Georgia Department of Public Health

Injury Prevention Strategic Plan

DPH | Injury Prevention Program (DPH IPP)

DPH.GEORGIA.GOV/INJURY-PREVENTION-PROGRAM

GEORGIA DEPARTMENT OF PUBLIC HEALTH

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Introduction

Injuries impact Georgians every day - they seem to be an unavoidable part of life. However, with a comprehensive approach to injury prevention that goes beyond one individual action at one moment in time, we can reduce the burden of injuries. Injury prevention analyzes risk and protective factors, informs policy, and influences environmental modifications to reduce the human and financial costs of injuries and violence. Intentional and unintentional injuries combined are a leading cause of premature death in Georgia, but they do not have to be.

Georgia's Department of Public Health, Injury Prevention Program (DPH IPP) aims to galvanize agencies and resources into a comprehensive and coordinated effort to prevent injuries and violence across the state. Our plan combines fresh ways of looking at the connections between causes of different types of injuries—shared risk and protective factors—with existing building blocks, like evidence-based strategies already being implemented around the state as well as existing and new critical priority areas for intervention and prevention. These critical priority areas include Transportation, Interpersonal Violence, Child Abuse and Neglect (CAN), Safe Infant Sleep, Suicide, Falls, Poisoning and Drug Safety, and Traumatic Brain Injury (TBI), as well as Alzheimer's Disease and Related Dementia as risk factors for Injury. This plan considers how interventions affect change at four key personal and social levels: individual, relationship, community and societal. This approach ensures maximum reach and impact.

The Public Health Approach

Our Mission

We prevent injuries by empowering state and local coalitions through the provision of data, training, and leadership, and the leveraging of resources for prevention programs.

Our Vision

A state where injuries and their burdens are fully minimized by empowering state and local coalitions through the provision of data, training, coordination, and leadership, and leveraging resources for programs to achieve a safety culture.

History and Current Programs

The work of the Injury Prevention Program (IPP) started in 1988 as a single project with a grant from the Governor's Office of Highway Safety (GOHS) and with support to Safe Kids Georgia at

Egleston Children's hospital. Over time, the program received additional grants, the staff increased, and content expertise grew; this increased capacity supported more partners and coalitions.

The IPP is housed within the Georgia Department of Public Health, Division of Health Protection. The main functions of the IPP include:

- The provision of technical assistance in program evaluation and coalition building to local community groups;
- The provision of injury data to community groups and the public at large;
- The distribution of safety equipment such as bassinets and child safety seats;
- The dissemination of knowledge on proper use of safety equipment; and,
- The provision of general support to local and state coalitions in helping promote safe and injury free lifestyles and behaviors.

These injury prevention activities are primarily grant-driven with the Centers for Disease Control and Prevention (CDC), the state's GOHS, and the Maternal and Child Health Section (DPH MCH) being the major funders.

Historic Programs: Smoke Detector Safety Program, Shaken Baby Syndrome, Suicide, Intimate Partner Violence, Rural Roads/Teen Driver Safety, Albany Department of Justice (DOJ) Innovation Grant

Current Programs

- **55+ Driver:**
  Provides education to professionals and community members to manage safety and mobility for the 55+ population.
- **Cardiff Model Expansion Project:**
  Aims to reduce injuries and deaths from interpersonal violence through data-informed decisions and partnerships between hospitals, law enforcement, and other community violence-prevention stakeholders.

- **Child Occupant Safety Project (COSP):**

  Provides car seat education and distribution, Child Passenger Safety Technician (CPST) training, and a specialized training for technicians working with families of children with special healthcare needs.

- **Core State Violence and Injury Prevention Program (CORE SVIPP):**

  Implements, evaluates, and disseminates strategies that address the following injury and violence issues: child abuse and neglect, traumatic brain injury, motor vehicle crash injury and death, and sexual and intimate partner violence.

- **Crash Outcome Data Evaluation System (CODES):**

  Brings together multiple agencies and highway safety data owners to identify opportunities for crash prevention by linking and analyzing crash, vehicle, and behavioral characteristics to medical and financial data.

- **Safe Infant Sleep Program:**

  Coordinates statewide public health interventions intended to protect infants from Sudden Infant Death Syndrome (SIDS) and other sleep-related causes of death.

- **SPLASH (Supervise, Prevention, Life jacket, Arms length, Swim lessons, Have a safety plan):**

  A collaborative effort led by the Department of Natural Resources (DNR) to prevent drowning deaths wherever they may occur. Splash brings together agencies and organizations to work on various aspects of drowning prevention and water safety, primarily during warm weather months.

Strategic Plan Development Process

Advantage Consulting, LLC (Atlanta, GA) was engaged to facilitate the design and development of the 2020–2025 strategic planning process. The planning process commenced in January 2019 and was completed in October 2019. The process involved over 110 participants representing 57 state and community-based organizations.

The initial step was to design an inclusive and efficient process. **The Center for Disease Control and Prevention's Core State Violence and Injury Prevention Program (Core SVIPP) Comprehensive Index Tool** was adopted as the framework to engage partners and define strategies that lead to the reduction and prevention of injury and violence. We conducted a scan of other state health department injury and violence prevention plans and examined their processes and methodologies (e.g., Utah, Colorado, Illinois, Alaska, Louisiana, Florida). We adopted a shared risk and protective factors approach and embedded this framework into the planning sessions and data collection strategies. Finally, we engaged the **Georgia Injury Prevention Advisory Council (GIPAC)** in refining the final process and ensuring deep stakeholder participation.

We conducted a survey of 89 subject matter experts across multiple injury topic areas regarding the opportunities and challenges in injury and violence prevention in Georgia. The survey targeted government agencies, professional organizations, academic institutions, medical providers, non-health related businesses, nonprofits, and community-based organizations. Through the survey, we identified 15 promising shared risk and protective factors that presented meaningful opportunities to connect and elevate the work of partners and stakeholders across the state.

Next, six planning sessions were held with community partners and stakeholders. The first session included diverse representation from across multiple injury topic areas. The focus of this session was to define why these injury areas were important to address in Georgia, what important work was already underway to address these issues, and to begin identifying strategies needed to reduce the incidence and prevalence of injury and violence. Additionally, participants reviewed the results of the survey and identified six shared risk and protective factors that best unified and integrated opportunities across multiple areas. The shared risk and protective factors, reframed as objectives, included:

1. Increasing coordination of resources and services across agencies and organizations

2. Increasing social capital and community connectedness

3. Increasing data informed decisions

4. Increasing family support and connectedness

5. Promoting policies and laws aligned with the best available evidence

Goals

The Georgia Department of Public Health-Injury Prevention Program will:

Actively pursue and intervene in root causes of health inequity and disparity to include social determinants of health using a shared risk and protective factors approach;

Create communication strategies targeted at both internal and external stakeholders to share evidence-based education on reducing injury and violence and promoting health;

Be vigilant and develop targeted, collaborative approaches to combat injury and violence risk in vulnerable communities;

Continually improve and sustain internal processes, policies, and procedures, and align performance with best practices that result in the reduction of health inequities and disparities.

Georgia's long-term goals:

- Georgia has created safe, stable, nurturing relationships and environments for all children.
- Georgians understand the risks associated with falls and are equipped to prevent them.
- Georgia has created an environment that recognizes suicide risks, empowers communities to proactively respond and ensures access to necessary suicide prevention and treatment resources.
- Georgia prevents deaths and serious traumatic injuries due to motor vehicle crashes by mitigating pre-crash, during crash and post-crash risk factors.
- Georgians understand Alzheimer's disease and related dementias as a risk factor for injury and death.
- Georgians understand the biological, environmental, social, and behavioral causes of drug addiction, understand the consequences of substance abuse as it relates to other injury and violence outcomes and adopt evidence-based prevention and treatment strategies.
- Georgians understand the root causes of interpersonal violence, support evidence-based approaches to violence prevention and ensure victims have the support needed.
- Georgia parents, caregivers, and practitioners are educated about ways to increase protection for infants against Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUID) and help to end sleep-related causes of infant death.

Table 1: 10 Leading Causes of Death by Age Group, Georgia, 2013–2017

Rank	<1	1-4	5-9	10-14	15-24
1	Short Gestation 1,066	Unintentional Injury 268	Unintentional Injury 180	Unintentional Injury 164	Unintentional Injury 2,129
2	Congenital Anomalies 854	Homicide 77	Malignant Neoplasms 77	Suicide 79	Homicide 1,052
3	SIDS 509	Congenital Anomalies 74	Congenital Anomalies 33	Malignant Neoplasms 71	Suicide 881
4	Maternal Pregnancy Comp. 265	Malignant Neoplasms 60	Heart Disease 21	Homicide 36	Malignant Neoplasms 236
5	Unintentional Injury 219	Heart Disease 37	Homicide 20	Heart Disease 28	Heart Disease 217
6	Placenta Cord Membranes 134	Influenza & Pneumonia 18	Chronic Low. Respiratory Disease 17	Congenital Anomalies 27	Congenital Anomalies 74
7	Bacterial Sepsis 127	Septicemia 18	Cerebro-vascular 10	Chronic Low. Respiratory Disease 20	Complicated Pregnancy 44
8	Circulatory System Disease 92	Cerebro-vascular 11	Influenza & Pneumonia 10	Cerebro-vascular ---	Septicemia 43
9	Necrotizing Enterocolitis 91	Chronic Low. Respiratory Disease ---	Benign Neoplasms ---	Influenza & Pneumonia ---	Diabetes Mellitus 42
10	Respiratory Distress 85	Perinatal Period ---	Septicemia ---	Anemias ---	HIV 32

Data Source: CDC WISQARS

Note: Causes with case numbers below 10 have been suppressed.
Red cells indicate injury deaths. Injury deaths are classified by intent.

