

***Vital Signs* Town Hall Teleconference**  
**Motor Vehicle Injury Prevention — United States and 19 Comparison Countries**  
**July 12, 2016**  
**2:00 pm ET**

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode until the question and answer session of today's call. At that time, if you'd like to ask a question please press Star 1. Today's conference is being recorded. If you have any objections you may disconnect at this time.

I would now like to turn the meeting over to Susan Hardman. Thank you and you may begin.

Susan Hardman: Good afternoon. I'm Susan Hardman, the Public Health Associate Program Team Lead for Training and Education in CDC's Office for State, Tribal, Local and Territorial Support. I'm glad you could join us today. We'll be discussing the latest Vital Signs report on motor vehicle injury prevention.

Before we get started, let's go over some housekeeping details. You can go online and download today's PowerPoint presentations so you can follow along with the presenters. The Web address is [www.cdc.gov/stltpublichealth](http://www.cdc.gov/stltpublichealth). Look on the far right side of the page for the Vital Signs Town Hall Teleconferences link, or you can Google CDC Vital Signs Town Hall and click on the top link - that should get you there.

There you can access the bios for today's presenters. On the same Web page, the audio recording of the teleconference and the transcript will be available to you next week. There will be time for questions after today's presentation, but you can get in the queue at any time to ask a question. Just press Star 1 and

say your name when prompted. Now back to our topic for today -- Motor Vehicle Injury Prevention- United States and 19 Comparison Countries.

We're going to hear from three colleagues today. First, we'll hear from Dr. Erin Sauber-Schatz, the Team Lead for Transportation Safety in the Division of Unintentional Injury Prevention in CDC's National Center for Injury Prevention and Control. She'll talk about the findings in this month's Vital Signs report.

Then, Lindsey Myers will present. She directs the Injury and Substance Abuse Prevention Section at the Colorado Department of Public Health and Environment. She will discuss improving Colorado's road health, which takes a look at motor vehicle safety strategies being used there.

Lindsey will then hand the call over to Leah Shahum, founder and Director of Vision Zero network. She will talk about growing the vision for safe mobility.

I now turn the call over to Dr. Sauber-Schatz.

Dr. Erin Sauber-Schatz:

Thank you Susan. As Susan said, I'm Erin Sauber-Schatz, the Team Lead of the Transportation Safety Team at CDC's Injury Center, and today I'll be giving an overview of the Vital Signs report that was released last week, titled Motor Vehicle Injury Prevention, United States and 19 Comparison Countries. This report helps to answer the question - how is the US doing in motor vehicle injury prevention, which is a CDC winnable battle.

If you're following along in your presentation -- that you can download from the Town Hall Web site -- we're now on Slide 5 of the presentation. So to begin with, as background, reducing motor vehicle crash deaths was

previously reported as one of ten great public health achievements of the 20th century. However, despite this success, motor vehicle crashes remain a leading cause of death for Americans aged 1 through 54.

In fact, each year in the United States there are more than 32,000 deaths, more than 2 million non-fatal injuries, and hundreds of millions of dollars spend in direct medical costs due to motor vehicle crashes. For this Vital Signs report, we sought to answer the question of - how does the US compare to other high-income countries for motor vehicle injury prevention? Next slide.

Therefore, the purpose of this study were to describe motor vehicle death data -- for the United States and other high-income countries -- and to report the percentage of death that involved alcohol-impaired driving and speeding, and also to report the national seatbelt use by seating location - meaning specifically front and rear-seat use. Next slide.

So we're now on Slide 7 of the PDF of the presentation. The data sources for this study included the World Health Organization's Global Status Report on Road Safety that was published in 2015. From the Global Status Report, we pulled information on alcohol-impaired driving deaths, reported seatbelt use, and the number of registered vehicles. We also used the International Road Traffic and Accident Database, from which we pulled information on vehicle miles traveled and deaths related to speeding.

With United States data for 2013, we used National Highway Traffic Safety Administration Data, and Canadian data from 2013 were obtained from the Transport Canada National Collision Database. Original data presented in kilometers were converted into miles. Next slide please.

To be included in this study, a country was required to have membership in the Organization of Economic Cooperation and Development or OECD. Also, to meet the World Bank definition for high income - which is gross national income per capita of greater than or equal to \$12,736, have a population of more than 1 million people, and report the annual number of motor vehicle deaths and vehicle miles traveled. In addition, the difference between the country-reported motor vehicle crash death rate and the WHO-estimated rate could not exceed 1 death per 100,000 population. Next slide.

The United States and 19 of the 34 OECD member countries met these inclusion criteria, including 2 countries in the Americas -- namely the US and Canada -- 14 countries in Europe including Austria, Belgium, Denmark, Finland, France, Germany, Ireland, the Netherlands, Norway, Slovenia, Spain, Sweden, Switzerland, and the United Kingdom, 2 countries in Asia -- Israel and Japan -- and 2 in Oceania - Australia and New Zealand. New slide please.

Now I'll get into some of the results of the Vital Signs. Next slide - we're now on Slide 11. This figure shows the motor vehicle crash deaths per 100,000 population in 2000 and 2013, among the 20 countries included in our study. The death rate per 100,000 population is on the Y-axis and the country is on the X-axis, in order of highest to lowest rate in 2013. Rates in 2000 are in light blue and 2013 rates are in dark blue.

From 2000 to 2013, the US motor vehicle death rate decreased 31% - from 14.9 to 10.3 deaths per 100,000 population, whereas the average death rate among all 19 of the comparison countries declined 56% between 2000 and 2013, from 10 deaths per 100,000 to 4.4 deaths per 100,000. Each of the 19 comparison countries had a higher percentage reduction in their motor vehicle crash death rate than did the United States, ranging from 38.3% in Finland to 75.1% in Spain.

In addition, the rate of motor vehicle crashes - crash deaths in the United States in 2013 -- which was 10.3 per 100,000 population -- was more than twice the average rate of the comparison countries in the same year. Next slide please.

Clearly, the United States is larger and more populous than the comparison countries in our study, and has a lower population density than most. Travel behaviors, transportation modes and infrastructure also vary widely among countries. This can account for some of the differences in the motor vehicle crash death rates, so to partially adjust for these differences we also calculated death rates per 100 million vehicle miles traveled, and per 10,000 registered vehicles in each country.

For 100 million vehicle miles traveled, the US had the 5th highest rate at 1.10. The average of the comparison countries was 0.85, and ranged from 0.54 in Sweden to 0.122 in Japan and Spain. When deaths per 10,000 registered vehicles was calculated, the US had the highest rate at 1.24 deaths per 10,000 registered vehicles. The comparison country average was 0.68, and ranged from 0.44 in Finland to 1.04 in Belgium. Next slide.

Shown here on Slide 13 are the countries with the ten highest percentages of crash deaths involving alcohol -- in blue on the left -- or speed - in orange on the right. Alcohol-impaired driving was involved in 31% of US motor vehicle crash deaths. Therefore, the United States tied with New Zealand for the second-highest percentage of motor vehicle crash deaths related to alcohol impairment.

Speeding was involved in 29% of US motor vehicle crash deaths. Thus, the US had the eighth highest percentage of speeding-involved death. With about

a third of deaths in the United States involving an alcohol-impaired driver and/or speed, you can see that these are major risk factors for motor vehicle deaths. Next slide.

Another major risk factor is seatbelt use. From this graphic on Slide 14, you can see that seatbelt use in the front seat was highest in France at 99%. The average percentage for front-seatbelt use -- among the 19 comparison countries -- was 94%. The US use was 87%, and the lowest use was reported by Austria at 86%. 87% might seem relatively high, but the US ranked low -- at 18th -- out of 20 countries reporting these data for this study.

Seatbelt use is even lower in the rear seat, at 78% in the US, putting the US at 13th out of 18 countries reporting rear seatbelt use. Whereas in Germany - you can see rear-seatbelt use was 97%, Austria -- at the low -- with 65%, and the average for the comparison countries was 82.1%. Also of significance is that - of occupants, or drivers and passengers, who died in crashes in 2013 in the United States -- 49% were not buckled up in the US. This shows much room for improvement. Next slide.

So in conclusion - next slide. Progress has been made, but we have more to do. Although substantial progress has been made in reducing the number of motor vehicle crash deaths in the United States -- with a 31% reduction in the US crash death rate from 2000 to 2013 -- 90 people are killed each day in the US and thousands more are injured. This results in hundreds of millions of dollars in direct medical costs each year.

Compared with 19 other high-income countries and the United States, the US had the most motor vehicle crash deaths per 100,000 population and per 10,000 registered vehicles. We had the second-highest percentage of alcohol-impaired driving death, the third-lowest national front-seatbelt use, and the

lowest percentage decline in the rate of crash deaths from 2000 to 2013. Next slide.

We need to focus on what can be achieved -- and has been achieved -- by many other high-income countries. For instance, on Slide 17 you can see that if the United States had the same motor vehicle crash death rates as Belgium -- which was the country with the second-highest death rate -- 12,000 fewer lives would have been lost in 2013, and an estimated \$140 million in direct medical costs would have been averted.

Similarly, if the United States had the same motor vehicle crash death rate as the average in the 19 comparison countries, 18,000 fewer lives would have been lost, and estimated \$210 million in direct medical costs would've been averted in 2013. And finally, if the United States had had the same motor vehicle crash death rate as Sweden -- which was the best-performing country in this study -- we would have had at least 24,000 fewer lives - would have been lost in 2013, and an estimated \$281 million in direct medical costs would have been averted. Next slide.

We're now on Slide 18. So the complexity of improving road safety requires a broad view, and a more universal implementation and enforcement of existing and effective strategies in the United States, as well as system-level changes in vehicle safety and transportation infrastructure. In order to maximize lives saved and injuries prevented in the US, increasing restraint use and reducing alcohol-impaired driving could have the most as well as an immediate impact.

Each year, approximately half of the occupants who die in crashes in the US are unrestrained. Implementing primary enforcement seatbelt laws that cover occupants in all seating positions and requiring the use of car seats and booster seats for motor vehicle passengers through at least age eight could

increase restraint use, prevent injuries and deaths in the United States. If restraint use was at 100% in the United States, an additional 3,000 lives would be saved in a single year.

Several proven prevention strategies could also accelerate progress in the United States for alcohol-impaired driving. These include publicized sobriety checkpoints, ignition interlocks for all convicted offenders, having lower blood-alcohol concentration limits, and maintaining and enforcing the minimum legal US drinking age of 21 years. With about 10,000 people dying each year in alcohol-impaired driving crashes, we have the potential to save many thousands of lives each year by eliminating alcohol-impaired driving.

In addition to effective interventions, there is an approach to road safety that began in Sweden and is gaining traction in the United States called Vision Zero. You will hear more about Vision Zero from Leah Shahum, one of our Town Hall speakers today. Similar to Vision Zero is a national strategy on highway safety called Towards Zero Deaths. Both Vision Zero and Towards Zero Deaths have a vision that seeks to eliminate death and serious injury on our roads, and change our safety culture to a culture that believes no loss of life on the road is acceptable.

Although this was not part of our study, it's important to note that on July 1 the National Highway Traffic Safety Administration -- or NHTSA -- released the estimated number of deaths for the US in 2015. The number was 35,200 deaths. This number is a 7.7% increase over the number of deaths in 2014, and the highest number of deaths since 2008 in the United States. These new numbers put even more emphasis on our need to put effective interventions into work - into place, to save lives and prevent injuries from motor vehicle crashes.

Finally, if you would like to learn more, on Slide 19 I have listed several references, including the Vital Signs report, CDC's Prevention Status Reports, CDC's MV PICCS tool -- which is a calculator for the costs and lives saved and injuries prevented for 14 motor vehicle injury prevention interventions -- state fact sheets that we have on the costs of motor vehicle deaths, restraint use and impaired-driving at the state level, and also information on our tribal road safety work in a Tribal Road Safety Toolkit.

Finally, I would like to acknowledge my coauthors, Dave Ederer, Dr. Anne Dellinger and Dr. