. NC Child Fatality Task Force

County Level Government (n=3 comments)

1. County Commissioners
2. County Manager
3. Alliance for Behavioral Health

City Level Government (n=2 comments)

1. City/Town council members
2. Local government—law enforcement, traffic control

Governmental Legal Assistance (n=4 comments)

1. Department of Juvenile Justice/Law Enforcement
2. Court counselors—have the relationships with youth and parents
3. District Judges
4. [Juvenile Crime Prevention Council] gang prevention groups

Governmental First Responders (n=3 comments)

1. Public Safety
2. Emergency Response personnel
3. Police (for enforcement of laws)

Schools/Day Care (n=9 comments)

1. Schools (mentioned at several tables)
2. School system and school board
3. Schools (supervision for safety but education as well)
4. School Superintendents at county and state levels
5. Mediators (e.g., Campbell Law)
6. Universities—to educate/train those who work with youth
7. Childcare center workers, teachers, afterschool providers

1. Identify decision makers who can change social and physical environments that would reduce childhood injury. (continued)

Schools/Day Care (n=9 comments continued)

8. Daycare providers
9. Break out by age groups at day cares, schools

Non-profits/Businesses (n=6 comments)

1. Non-profit board members, funders—are directing the work
2. National Association for the Advancement of Colored People (NAACP)
3. Downtown Raleigh Association
4. Triangle J Council of Government—direct line to the police, parents, and Policy Changes supervision
5. Business owners
6. Business community

Parents/Caregivers (n=4 comments)

1. Parents—need to come together, underserved parents need to feel empowered and educated enough to feel they can speak
2. Parents As Teachers at Home (PATH)
3. Parent Teacher Association (PTA)
4. Families/peers

Faith-Based Organizations (n=2 comments)

1. Faith leaders
2. Faith community (e.g., NC Council of Churches)

Health Care/Insurers (n=2 comments)

1. Medical Facilities
2. Insurance Regulators

Network/Collaborate with Other Agencies (n=2 comments)

1. Network with similar organizations
2. A Falls Prevention Coalition

Gatekeepers (n=1 comment)

1. Grassroots "gatekeepers" (e.g., hairdressers in Hispanic community are often "connectors" for info)

Youth (n=1 comment)

1. Youth advocates—to tell their own issues, be involved in own solutions and decision-making

2. How do you or can you influence these decisions makers?

Collaborate/ Work with local agencies interested in Child Safety (n=16 comments)

1. Share information from today with Child Fatality Committee, talk about measures
2. Share more via juvenile court
3. State agencies(e.g., Department of Mental Health/Development Disabilities/Substance Abuse Services & Department of Social Services & Department of Public Health & Department of Public Instruction): citizens have the ability to approach agencies, but working with for- or non-profit organizations can do so as well, so for the latter, it's important to get involved with consumer advisory councils or boards
4. Involve youth voices in coalitions—very powerful, teach them about layers of gov't and what they want to influence and how to focus

2. How do you or can you influence these decisions makers? (continued)

5. Health Care/Insurers/Clinicians
    1. Health Departments
    2. Medical Facilities
    3. Insurance Regulators
    4. Pediatricians and OBGYNs
    5. NC Medical
    6. Insurance companies, property management, builders (to create environments where kids can thrive)
6. Faith community (e.g., NC Council of Churches)
7. Schools
    1. Schools (supervision for safety but education as well)
    2. [Physical Education] teachers
8. Community Involvement
    1. Really need to establish relationships with community action committees.
    2. Listen to community members when they say there is a problem with safety in a certain area
    3. Help people connect the dots—e.g., Between injury and the economic situation of a community

Advocacy Education (n=10 comments)

1. Provide workshops to give parents tools, show them they have the right and ability to advocate
2. Meet youth where they are—teach them leadership and advocacy skills, peer-to-peer mentoring opportunities (at all age levels, not just High School and college), help youth see benefits for them to get their investment in an issue
3. Re-elect them (or not)
4. Educate them
5. Having the right data to educate people
6. Educating—could do more about injury prevention if not already discussing
7. By accessing parents
8. Advocacy groups to work around parents
9. Legislature [passing laws to be enforced]
10. Dialogue with citizens, have them speak for themselves

Target messages (n=9 comments)

1. General Assembly Legislators: approach legislatures with scope of the problem and get them to commit to working on a bill or a legislative activity that supports your efforts; key here is to get community groups to help communicate your message and ensure that you are communicating about the gaps. By educating community groups to do this work, you also affect the individuals themselves who are part of the community groups. Leveraging media – developing a relationship with a reporter (someone who routine reports on health issues) and leverage individuals to tell their own stories (human interest stories) – let them be your spokesperson. Remember that news stories are not the only media outlet.
2. Target messages to the environment and audience—minimize translation issues, whether by language, education, or cultural differences (e.g., The need to find the "sweet spot" of implementing solutions that don't unintentionally cause more problems based on cultural differences)
3. Tell real, memorable impact stories
4. Framing the issue based on what's important to them to make the appeal
5. "Drill down" the data
6. Take it beyond data—tell stories in context
7. Include different perspectives

2. How do you or can you influence these decisions makers? (continued)

8. Provide education about the developmental context—explain why just educating kids is not enough
9. Make the economic argument—lost days of work, etc.

Work with New Populations (n=3 comments)

1. Empowering parents/caretakers with knowledge and how to make their children safe. Substitute something unsafe with something safe (for the parents like with the children)
2. Emergency Response personnel: provide them a clear-cut set of criteria to release someone who does not really need to come to an emergency room; develop relationships and learn what they need and try to fill that need (don't assume you know what they need or want).
3. Police (for enforcement of laws): training them for crisis intervention training (for someone arrested with a mental health issues) and how to identify someone who might have a brain injury (slurred speech, movement disorder, impaired judgment – train them how to de-escalate a situation).

Environmental and Social Changes (n=3 comments

1. District Engineer (Department Of Transportation)
2. City Planner
3. Help them understand individuals can't be asked to change unless the "climate/context" changes

Expand Efforts (n=2 comments)

1. Remind existing contacts of the injury prevention aspect
2. Present at their meetings

Develop/Maintain Relationships (n=1 comment)

1. Build trust within specific communities

Increase Accuracy of Media Portrayal (n=1 comment)

1. Debunk big media ideas about violence prevention that are non-evidence-based

Data (n=1 comment)

1. Find a method of systematically reviewing injury data in certain settings

Other (n=1 comment)

1. Something usually has to happen to children (an injury, a fatality) in order for action to be taken within the city

3. How can you enhance the focus of your current activities/skills to more effectively influence decision makers in the future?

Target Populations (n=12 comments)

1. Give youth a voice—Youth Empowerment Solutions can help with youth advocates
2. Take advantage of [working with] mobilized youth (e.g., Teen Health Advocacy Council at Poe Center) to advocate policy change
3. Incorporate more injury prevention education with homeless population (CPR, human trafficking education)
4. Look at the opportunities to reach populations of migrant workers, [English as a Second Language] populations
5. Reach out more collaboratively to young parents
6. Work more with teachers

3. How can you enhance the focus of your current activities/skills to more effectively influence decision makers in the future? (continued)

7. Training with pediatricians and auxiliary groups
8. [work with] Public Health officials to raise awareness
9. Do what we can to educate school system, hospital system.
10. Being a better community partner in general is important.
11. [Engage] property owners in multiple-family properties—are the properties designed well?
12. Designing cultural activities well, safely (festivals, sports organizations, etc.)

Incorporate Data and Information in Activities (n=8 comments)

1. Address issues with unreported incidents
2. Use an injury perspective when looking at the data
3. Prioritize if a certain area needs to be changed
4. "Adding precision to the passion."
5. Child fatality review info
6. Sharing patterns of interventions
7. Focus on evidence-based interventions
8. Focus injury prevention community on child development issues

Increase Collaboration (n=6 comments)

1. Collaboration: of community agencies, churches, civic leagues—"power in numbers"
2. Enhance collaboration at individual level to be more impactful—helping parents identify how to engage each other in injury prev. efforts
3. For Holly Springs Hospital, they've leveraged different types of relationships. Partner with Law Enforcement and Emergency Medical Services (EMS) to do a golf tournament for the 200 club of Wake County.
4. We all have so many values in common. We are making investments in the future. We are saving money. It takes time. 20-30 years ago, we couldn't talk about cancer; but now there are so many people are survivors and who are visible and willing to speak out (including celebrities). Injuries that people would have died from before are now surviving.
5. Come together with 2 or more groups to be more effective
6. Networking through the right channels — e.g., not complaining to the neighborhood, but going to the Department of Transportation with an issue

Target Messaging (n=6 comments)

1. Come up with creative ways to talk about stigmatized issues (like human trafficking).
2. Social marketing campaigns (i.e., "Got Milk?")
3. Be forward-thinking [in] reaching business leaders, decision-makers
4. Knowing your audience
5. Use strengths—based on perspective when working with a family
6. Use tangible descriptions, visuals

Allocate Funds/Resources (n=2 comments)

1. Provide grant funding/re-allocate funding for childhood injury prevention
2. Offer additional support to further our ability to approach decision-makers with Positive Youth Development (PYD) perspective

3. How can you enhance the focus of your current activities/skills to more effectively influence decision makers in the future? (continued)

Positive Framing/Good will (n=2 comments)

1. Build good will for those who can help out.
2. Take a positive approach!

Other (n=4 comments)

1. Take a systems-dynamic approach: analyze all systems that add to or take away from impact outcomes
2. Demonstrate relationship between (e.g., abuse of child at home and connection with likelihood of that child being trafficked [if run away])
3. For Brain Injury Association, this is a natural part of their work; but they are really small (only nine employees with five offices across the state).
4. When thinking of health, add a safety focus

Appendix H. Summary of Facilitated Discussion # 2 Building Effective Networks

Objective: To build effective Wake County Childhood Injury Prevention networks through discussion and collaboration.
Breakout Groups: Breakout by SAME Injury event AND MIXED work focus area (e.g. counseling, advocacy).

1. How can you be more strategic in your networking (sharing information)?

Expand Partnerships (n=14 comments)

1. Health Department
2. [With] cell phone companies
3. University researchers
4. Local service providers
5. National "experts"
6. State infant and toddler programs
7. Specific Partnerships
    1. North Carolina Department of Public Health (NCDPH)
    2. Brain Injury NC
    3. Allied Partners
    4. Highway Safety
    5. National SafeKids
    6. Religious Organizations
    7. Marbles Kids Museum
    8. Poe Center

Increase Collaboration with Novel Partnerships (n=7 comments)

1. From brain injury perspective, [can get] info to other groups working with assault injuries to educate them about cognitive impairment, likelihood for poor decisions, [how the injured can be] easily exploited, and the likelihood of additional injuries after the first incident
2. Get out of our silos
3. Help folks outside of your field make the connections about injury prevention.
4. Find out how the people actually directly involved (not just decision-makers) can make an impact
5. Working with a team and making sure you share information
6. Sharing resources—bringing an eclectic group of people in one place and developing coordinating/intentional messages
7. Identify and then relate to existing community collaboratives (e.g., Wake County Mental Health Alliance); this could lead to a broader collaborate.

Education (n=4 comments)

1. [Let] leaders know the details so they can share the importance of proper child seats
2. Education on front and rear seats and when to switch
3. Educate school personnel and students on ways to address assault
4. Training counselors about local resources (so crisis line operators know of entities that they can refer people to).

Environmental/Social Changes (n=3 comments)

1. Changing the perception that this is ok
2. Use social media for points of contact
3. Changing environment and social norms

1. How can you be more strategic in your networking (sharing information)? (continued)

Expand Outreach Methods (n=2 comments)

1. Take the info to the people/parents, instead of requiring them to come to you (for example, information exists in different languages at schools, but you have to go to the school to get it)
2. Get more info out about the cross between brain injury and human trafficking, etc.

Use Data in Activity Development and Implementation (n=1 comment)

1. Evidence-based teen driving program

Designate Tasks/Roles (n=1 comment)

1. Hired someone just dedicated to program management and having the responsibility to conducting networking; being deliberate about recording and keeping up with the list of organizations we work with and summarizing what they do; giving other organizations their turf too, is important;

2. How can we increase collaboration and partnerships (sharing work)?

Expand Current Collaboration (n=19 comments)

1. Look at using "Adverse Childhood Experiences (ACE)" more
2. Remove turf wars for funding and recognition
3. Remove silos
4. Alleviate turf wars
5. Align across different groups with similar values
6. Groups coming together
7. Agreeing on subjects
8. Where are the men in this room????
9. New Partners/Populations
    1. Identifying who we're <u>not</u> presently working with and expanding our network
    2. Reaching out, extending invitations to groups that would benefit from a partnership
    3. More foster care outreach
    4. Engage Millennials and how they operate
    5. Work with Mexican Consulate
    6. Work more with faith communities and other cross sections
    7. Seek out unlikely partners (e.g., Faith communities)
    8. Working with coalitions and lobbyists
    9. Extending info and invitation to Latino groups
    10. Bring different folks to the table
    11. Go out into the community

Target Messages/Approaches (n=10 comments)

1. Expanding communication about taboo subjects—homelessness, abuse, etc.
2. Tell stories to get the word out.
3. We really can be models of collaboration in other counties.
4. By moving away from "fairs" every weekend to more initiatives/awareness programs with other organizations (youth clinics at Substance Abuse Services, Safety presentations at Lyons Club, etc.)
5. "Train the trainer"
6. Tailor interventions to place and impact levels
7. Know where children are in reality, not where expect them to be [developmentally]
8. Apply Data/Information to Program Development
    1. Determine what unmet needs are, helps with prioritizing
    2. Individual impact stories paired with good data
    3. Improve data about problems you know may be an issue but are not captured in traditional data sources.

2. How can we increase collaboration and partnerships (sharing work)? (continued)

Share Resources/Increase Communication (n=8 comments)

1. Host a centralized place for similar Non-profits to share info and learn from each other (like a "business" expo for Non-profits); statewide or countywide
2. Build community networks
3. Have youth summits/forums that focus on relevant topics and what the issues really are; Include home-schooled students and parents
4. Think about and approach opposition (or perceived opposition)
5. Sharing info among groups
6. List collaborative groups by name and publicly recognize all
7. Web-based resources are a great "hub" to reach out
8. A forum where messages can be posted to see how groups can help each other

Maintain Current Collaboration (n=6 comments)

1. Show up at each other's meetings, conferences (even if it seems out of your sphere)
2. Seek out other conferences, board engagements, etc.
3. Figure out how we can "cross-pollinate"
4. Better marketing of existing coalitions
5. Find ways to complement each other
6. Awareness programs—renewed interest in additional partners

Increase Funding/Resources for Collaboration (n=4 comments)

1. Opportunity for grantors to offer recognition and eliminate competition among organizations with similar focus areas
2. Publicize initiatives like the Healthy Schools Initiatives; make sure there is broad range of groups invited to attend these types of networking events.
3. Have more funding geared to more than one org. and cross-disciplinary agencies
4. Be sure that when hosting networking and collaboration events, you invite non-traditional stakeholders to the table.

Other (n=1 comment)

1. Early intervention

3. What resources can we share to do our work well?

Increase Transparency and Communication (n=15 comments)

1. We need to change the model where organizations have to compete with each other, but instead, can work together to secure funding to support a broader effort, with shared responsibilities based on where expertise lies to complete project work.
2. Work with organizations that fill a gap in services (e.g., Juvenile Justice connect with Human Trafficking org because many "runaways" are at risk for trafficking)
3. Social media, Google groups (mentioned at several tables)
4. Communication—letter writing, work together on presentations
5. [create] documents of understanding to clarify partners/coalitions
6. Unite skill sets—advocacy, fundraising, communication
7. Collaborating with "unlikely" resources—other kids, people in the community, face-to-face time
8. Developing and sharing an action plan
9. Sharing people and expertise. Talk about what suicide is and what you can do and how it can affect you. Looking for and figuring out how you have opportunities.

3. What resources can we share to do our work well? (continued)

10. Sharing printed materials is still very important. Broad distribution of these, along with advice about how they can be used.
11. List other organizations on their website (and not necessarily just organizations. focused on your own issue).
12. Build structure that supports multiple organizations, so that they can focus on the work they need to do.
13. Wonder if [John Rex Endowment] will support a project designed to build the networking web.
14. Who is working on various projects
15. Time—make time to go in person and meet with the right people

Incorporate Data (n=7 comments)

1. Show youth the data in an engaging way so they're informed, encouraged to act, provide "safe places" for them to act and speak up (e.g., With assaults in schools)
2. Better data/more accurate recording and reporting
3. Knowing both the problem and the process
4. Data is key
5. Use county-level data
6. Evidence-based practices
7. Intentional evaluation to know what worked and what didn't

Other (n=6 comments)

1. Situations "on the ground" out in the community
2. Use cultural competency
3. Look at what Child Fatality Task Force is championing and suggest other focus areas
4. United Way 211
5. New products—cellphone apps that can send a text for you when your phone is in motion
6. Coaches/teachers being able to identify issues before they escalate

Increase Outreach (n=4 comments)

1. Making sure people know where to go to get help
2. Increasing leadership/self-esteem and outreach
3. Involve youth in developing and delivering messages
4. Target programs to the audience

Use Existing Resources (n=2 comments)

1. Public Health Foundation offers a 'scaffolding' home to support some of the administrative work that is needed before the public health program an organization wants to conduct can get started.
2. Share outreach programs on brain injury particularly in the Latino community where brain injury is so prevalent

Work with Existing Coalitions (n=2 comments)

1. Coalitions are a good way to access resources; need more knowledge on what coalitions exist
2. Mobilizing our networking

Advocate (n=1 comment)

1. Knowledge—present at legislative days