Table 1: 10 Leading Causes of Death by Age Group, Georgia, 2013–2017

25-34	35-44	45-54	55-64	65+	All Ages
Unintentional Injury 3,097	Unintentional Injury 2,791	Malignant Neoplasms 7,325	Malignant Neoplasms 18,432	Heart Disease 63,630	Heart Disease 87,958
Suicide 1,101	Heart Disease 2,165	Heart Disease 6,892	Heart Disease 14,208	Malignant Neoplasms 55,583	Malignant Neoplasms 84,365
Homicide 990	Malignant Neoplasms 1,926	Unintentional Injury 3,211	Chronic Low. Respiratory Disease 3,131	Chronic Low. Respiratory Disease 18,545	Chronic Low. Respiratory Disease 22,782
Heart Disease 696	Suicide 1,059	Suicide 1,360	Unintentional Injury 3,008	Alzheimer's Disease 16,548	Unintentional Injury 21,447
Malignant Neoplasms 643	Homicide 600	Cerebro-vascular 1,166	Cerebro-vascular 2,419	Cerebro-vascular 16,505	Cerebro-vascular 20,725
HIV 231	Cerebro-vascular 433	Diabetes Mellitus 1,131	Diabetes Mellitus 2,329	Diabetes Mellitus 7,168	Alzheimer's Disease 16,743
Complicated Pregnancy 140	Diabetes Mellitus 416	Liver Disease 1,075	Liver Disease 1,701	Nephritis 6,987	Diabetes Mellitus 11,225
Diabetes Mellitus 135	HIV 354	Chronic Low. Respiratory Disease 839	Septicemia 1,327	Unintentional Injury 6,379	Nephritis 9,081
Cerebro-vascular 121	Liver Disease 311	Septicemia 642	Nephritis 1,276	Influenza & Pneumonia 5,636	Septicemia 7,753
Two Tied 89	Septicemia 209	HIV 547	Suicide 1,107	Septicemia 5,378	Influenza & Pneumonia 7,294

Data Source: CDC WISQARS

Note: Causes with case numbers below 10 have been suppressed.
Red cells indicate injury deaths. Injury deaths are classified by intent.

Table 2: 10 Leading Causes of Injury Death by Age Group, Georgia 2013–2017

Rank	<1	1-4	5-9	10-14	15-24
1	Unintentional Suffocation 181	Unintentional Drowning 96	Unintentional MV Traffic 82	Unintentional MV Traffic 81	Unintentional MV Traffic 1,272
2	Homicide Unspecified 30	Unintentional MV Traffic 67	Unintentional Drowning 35	Suicide Suffocation 43	Homicide Firearm 986
3	Unintentional MV Traffic 19	Homicide Unspecified 33	Unintentional Fire/burn 23	Unintentional Drowning 33	Unintentional Poisoning 519
4	Homicide Other Spec., classifiable 13	Unintentional Suffocation 28	Homicide Firearm 13	Suicide Firearm 32	Suicide Firearm 503
5	Undetermined Unspecified ---	Unintentional Fire/burn 23	Unintentional Suffocation 10	Homicide Firearm 25	Suicide Suffocation 278
6	Unintentional Drowning ---	Unintentional Pedestrian, Other 23	Unintentional Other Land Transport ---	Unintentional Fire/burn 13	Unintentional Drowning 103
7	Unintentional Unspecified ---	Homicide Other Spec., classifiable 14	Unintentional Other Spec., classifiable ---	Unintentional Other Land Transport 11	Suicide Poisoning 52
8	Unintentional Fire/burn ---	Homicide Firearm 10	Unintentional Other Transport ---	Unintentional Other Spec., classifiable ---	Unintentional Other Land Transport 34
9	Three Tied ---	Homicide Suffocation ---	Five Tied ---	Unintentional Poisoning ---	Homicide Cut/pierce 33
10	Three Tied ---	Unintentional Natural/ Environment ---	Five Tied ---	Unintentional Suffocation ---	Unintentional Fall 31

Source: CDC WISQARS

Note: Causes with case numbers below 10 have been suppressed.
Causes are classified by both intent and mechanism.

Table 2: 10 Leading Causes of Injury Death by Age Group, Georgia 2013–2017

25-34	35-44	45-54	55-64	65+	All Ages
Unintentional Poisoning 1,410	Unintentional Poisoning 1,385	Unintentional Poisoning 1,471	Unintentional Poisoning 993	Unintentional Fall 2,910	Unintentional MV Traffic 6,944
Unintentional MV Traffic 1,306	Unintentional MV Traffic 941	Unintentional MV Traffic 1,009	Unintentional MV Traffic 977	Unintentional MV Traffic 1,190	Unintentional Poisoning 6,132
Homicide Firearm 857	Suicide Firearm 603	Suicide Firearm 803	Suicide Firearm 698	Suicide Firearm 920	Suicide Firearm 4,190
Suicide Firearm 630	Homicide Firearm 485	Homicide Firearm 279	Unintentional Fall 353	Unintentional Suffocation 617	Unintentional Fall 3,637
Suicide Suffocation 314	Suicide Suffocation 243	Suicide Suffocation 264	Suicide Suffocation 169	Unintentional Unspecified 612	Homicide Firearm ---
Suicide Poisoning 107	Suicide Poisoning 148	Suicide Poisoning 215	Suicide Poisoning 165	Unintentional Poisoning 342	Suicide Suffocation 1,365
Unintentional Drowning 78	Unintentional Fall 103	Unintentional Fall 194	Homicide Firearm 136	Adverse Effects 294	Unintentional Suffocation 1,120
Homicide Cut/pierce 65	Unintentional Drowning 63	Unintentional Fire/burn 93	Unintentional Fire/burn 131	Unintentional Fire/burn 239	Unintentional Unspecified 860
Unintentional Fall 43	Homicide Cut/pierce 44	Unintentional Drowning 64	Unintentional Suffocation 131	Homicide Firearm 88	Suicide Poisoning 775
Unintentional Fire/burn 42	Unintentional Fire/burn 44	Two Tied 58	Unintentional Unspecified 104	Unintentional Natural/ Environment 86	Unintentional Fire/burn 636

Data Source: CDC WISQARS

Note: Causes with case numbers below 10 have been suppressed.
Causes are classified by both intent and mechanism.

Table 3: Injury Death, Death Rates and Excess Deaths Per Year, Georgia 2013–2017

Type of Injury	Number	Average per Year	Age-Adjusted Death Rate, GA	Age-Adjusted Death Rate, US	Excess Deaths per Year, GA
Unintentional Injuries	21447	4289	42.57	43.90	-136
Motor Vehicle*	6944	1389	13.42	10.94	253
Poisoning	6232	1246	11.90	15.69	-387
Falls	3637	727	7.79	8.94	-117
Suffocation	1120	224	2.31	1.93	39
Fire/Burn	636	127	1.22	0.79	44
Drowning	628	126	1.23	1.10	13
Other Motor Vehicle Transportation*	261	52	0.52	0.48	4
Other Unintentional	1989	398	4.18	4.03	15
Suicide	6684	1337	12.84	13.24	-41
Homicide	3653	731	7.18	5.62	159
Legal Intervention	97	19	0.19	0.18	1
Other and Undetermined	359	72	0.69	1.58	-91
All Injuries	32240	6448	63.47	64.52	-107

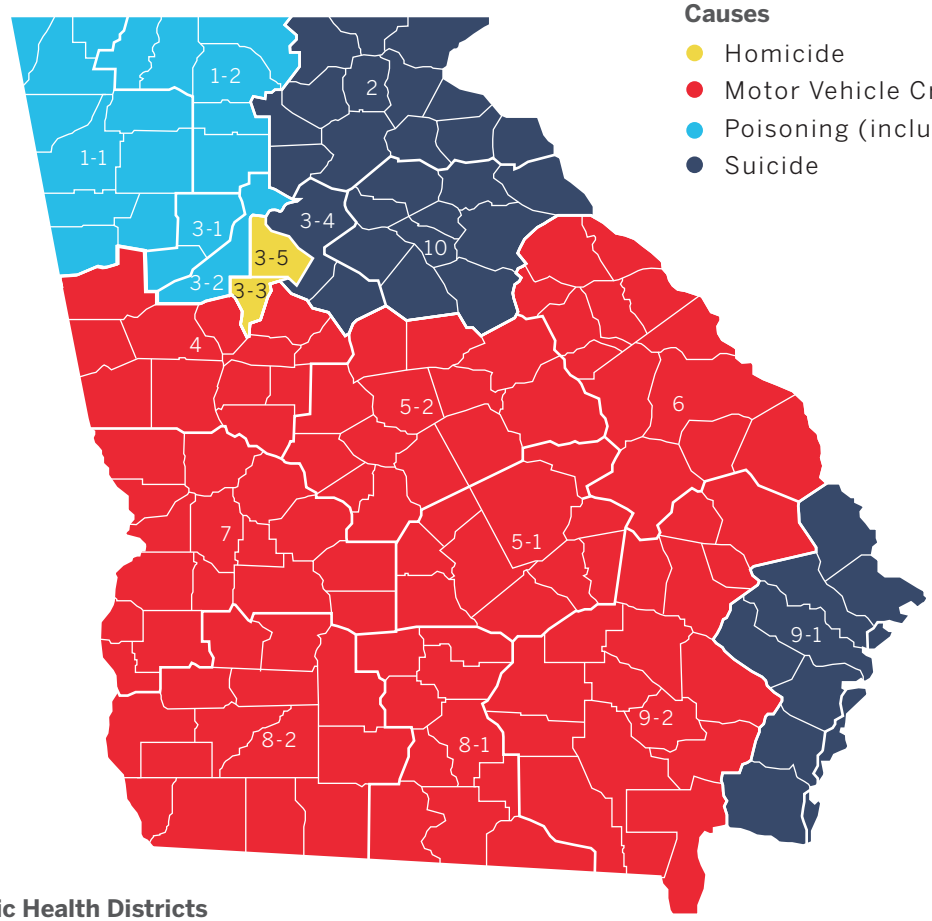
Source: CDC WISQARS | Note: *Motor Vehicle includes traffic related only; Other Motor Vehicle Transportation includes non-traffic related deaths*

Leading Causes of Injury

As shown in Table 3, the three leading causes of injury deaths are motor vehicle (traffic), suicide, and poisoning (including overdoses). These three types of injury comprise nearly 62 percent of the injury deaths in Georgia, based on data from 2013 to 2017. Falls account for the highest rates of emergency room visits and hospitalizations. Motor vehicle crashes are the leading mechanism of injury resulting in death, and the second most common mechanism resulting in emergency room visits and hospitalizations.

There has been an upward trend in suicide among Georgians 10 to 17 years of age between 2008 and 2017. Suicide rates for Georgians 10–17 years of age were 2.4 times higher in 2017 than in 2008 (5.0 vs 2.1 per 100,000 population).

Figure 1: Leading Cause of Injury Related Deaths by Public Health District, Georgia, 2013 - 2017



Public Health Districts

1-1. Northwest (Rome)	1-2. North Georgia (Dalton)	2. North (Gainesville)
3-1. Cobb-Douglas	3-2. Fulton	3-3. Clayton (Jonesboro)
3-4. East Metro	3-5. Dekalb	4. LaGrange
5-1. South Central (Dublin)	5-2. North Central (Macon)	6. East Central (Augusta)
7. West Central (Columbus)	8-1. South (Valdosta)	8-2. Southwest (Albany)
9-1. Coastal (Savannah)	9-2. Southeast (Waycross)	10. Northeast (Athens)

Data Source: Georgia DPH OASIS

(https://oasis.state.ga.us/)
Leading cause determined by count of cases.
GA DPH Injury Prevention Program.

Critical Success Factors

In addition to analyzing the burden of violence and injury as determined by death, hospitalization and emergency department data, the Georgia Department of Public Health, Injury Prevention Program, and its partners used the following factors to prioritize critical target areas for prevention and intervention efforts across the state:

1. Political will to prevent violence and injury.
2. The availability of funding and ability to leverage various funding sources to address multiple forms of violence and injury.
3. The priorities and critical target areas set by our state and local partners.
4. The existence of, and feasibility of implementing, evidence-based strategies to decrease the burden of violence and injury across the state.

The Georgia Department of Public Health has identified these nine critical areas in Injury Prevention:

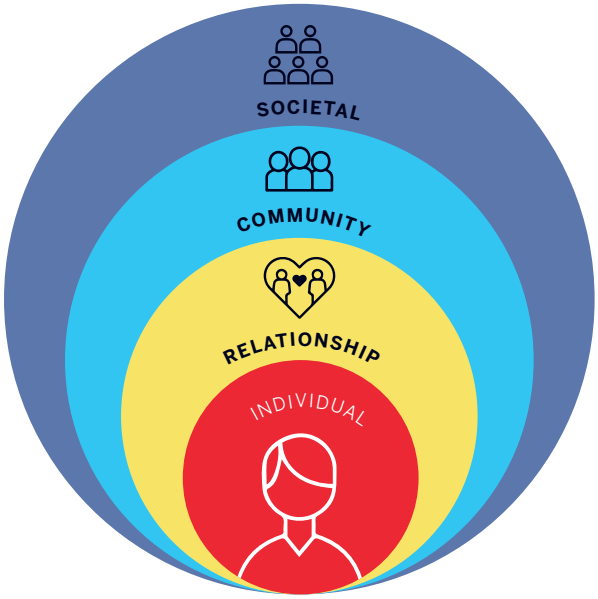
Continuing efforts in and across these critical areas are identified and promoted considering four primary success factors: political will, existing or available funding sources, priorities of partners, and the presence of evidence-based or research-informed strategies.

Table 4: Critical Success Factors

	Political Will	Existing/ Potential Funding Source	Partner Priority	Evidence-based / Research-informed Strategies Available
FALLS	YES	Potential New Sources*	High	YES
SUICIDE	NO	Existing & Potential New Sources*	High	YES
TRANSPORTATION	YES	Existing & Potential New Sources*	High	YES (CPS) AND NO (Older Driver)
CHILD ABUSE AND NEGLECT	YES	Existing & Potential New Sources*	High	YES
INTER- PERSONAL VIOLENCE	YES	Existing & Potential New Sources*	High	YES
ALZHEIMER'S DISEASE AND RELATED DEMENTIA	YES	Existing & Potential New Sources*	High	YES
TRAUMATIC BRAIN INJURY	YES	Existing & Potential New Sources*	High	YES
POISONING & DRUG SAFETY	YES	Existing & Potential New Sources*	High	YES
SAFE INFANT SLEEP	NO	Existing & Potential New Sources*	High	YES

***note: new funding sources are generally limited, competitive and temporary.**

Figure 2: CDC Social-Ecological Model for Prevention



In developing and finalizing strategies, DPH IPP staff also used the CDC Social-Ecological Model for Prevention.[1] The four-level social-ecological model represents the interaction between individual, relationship, community, and societal factors related to injury and violence. It addresses a range of risk and protective factors related to multiple sources of injury across these different levels. The model suggests that in order to prevent injuries and violence, it is necessary to act at multiple levels of the model at the same time to achieve maximum impact.

The first level (individual) concerns biological and personal factors that affect the risk of injury and violence. Examples include age, developmental history, education, income, substance use, and history of abuse. Prevention strategies at this level promote attitudes, beliefs, and behaviors that reduce the risk of injury and prevent violence.

The second level (relationship) examines social relationships such as friendships, family relationships, and social networks that may influence the risk of experiencing injury or violence as a victim or perpetrator. Prevention strategies at this level may include parenting skills education, increasing family support, youth mentoring, and promoting healthy relationships.

The third level (community) explores the settings in which social relationships occur, such as schools, workplaces, places of worship, and neighborhoods. Prevention strategies at this level impact the social and physical environment by promoting social connectedness, improving economic opportunities, and addressing norms and policies within organizational settings.

The fourth level (societal) looks at the broad factors that help create a climate in which injury occurs. These factors include social and cultural norms, as well as health, economic, educational, and social policies that address risk and protectives factors related to injury and violence.

Strategies adopted in this plan address the following social-ecological factors:

Table 6: Ecological model factors stratified by priority strategies

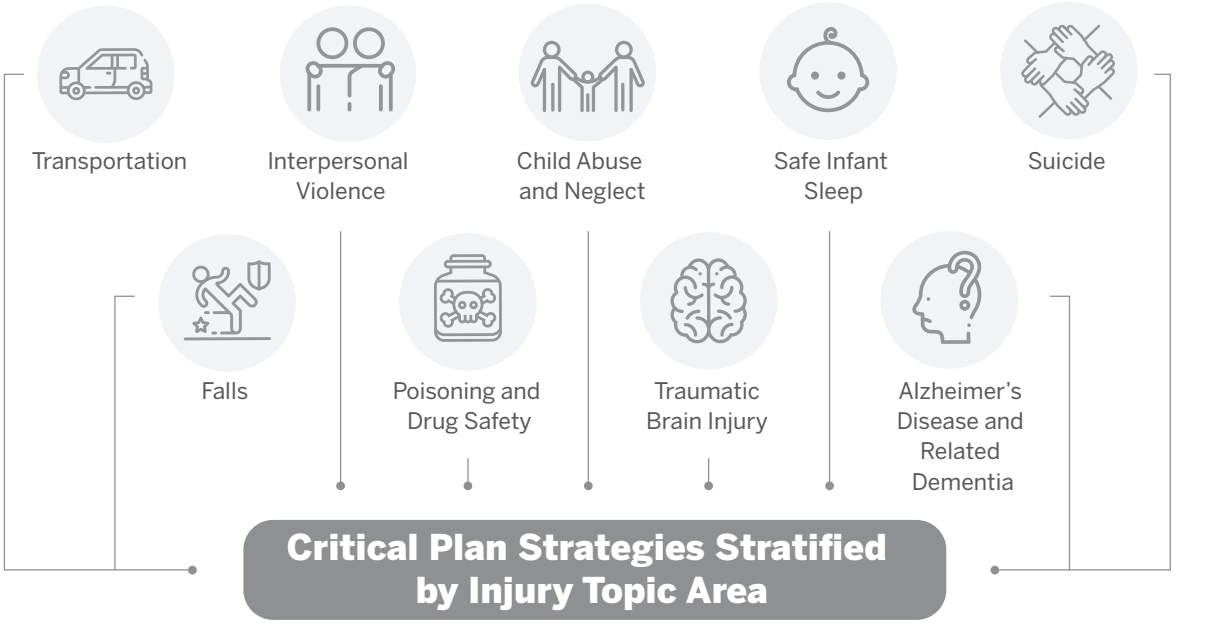
	Individual	Relationship	Community	Societal
Increase the coordination of resources and services across agencies and organizations	YES	YES	YES	YES
Increase social capital and community connectedness	YES	YES	YES	YES
Increase data-informed decisions			YES	YES
Increase policies and laws aligned with the best available evidence			YES	YES
Increase family support and connectedness	YES	YES		

Addressing Shared Risk & Protective Factors

Every Georgian is affected by injuries and violence, whether through direct experience or from the effects of the injury or death of a family member, friend, neighbor, or other close person. The ripple effects stretch beyond those first few degrees of separation and have social and economic impact on whole communities and our state.

Put simply, a risk factor increases the likelihood of an injury or violence. A protective factor decreases this likelihood. By looking at risk and protective factors that are shared across different types of injury and violence, we intend to magnify impact by maximizing the deployment of resources—human, financial, and cross-organizational (partnerships)—across multiple critical areas.

In Georgia, we have identified the following shared risk and protective factors, aligned across critical areas:



Objectives & Strategies

1. Increase the coordination of resources and services across agencies and organizations

1.1 Educate DPH Workforce on available resources, particularly those that interact with the public and direct service partners.

Focus Areas

Implementation Partners[2]:

Internal: Georgia Injury Prevention Advisory Council (GIPAC); Home Visiting; Human Resources; Supplemental Nutrition Assistance Program (SNAP); Women, Infants, and Children Supplemental Nutrition Program (WIC); Worksite Wellness

External: Child Fatality Review (CFR); Georgia Department of Early Care and Learning (DECAL); Georgia Department of Human Services, Division of Family and Children Services (DHS DFCS); Georgia Early Education Alliance for Ready Students (GEEARS); Georgia Essentials for Childhood (Essentials); Georgia Trauma Commission (GTC); National Alliance on Mental Illness – Georgia (NAMI Georgia); Prevent Child Abuse Georgia (PCA GA); Voices for Georgia's Children (Voices)

Indicator: # of partners reporting an increase in capacity due to improved resource and service coordination.

1.2 Foster local coalition building by providing access to tool kits, technical assistance and state level connections.

Focus Areas

Implementation Partners :

Internal: GIPAC

External: Alzheimer's Association – Georgia Chapter (AAGC); Area Agencies on Aging (AAAs); Falls Prevention Coalition (FPC); Georgia Department of Human Services, Division of Aging Services (DHS DAS); GTC; local health departments

Indicator: Establishment of at least 3 new local coalitions by 2024.

1.3 Enhance existing electronic platforms to promote resources, services, and training to link all collaborating agencies and organizations.

Focus Areas

Implementation Partners :

Internal: GIPAC; interns

External: AAGC; Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (CDC NCIPC); DHS DAS; FPC

Indicator: Creation of dedicated webpages; # of page visits and downloads.

1.4 Develop social-media tools and resources using consistent highway safety messages to promote safe-driving.

Focus Areas

Implementation Partners :

Internal: Child Occupant Safety Project (COSP); Communications; GIPAC

External: Atlanta Regional Commission (ARC); Children's Injury Prevention Program (CHIPP); Georgia Governor's Office of Highway Safety (GOHS); Injury Prevention Research Center at Emory University (IPRCE); fire departments; law enforcement agencies; National Highway Traffic Safety Administration (NHTSA), Crash Outcome Data Evaluation System (CODES); population-specific experts and local health departments; Safe Kids Coalitions

Indicator: # of campaign message shares and views.

1.5 Assist partners in educating parents on the most appropriate child safety restraint systems.

Focus Areas

Implementation Partners :

Internal: Child Passenger Safety Technicians (CPSTs) across the state; COSP mini-grantees; GIPAC

External: Early Head Start Programs; Emergency responders; Georgia Association for the Education of Young Children (GAEYC); GEEARS; law enforcement; nurses; Safe Kids Coalitions; social workers; University of Georgia Traffic Safety Research Group

Indicator: # of CSPTs in Georgia counties with the highest rates of Motor Vehicle Crashes; # of CPSTs in Georgia counties with the smallest proportion of technicians (based on county population); # of parents/caregivers who install child restraints correctly.

1.6 Identify and support all Georgia agencies and key partners engaged in suicide prevention, intervention and postvention.

Focus Areas

Implementation Partners :

Internal: DPH Epidemiology (DPH EPI); GIPAC; Office of Health Indicators for Planning (DPH OHIP)

External: American Foundation for Suicide Prevention – Georgia; Amerigroup; CDC; Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD); NAMI Georgia; IPRCE; Mental Health America of Georgia; suicide data collectors; Suicide Prevention Action Network – Georgia (SPAN-GA)

Indicator: # resources reviewed/verified; #of training workshops/conversations on the importance of suicide data collection; # of shares/posting of NAMI Georgia resource guide; #partners and agencies gathered; # of parents/caregivers who install child restraints correctly.

2. Increase social capital and community connectedness

2.1 Increase culturally sensitive marketing messages to address the stigma around help-seeking behavior.

Focus Areas

Implementation Partners :

Internal: Communications; Georgia's SNAP-Ed and implementing agencies; GIPAC; Home Visiting; IPP Interns; WIC

External: CFR; Children's Healthcare of Atlanta (CHOA); DECAL; DHS DAS; DHS DFCS; Essentials (steering committee and working groups); GEEARS; Georgia Teen Advocates; GOHS; GTC; IPRCE; Partnership Against Domestic Violence (PADV); PCA GA; Project Safe, Inc.; SPAN-GA; Voices

Indicator: # and frequency of partners using messages.

2.2 Identify strategies to reduce the stigma of talking about falls risk and encourage conversations.

Focus Areas

Implementation Partners :

Internal: Interns; Alzheimer and Related Dementia Implementation Team.

External: AAGC; CDC NCIPC; DHS DAS; FPC; IPRCE Falls Prevention Task Team.

Indicator: # and frequency of partners using strategies.

2.3 Identify barriers to mobility including an analysis of current infrastructure, underserved populations, mobility-resource gaps, and systems for community feedback.

Focus Areas

Implementation Partners :

Internal: Interns; Alzheimer and Related Dementia Implementation Team.

External: AAGC; CDC NCIPC; DHS DAS; FPC; IPRCE Falls Prevention Task Team.

Indicator: # and frequency of partners using strategies.

3. Increase data informed decisions

3.1 Assist partners by producing clear and compelling national, state and local data analysis presentations and visualizations using a variety of formats.

Focus Areas

Implementation Partners :

Internal: DPH; DPH EPI; DPH OHIP; Georgia Central Trauma Registry; GIPAC; IPV partners; Motor Vehicle Crash (MVC) partners; Safe to Sleep; Safe to Sleep Campaign

External: CODES; Essentials, Data Working Group; GEEARS; Georgia Commission on Family Violence; Georgia Teen Advocates; GOHS; IPRCE; PADV; Project Safe, Inc.; SPAN-GA; Voices

Indicator: # and frequency of partners using presentations and visualizations.

3.2 Develop a plan for implementing a transportation data integration/linkage model across multiple data sets and include multiple stakeholders.

Focus Areas

Implementation Partners :

Internal: DPH OHIP; Georgia Department of Public Health, Office of Emergency Medical Services (DPH OEMS)

External: CDC; CODES Board; Georgia Department of Driver Services (DDS); Georgia Department of Transportation (GDOT); GOHS; IPRCE; NHTSA

Indicator: Creation of a plan; # of partners adopting the plan.

3.3 Support partners in the collection, reporting and usage of Georgia Adverse Childhood Experiences (ACEs) data.

Focus Areas

Implementation Partners :

Internal: DPH EPI; DPH OHIP; GIPAC

External: CHOA; Criminal Justice Coordinating Council (CJCC); DHS; DFCS; Essentials; GEEARS; Georgia Child Care Association (GCCA); Georgia Office of the Child Advocate (OCA); IPRCE; PCA GA; Voices

Indicator: # of partners collecting and reporting Georgia ACEs data; # of partners using Georgia ACEs data in planning and decision making.

3.4 Disseminate incidence, location, and demographic data to partners to increase the implementation of prevention programming and influence local policies for Falls and TBI.

Focus Areas

Implementation Partners :

Internal: DPH EPI, DPH OHIP

External: Aging network partners – partners that work on falls among the pediatric population as well

Indicator: creation of annual fact sheets to appropriate audiences; # of sheets distributed; # of visualizations used by multiple agencies in prevention work

3.5 Implement the Cardiff Model to detect and address previously unknown geospatial patterns of injury.

Focus Areas

Implementation Partners :

Internal: (none identified)

External: Association of State and Territorial Health Officials (ASTHO); CDC; DeKalb Police Department (DeKalb PD); Grady Memorial Hospital; IPRCE

Indicator: # of new geospatial patterns of injury identified.

4. Increase education on policies and laws aligned with the best available evidence or best practices

4.1 Educate partners on emerging and existing injury and violence related policies.

Focus Areas

Implementation Partners :

Internal: COSP; CPSTs; GIPAC

External: CHOA; CJCC; Georgia Coalition Against Domestic Violence (GCADV); Concentric Consulting; Essentials; Georgia Commission on Family Violence; Georgia Teen Advocates Network; Georgia Teen Advocates; GOHS; Grady Memorial Hospital; Gwinnett Medical Center Sports Medicine and Concussion Institute; IPRCE; Live SAFE Resources; PADV; Project Safe, Inc.; Safe Kids Columbus; Securus House; State Highway Safety Plan (SHSP); Voices

Indicator: # and types of partners educated on injury and violence related policies.

4.2 Adopt and promote observational tools for seat belts/restraints and distracted driving that can be implemented across the state.

Focus Areas

Implementation Partners :

Internal: COSP; CPSTs; GIPAC

External: CHIPP; CHOA; GOHS; IPRCE; NHTSA; Safe Kids Columbus; SHSP

Indicator: Creation of tools; # of implemented tools; # of locations of implemented tools.

5. Increase family support and connectedness

5.1 Promote family support tools across the state.

Focus Areas

Implementation Partners :

Internal: Communications; COSP; CPSTs; Falls prevention coalition/task force

External: AAAs; CFR; CHOA MVC Task Team; DBHDD; DECAL; DHS DAS; DHS DFCS; Essentials; fire departments; GEEARS; Georgia Teen Advocates; GOHS; GTC; local health departments; IPRCE; IPRCE Task Team; law enforcement; NAMI Georgia; PADV; PCA GA; population-specific experts (e.g., older-driver safety, teen-driver safety, motorcycle safety); Project Safe, Inc.; Safe Kids Coalitions; Safe Kids Columbus; Voices for Georgia's Children

Indicator: # of tools promoted; # of times tools promoted; # of locations where tools are promoted; # of times resource navigation tool is shared or distributed amongst partners (IPV, Alzheimer's, and Safe Sleep), # of meetings/conversations to create resource navigation tool (IPV, Alzheimer's, and Safe Sleep); # of PI&E distributed to agencies (Falls, Transportation, CAN, TBI, Opioid, &Suicide), # of online shares/postings of resources (Falls, Transportation, CAN, TBI, Opioid, &Suicide)

5.2 **Support the Georgia Safe to Sleep Campaign to empower professionals to educate families and empower families to make informed decisions about infant sleep.**

Focus Areas

Implementation Partners :

Internal: DPH; Maternal and Child Health Section (DPH MCH); GIPAC; WIC Breastfeeding

External: American Academy of Pediatrics – Georgia Chapter; birthing hospitals; DHS DFCS; GAYEC; GEEARS; Georgia Bureau of Investigation (GBI); Georgia Children's Cabinet; Georgia Family Connection Partnership (GaFCP); Georgia Hospital Association; Georgia Obstetrical and Gynecological Society; local and district health departments; other child and family serving agencies; Safe Kids Georgia; Voices for Georgia's Children

Indicators: # materials distributed; # of messages disseminated, frequency of materials being used.

The Burden of Injury in Georgia

The leading cause of death of Georgians ages 1–44 years old is unintentional injuries, and across all ages it ranks third behind only heart disease and cancer. On average, nearly 4,300 Georgians die from unintentional injuries each year, taking a toll on families, friends, neighbors, and the community.[3] In Georgia, more than 74,000 hospitalizations and ER visits result from injuries every year. According to the Centers for Disease Control and Prevention, the lifetime medical and work loss costs of nonfatal injuries in the US was over $457 billion.[4]

Across the eight priority injury areas in Georgia, the impact to individuals, communities, and the state is significant. The following sections are organized by excess death in Georgia compared to overall U.S. rates (table 3).

Transportation

Motor vehicle crashes (MVCs) are the leading cause of injury deaths and second leading cause of hospitalizations and ER visits in Georgia. MVCs include both traffic and non-traffic cases. They affect Georgians across the state and life span.[5] In 2017, motor vehicle traffic deaths were the leading cause of injury deaths for children and adults between 5 and 24 years of age in addition to adults age 55 to 64.[6] In that same year, Georgia had the 4th greatest number of traffic fatalities (1,540) in the nation[7], even though Georgia has the 8th largest population in the United States.[8]

Georgia has addressed transportation safety across the lifespan through cross-agency interventions in education and enforcement. The CPST Certification Training Program and Safe Kids Coalitions emphasize child safety in cars. The CarFit program and Yellow Dot Program assess adult driver's ergonomic fit in vehicles and act as a communication tool, respectively to 55+ drivers who are most vulnerable to injury on Georgia roads. To maximize impact, DPH maintains vital partnerships for this work, including the medical community (e.g., Children's Healthcare of Atlanta's Children's Injury Prevention Program, or CHIPP); law enforcement and fire departments; Shepherd Center; Area Agencies on Aging; Department of Human Services, Division of Aging Services; and insurance companies and related organizations (e.g., State Farm, AAA). DPH additionally works with and supports the Georgia Strategic Highway Safety Plan by leading the Older drivers, Occupant Protection, and Risk Analysis and Evaluation task teams. The CODES data group is the Risk Analysis and Evaluation team that provides data support to the various State Highway Safety Plan (SHSP) emphasis task teams.

Interpersonal Violence

Interpersonal violence is the intentional use of physical, sexual, emotional, economic, or psychological actions or threats that may or may not result in injury or death.

More than 25% of Georgians report experiencing interpersonal violence, 1 in 3 women report abuse or domestic violence and 1 in 4 men report sexual violence by an intimate partner.[10] One in 3 teens report experiencing some form of dating violence, and teens who experience sexual abuse or domestic violence are more likely to attempt, or succeed in, suicide. [10] Experiencing interpersonal violence is a risk factor for later family-related

homicide and suicide. The situation is stark for Black/African American females, who are victims of homicide at twice the rate of white females.[11] Interpersonal violence puts a significant burden on Georgia's healthcare system, in both medical and mental-health interventions and treatment, with violence against the vulnerable populations of children, seniors, and low-income households driving up costs to Medicaid and Medicare. [12]

DPH and partners have been able to make inroads in addressing interpersonal violence thanks to improved data collection and analysis across State agencies. Adverse Childhood Experiences (ACEs) data is showing the link between early violence and later exposure to violence in adulthood, which shapes how, when, and where prevention efforts can be targeted. DPH promotes Trauma-Informed Care models and Cognitive Behavioral Therapy for survivors, as well as increased screening for interpersonal violence by physicians.

Child Abuse and Neglect

In the United States, Georgia ranks 39th for child wellbeing.[13] An estimated 1 in 10 children will experience sexual abuse before their 18th birthday.[14] The total direct costs of childhood maltreatment in a victim's lifetime is estimated to be at least $226,000. In 2017, 122,752 maltreatment reports were received by Child Protective Services in Georgia, with 72% of reports having enough information to be "screened in," representing 207,982 children. Of this number, the reports of 10,487 children were substantiated, and 97 children died as a result of abuse and neglect.[15] Children who experience child maltreatment such as physical abuse or neglect earlier in their lives are at greater risk for committing violence against peers, bullying, teen dating violence, and committing child abuse, elder abuse, intimate partner violence, and sexual violence later in life.[16]

DPH is a statewide leader in the effort to foster and support safe, stable, and nurturing relationships and environments for children in Georgia. Efforts include awareness around ACEs, supporting Court Appointed Special Advocate (CASA) programs, Home Visiting, and other family- and parent-engagement programs, a focus on trauma-focused therapies, and promoting professional-practice reforms (e.g., pediatrician training programs). DPH participates in networks and

initiatives like Strengthening Families Georgia, Georgia Essentials for Childhood (one of three backbone organizations for this collective-impact initiative), the Prevent Child Abuse Georgia Network, and the Georgia Family Connection Partnership Network.

Safe Infant Sleep

Each year in the U.S., more than 3,500 infants, without a prior known illness or injury, die suddenly and unexpectedly. In 2017, Georgia experienced 167 infant sleep-related deaths, which averaged to more than three infant deaths per week due to sleep-related causes such as suffocation and strangulation in bed, entrapment, and SIDS.[17] Georgia has one of the highest infant mortality rates in the country.[18] Sleep-related infant deaths occur suddenly, but parents and caregivers can reduce the risk of these tragic deaths by following evidence-based recommendations.[19]

The goal of Georgia's Safe to Sleep initiative is to provide tools and resources that strengthen policy, provide consistent education and change infant sleep environments to: prevent infant sleep-related deaths in Georgia; empower professionals to educate parents; empower families to make informed decisions about infant sleep; increase access to resources that support behaviors that protect infants from sleep-related deaths; and promote the ABCs of Safe Sleep and other recommendations of the American of Academy of Pediatrics.

Suicide

The risk of suicide persists across the life span, with significant lasting effects on families and communities. Additionally, victims of adverse childhood experiences such as child maltreatment, physical and sexual abuse and exposure to violence and substance abuse are at higher risk of suicide.[20] While rates of suicide across the whole population tend to peak in middle age, males experience much higher rates of suicide after age 65. Across all ages, rates of suicides for males are about twice those for females. Suicide also has a regional dimension in Georgia, with suicide as the leading cause of injury-related death in the northeastern and coastal regions of the state.[6]

There has been an upward trend in suicide among Georgians 10–17 years of age between 2008 and 2017. In 2017 alone, there were 58 suicides age 10–17 in Georgia, resulting in 3,439 years of potential life lost. Suicide rates for Georgians 10–17 years of age were 2.4 times higher in 2017 than in 2008 (5.0 vs 2.1 per 100,000 population).[9] From 2012 to 2018, the number of students

who reported considering suicide increased by 63% and the number of students who reported attempting suicide increased by 41%.[21] Moreover, from 2013 to 2017, there were 64.6 ER visits and 32.8 hospitalizations for intentional self-harm for every 100,000 Georgians. Females experience higher rates of intentional self-harm related hospitalization, particularly as teenagers and throughout middle age. Self-harm related hospitalization rates tend to decline later in life.[9]

Suicide prevention is a priority of numerous organizations and agencies, and DPH works closely with them. The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) has expanded its suicide-prevention programs and supports increased numbers of mental-health providers in schools. Voices for Georgia's Children maintains suicide prevention as a priority, especially in the face of upward trends in reported suicidal ideation among young Georgians. The Georgia Alzheimer's and related Dementia Task Force Safety work group has identified suicide prevention as a priority project. Additionally, Governor Kemp signed a bill from the State Legislature to increase funding toward suicide reduction.

Falls

Falls are a leading cause of injury-related ER visits and hospitalizations in Georgia[9], as well as the leading cause of traumatic brain injury in the state.[22] Falls have their greatest impact at the extremes of age (0–4 years old and 65 years of age and older). Georgians 65 years of age or older are disproportionately impacted by falls, suffering worse outcomes than the general population. Georgians 65 years of age or older make up 12.8% of the population and 26% of fall related ER visits, but account for 71.8% of fall related hospitalizations and 80.0% of fatal falls in the state.[22] However, the economic burden is present across all age groups, factoring in direct costs like hospital admissions and stays (such as intensive-care units) and long-term consequences of falls.

Despite the impact of falls on Georgians—personally, socially, and economically—falls are preventable. Georgia has found success in many evidence-based prevention approaches. STEADI (Stopping Elderly Accidents, Deaths, and Injuries) is a CDC initiative focused on the assessment of risk and referral to community-based programming by healthcare providers for their older patients.[23] Declaring that "falls are not an inevitable part of aging," it is part of a broader approach in Georgia to address falls in seniors, combined with community-level outreach to identify and support isolated seniors who are vulnerable to falls.

For young children, DPH and partners have begun looking at the top reasons for falls among children

0-4 so that professionals understand what type of education to provide parents of this high-risk age group. DPH has leveraged broader programs like car-seat and safe-sleep programs – and WIC, Head Start, and Home Visiting in order to broaden the reach of education to the professionals directly serving this population.

Poisoning and Drug Safety

Prescription drugs misuse and drug overdose deaths, including opioids, have become widespread public health problems, impacting families and communities across Georgia. Resembling national trends, there has been an increase of deaths from drug overdose among both men and women, all races, and adults of nearly all ages. While Georgia has a lower rate for all drug overdose deaths (11.9 per 100,000) compared to the U.S. average (14.7 per 100,000), 55 of the 159 counties in the state had higher rates than the U.S. average in 2014.[24]

In 2017, 94% of the 1,466 unintentional poisoning Georgian deaths were drug related overdose deaths.[6] In Georgia, 1,043 are due to opioid overdose.[25] Adults 25–34 years of age are more likely to die due to opioid overdose and be admitted to an emergency room.[25] Adults aged 45–84 were more likely to be hospitalized.[25] Also, adults who have an opioid use disorder were more likely to die by suicide than the general population.[26] Opioid poisoning is an issue across the state but has hit rural Georgia communities particularly hard and hospitalizations and deaths are increasing at a faster rate than most other injury areas.

There are over 300 statewide strategic planning partners partnerships focusing on Georgia's opioid crisis including representatives from more than 50 medical and licensing entities. Among the groups focusing on this issue is the Injury Prevention Research Center at Emory (IPRCE). Additionally, The Opioid and Substance Misuse Response Unit is housed within the Division of Health Protection in the Georgia Department of Public Health. The unit is responsible for leading statewide strategic planning efforts to respond to the opioid epidemic and other emerging substance misuse issues.[27]

Two other examples of efforts to increase drug safety in Georgia are the Georgia Drugs and Narcotics Agency and the Georgia Prescription Drug Abuse Prevention Initiative. The Georgia Drugs and Narcotics Agency was created to ensure and protect the health, safety, and welfare of Georgia citizens by enforcing Georgia laws and rules pertaining to manufactured or compounded drugs and to ensure only licensed facilities or persons dispensed or distributed pharmaceuticals. The Georgia Prescription Drug Abuse Prevention Initiative (GPDAPI) of The Council on Alcohol and

Drugs (The Council) focuses on five priority areas and eleven objectives in order to prevent and reduce prescription drug abuse in Georgia. These four areas have been identified in the Office of National Drug Control Policy's (ONDCP's) Prescription Drug Abuse Prevention Plan.[28]

Traumatic Brain Injury

Traumatic Brain Injury (TBI) is a significant issue that can have a wide range of cognitive, physical, and psychological consequences. Additionally, the impacts of TBI go beyond the individual; there are also substantial community, societal and economic burdens, increased emergency department (ED) visits, hospitalizations, and deaths. In 2016, the Georgia brain and spinal injury registry recorded 27,840 TBI injuries including 20,488 emergency and 7,352 hospital admissions.[29] According to the Brain and Spinal Injury Trust Fund Commission, TBIs cost Georgians over $1.5 billion annually in lost wages and medical costs. Additionally, injuries occurred most frequently among Georgian's birth to age 39 with the largest group being those aged 10-19. This population made up nearly 21% of all registered traumatic brain and or spinal cord injuries that year.[29]

Georgians 65 years of age or older are disproportionately affected by falls - which serve as the leading cause of injury and TBI in the state.[29] In 2016, there were high rates of intentional self-harm and TBI-related deaths (6.6 and 4.7 adjusted rate). It is critical to prevent and minimize TBI among individuals in all stages of life to promote health and wellbeing.[29]

Georgia has engaged in several prevention efforts that include coordination of resources and services across various service providers, agencies, and community organizations. For instance, Georgia's Central Registry was created to develop effective, focused programs to address the community needs of injury survivors. Central Registry data is used to contact each newly injured Georgian with information on available resources, identify trends and educate policymakers and community stakeholders about the incidence of traumatic brain and spinal injuries.[29]

The Brain and Spinal Injury Trust Fund Commission is Georgia's state agency that offers dedicated funding and support for individuals who have sustained a traumatic brain or spinal cord injury. Created by Constitutional amendment, the Commission's mission is to distribute much needed resources to eligible Georgia residents via direct grants for their post-acute care and rehabilitation. The Commission has a wide range of goods and services available for applicants to apply for including home modifications, transportation, medical services and therapies, personal support and respite, vocational training and supports, durable medical equipment, and health and wellness activities.[29]

Nationally, concussion education and management has been implemented through state-specific legislation, and in Georgia, the Return to Play Act (law) was passed in 2013 and became effective January 1, 2014 [GA CODE 20-2-324.1]. The law requires local boards of education, administrations of non-public schools and charter schools to: adopt and implement concussion management and return to play policies; remove from play any player suspected of concussion; obtain clearance from a healthcare provider prior to return to play; and provide information sheets to youth athletes' parents and/or legal guardians. The law also includes provisions for public recreation facilities.

Special Topics:

Alzheimer's Disease and Related Dementia as Risk Factors

Dementia, including Alzheimer's disease, is a public health problem. Georgia's death toll from Alzheimer's disease in 2015 increased by 201 percent since the year 2000, and now exceeds 3,700 people annually. An estimated 150,000 Georgians are living with Alzheimer's, and the number is expected to rise to 190,000 by 2025. Mortality from Alzheimer's has increased nationally as well, but the rate of increase is 123 percent, notably lower than in Georgia.[30]

The increase in the death rate is linked to several factors. The growing proportion of older adults in the country is not the only explanation for the increase in Alzheimer's death rates[30]. Other possible reasons include fewer deaths from other common causes in old age, such as heart disease and stroke; increased diagnosis of Alzheimer's, especially at earlier stages; and increased reporting of Alzheimer's and other types of dementia as a cause of death by physicians and others who fill out death certificates. [30]

Georgia has focused on creating new resources and adopting evidence based approaches to address this disease. Georgia DPH Alzheimer's and related dementia efforts include a media campaign encouraging individuals to 'Think About' possible signs of dementia, including Alzheimer's. The campaign and corresponding fact sheet provide an overview of possible warning signs, ways to reduce risk, and education on early diagnosis. These messages compliment work happening with partners across the aging network.

For instance, five "memory assessment centers" opened in Georgia, located in Augusta, Atlanta, Macon, Columbus, and Albany. Additionally, The Alzheimer's Association Georgia Chapter is the leading volunteer health organization in Alzheimer's disease care - serving 159 counties in Georgia with offices in Atlanta, Augusta, Columbus, Dalton, Macon, Savannah, and Tifton. The chapter provides local support groups, education classes and other local resources.

Georgia Alzheimer's and Related Dementias (GARD) are also a major focus of the Georgia Department of Human Services, Division of Aging (DAS) Services. The GARD Outreach & Partnerships workgroup developed a flyer to promote brain health and the early detection of dementia. The GARD Workforce Development workgroup developed the Competency Guide for Dementia Care: Direct Care Worker Workforce Development. This competency guide aims to help educators and employers of direct care workers (DCW) choose high-quality DCW education and identify strategies to improve work environment in ways that support both learning and quality of care. [31]

Conclusion

Research is revealing that risk and protective factors are shared across multiple forms of violence and injury. The time for states to approach their prevention strategies differently is now. Implementing a shared risk and protective factors approach has the potential to leverage limited resources and valuable partnerships in order to prevent multiple forms of violence and injury. With this plan as a guide, Georgia will create connected, informed, and supportive communities, free from violence and injury.

Appendix I: Georgia Leading Causes of Hospitalizations and Deaths, 2013-2017

Leading Causes of Injury by Hospital Discharges and Deaths, 2013–2017				
State	Outcome	1st Leading Cause	2nd Leading Cause	3rd Leading Cause
Georgia	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Motor Vehicle Crashes	Suicide/ Self-Harm	Poisoning (Including Overdoses)
Public Health District	1st Leading Cause	2nd Leading Cause	2nd Leading Cause	3rd Leading Cause
Northwest (Rome) (1-1)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Poisoning (Including Overdoses)	Motor Vehicle Crashes	Suicide/ Self-Harm
North Georgia (Dalton) (1-2)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Poisoning (Including Overdoses)	Suicide/ Self-Harm	Motor Vehicle Crashes
North (Gainesville) (2)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Suicide/ Self-Harm	Motor Vehicle Crashes	Poisoning (Including Overdoses)
Northwest (Rome) (1-1)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Poisoning (Including Overdoses)	Motor Vehicle Crashes	Suicide/ Self-Harm
Cobb/Douglas (3-1)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Poisoning (Including Overdoses)	Suicide/ Self-Harm	Motor Vehicle Crashes
Fulton (3-2)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Poisoning (Including Overdoses)	Suicide/ Self-Harm	Motor Vehicle Crashes

Leading Causes of Injury by Hospital Discharges and Deaths, 2013–2017

Public Health District	1st Leading Cause	2nd Leading Cause	2nd Leading Cause	3rd Leading Cause
Clayton (Jonesboro) (3-3)	Hospital Discharges	Falls	Motor Vehicle Crashes	Homicide/ Assault
	Deaths	Homicide/ Assault	Motor Vehicle Crashes	Poisoning (Including Overdoses)
East Metro (3-4)	Hospital Discharges	Falls	Motor Vehicle Crashes	Suicide/ Self-Harm
	Deaths	Suicide/ Self-Harm	Motor Vehicle Crashes	Poisoning (Including Overdoses)
DeKalb (3-5)	Hospital Discharges	Falls	Motor Vehicle Crashes	Homicide/ Assault
	Deaths	Homicide/ Assault	Motor Vehicle Crashes	Suicide/ Self-Harm
LaGrange (4)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Motor Vehicle Crashes	Poisoning (Including Overdoses)	Suicide/ Self-Harm
South Central (Dublin) (5-1)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Motor Vehicle Crashes	Suicide/ Self-Harm	Poisoning (Including Overdoses)
North Central (Macon) (5-2)	Hospital Discharges	Falls	Motor Vehicle Crashes	Suicide/ Self-Harm
	Deaths	Motor Vehicle Crashes	Suicide/ Self-Harm	Falls
East Central (Augusta) (6)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Motor Vehicle Crashes	Suicide/ Self-Harm	Poisoning (Including Overdoses)

Leading Causes of Injury by Hospital Discharges and Deaths, 2013–2017

Public Health District	1st Leading Cause	2nd Leading Cause	2nd Leading Cause	3rd Leading Cause
West Central (Columbus) (7)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Motor Vehicle Crashes	Suicide/ Self-Harm	Homicide/Assault
South (Valdosta) (8-1)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Motor Vehicle Crashes	Suicide/ Self-Harm	Falls
Southwest (Albany) (8-2)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Motor Vehicle Crashes	Suicide/ Self-Harm	Homicide/Assault
Coastal (Savannah) (9-1)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Suicide/ Self-Harm	Motor Vehicle Crashes	Poisoning (Including Overdoses)
Southeast (Waycross) (9-2)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Motor Vehicle Crashes	Suicide/ Self-Harm	Poisoning (Including Overdoses)
Northeast (Athens) (10)	Hospital Discharges	Falls	Motor Vehicle Crashes	Poisoning (Including Overdoses)
	Deaths	Suicide/ Self-Harm	Motor Vehicle Crashes	Poisoning (Including Overdoses)

Source: DPH OASIS (https://oasis.state.ga.us/).

Causes were ranked by count of hospital discharges and deaths by residence within each Public Health District. "Suicide" and "self-harm" were defined using the same ICD-10 codes but are differentiated by the severity of outcome. The same is true of "homicide" and "assault." The category of "all other unintentional injury" was excluded due to the inability to separate specific causes.

Appendix II: Acronyms & Abbreviations

AAAs	Area Agencies on Aging
AACG	Alzheimer's Association Georgia Chapter
ARC	Atlanta Regional Commission
ASTHO	Association of State and Territorial Health Officials
CAN	Child Abuse and Neglect
CASA	Court Appointed Special Advocate
CDC	Centers for Disease Control and Prevention
CFR	Child Fatality Review
CHIPP	Children's Injury Prevention Program
CHOA	Children's Healthcare of Atlanta
CJCC	Criminal Justice Coordinating Council
CODES	Crash Outcome Data Evaluation System
Core SVIPP	Core State Violence and Injury Prevention Program
COSP	Child Occupant Safety Project
CPSTs	Child Passenger Safety Technicians
DAS	Georgia Division of Aging Services
DBHDD	Georgia Department of Behavioral Health and Developmental Disabilities
DCW	Direct Care Workers
DDS	Georgia Department of Driver Services
DECAL	Georgia Department of Early Care and Learning
DeKalb PD	DeKalb Police Department
DFCS	Georgia Division of Family and Children Services
DHS	Georgia Department of Human Services
DNR	Georgia Department of Natural Resources
DOJ	Georgia Department of Justice
DPH	Georgia Department of Public Health
EPI	Epidemiology
Essentials:	Georgia Essentials for Childhood
FPC	Falls Prevention Coalition
GAEYC	Georgia Association for the Education of Young Children
GaFCP	Georgia Family Connection Partnership
GARD	Georgia Alzheimer's and Related Dementias
GBI	Georgia Bureau of Investigation
GCADV	Georgia Coalition Against Domestic Violence
GCCA	Georgia Child Care Association
GDOT	Georgia Department of Transportation
GEEARS	Georgia Early Education Alliance for Ready Students
GIPAC	Georgia Injury Prevention Advisory Council
GPDAPI	Georgia Prescription Drug Abuse Prevention Initiative
GOHS	Governor's Office of Highway Safety
GTC	Georgia Trauma Commission
IPRCE	Injury Prevention Research Center at Emory University
IPP	Injury Prevention Program
IPV	Interpersonal violence
MCH	Georgia's Maternal and Child Health Section
MVC	Motor vehicle crash
NAMI	National Alliance on Mental Illness
NCIPC	National Center for Injury Prevention and Control
NHTSA	National Highway Traffic Safety Administration
OCA	Georgia Office of the Child Advocate
OEMS	Georgia Office of Emergency Medical Services
OHIP	Georgia Office of Health Indicators for Planning
ONDCP	Office of National Drug Control Policy
PADV	Partnership Against Domestic Violence

Appendix II: Acronyms & Abbreviations

PCA GA	Prevent Child Abuse Georgia	**STEADI**	Stopping Elderly Accidents, Deaths, and Injuries
SHSP	State Highway Safety Plan	**SUID**	Sudden Unexplained Infant Death
SIDS	Sudden Infant Death Syndrome	**TBI**	Traumatic Brain Injury
SNAP	Supplemental Nutrition Assistance Program	**Voices**	Voices for Georgia's Children
SPAN-GA	Suicide Prevention Action Network – Georgia	**WIC**	Women, Infants and Children Supplemental Nutrition Program
SPLASH	Supervise, Prevention, Life Jacket, Arm's Length, Swim Lessons, Have a Safety Plan		

Appendix II: Definitions

Alzheimer's Disease and Related Dementia:[32]

- Alzheimer's disease is a type of dementia that causes problems with memory, thinking and behavior.
- Dementia is a general term for loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by physical changes in the brain. Alzheimer's Disease is the most common type of dementia, but there are many kinds.

Child Abuse and Neglect: All types of abuse and neglect of a child under the age of 18 by a parent, caregiver or another person in a custodial role that results in harm, potential for harm, or threat of harm to a child; result from the interaction of individual, family, societal, and environmental factors.[33]

Deaths: Includes all numbers and rates pertaining to the place of residence (not occurrence).

Excess Death: The additional or fewer number of deaths, if the Georgia rate was the same as the U.S. rate.

Falls: Defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. Fall-related injuries may be fatal or non-fatal.

Health Equity: The absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification; ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.[34]

Infant Sleep-Related Deaths: Includes SIDS, Suffocation in Bed or Unknown Intent, or unknown for children under 1 year of age.

Intentional injury: Includes violence-related injuries such as child abuse and neglect, interpersonal violence, sexual violence, suicide, and youth violence.[35]

Interpersonal Violence: Intentional use of physical, sexual, emotional, economic, or psychological actions or threats that may or may not result in injury or death; victimization and perpetration occur across the lifespan.

Motor Vehicle Fatalities: People who died on public roadways at least 30 days from the crash.

Promoting Data Informed Decisions: Bringing a high standard of research evidence into the decision-making process while considering contextual and experiential factors that influence decisions.[36]

Protective Factors: Factors that decrease the likelihood that an injury and/or violence will occur, or buffer against/lessen the harmful effects of risk factors.

Risk Factors: Factors that increase the likelihood that an injury and/or violence will occur.

Safe, Stable, Nurturing Relationships and Environments (SSNREs): Factors that are essential to prevent early adversity, including child abuse and neglect, and to assure that all children reach their full potential.[37]

Shared Risk and Protective Factors; The risk and protective factors that have been linked to multiple types of violence and injury outcomes.

Social Determinants of Health (SDOH): Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[38]

Suicide: Includes death caused by injuring oneself with the intent to die. A suicide attempt is when someone harms themselves with the intent to end their life, but they do not die as a result of their actions.

Transportation: Defined as motor vehicle traffic and non-traffic crashes.

Traumatic Brain Injury: Disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head, or penetrating head injury.[39]

Appendix III: Related Internal and External Partner Strategic Plans

1. Resilient Georgia Strategic Map, Resilient Georgia.
2. Georgia Child Abuse and Neglect Prevention Plan.
3. Georgia Domestic Violence Fatality Review Project, 2018 Annual Report.
4. Georgia Suicide Prevention Plan, Georgia Department of Behavioral Health and Developmental Disabilities.
5. Georgia Essentials for Childhood State Action Plan, Georgia Essentials for Childhood Steering Committee.
6. Multi-Stakeholder Opioid and Substance Abuse Response Plan; Georgia, 2018, Georgia Department of Public Health.
7. GA Dept of transportation strategic plan (2018-2021), Georgia Department of Transportation.
8. 2040 Statewide transportation plan/ 2015 Statewide Strategic Transportation plan, Georgia Department of Transportation.
9. GA Strategic Highway Safety Plan (2019-2021), Georgia Governor's Office of Highway Safety.
10. Georgia Highway Safety Plan 2018, Georgia Governor's Office of Highway Safety.
11. State of Georgia STOP Violence Against Women Formula Grant Program: (FFY 2017- FFY 2020) Implementation Plan, Georgia Criminal Justice.

Appendix IV: Participants & Contributors

Anderson, Bianca	DPH Prescription and Drug Monitoring Program
Aszman, Jenny	Georgia Commission on Family Violence
Barnes, Kaitlyn	Barton Child Law and Policy Center at Emory University
Bayakly, Rana	DPH EPI
Benefield, Cheryl	Georgia Department of Education
Black, Chad	Georgia EMS Association
Boy, Angie	Blank Center at CHOA
Brown, Tami	WellCare/National Alliance on Mental Health GA
Chininis, Maria	Gwinnett Medical Center Sports Medicine & Concussion Institute
Christiansen, Jan	Georgia Coalition Against Domestic Violence
Christou, Allison	Wellstar
Covarrubias, Elisa	Live SAFE Resources
Dale, Lindsey	DFCS PCS
Farrell, Deb	CAPTA Panels
Friauf, Nancy	PADV
Fullerton, Elizabeth	National Alliance on Mental Health Georgia
Gilchrist, Julie	Retired CDC
Gooding, Jewell	Mental Health America of Georgia
Goughnour, Haley	Project Safe, Inc.
Griggs, Laura	DHS DFCS
Haarbauer-Krupa, Julie	CDC
Haddon, Mary	Project Safe, Inc.
Harrington, Emma	Shepherd Center Falls
Havens, Paige	Gwinnett Medical Center Sports Medicine & Concussion Institute
Helmly, Victoria	DHS DAS
Hill, Rosalind	DeKalb Board of Health
Hogan, Jennifer	DHS DAS
Hogan, Sandy-Asari	CDC
Hossler, Jennifer	Georgia Center for Child Advocacy
Jackson, Belinda	NHTSA
Jennings, Taylor	PCA GA
Johnson, John	Children's Healthcare of Atlanta
Jones, Paige	DPH Maternal and Child Health
King, Jen	Georgia CASA
King, Pat	DHS DAS
Kroening, Sara	DPH Office of Nursing
Lisco, Claire	PADV
McDonald, Debbie	Douglas County Juvenile Court
McDowell, Naeshia	PCA GA
McGuiness, Sheri	SPAN-GA
McKibben, Ericka	Securus House
Merriweather, Catherine	DPH Prescription and Drug Monitoring Program
Moore, Jasmine	Grady Memorial Hospital
Neighbors, Julia	PCA GA
Newton, David	DPH OEMS
Nieb, Sharon	IPRCE
Rupp, Jonathan	IPRCE
Sawyer, Tiffany	Georgia Center for Child Advocacy
Stadnisky, Megan	DHS DAS
Stein, Jennifer	Family Resource Center of Northeast Georgia
Tait, Kenisha	Brain and Spinal Injury Trust Fund Commission
Tisdale, Walker	DBHDD
Valdez, Cynthia	CJCC
Walsh, Jyll	PCA GA
Wessels, Marcia	Concentric Consulting

DPH IPP Staff

Bolden, Nadira
Browne, Marcellia
Carter, John
Davidson, Steve
Dawson, Lisa
Dolce, Glen
Gibson, Meaghan
Harmon, Jaleiah
Head, Elizabeth
Hudson, Philip
Irvin, Carol
Jackson, Amanda
Johnson, Devon
Jones, Zetta
Kelly, Jim
Kum, Stacey
Lisco, Claire
McKeithan, Alex
Miller, Terri
Mills, Christine
Naim, Iman
Norton, Julia
Nwamuo, Chinyere
Oginga, Maureen
Reece, Traci
Scott, Siarra
Sharper, Cynthia
Smith, Thomas
Yeager, Denise

Advantage Consulting Team

Allers, Chris PhD - Project Lead
George, Mathew
Hassan, Khurram MPH

Appendix V: References

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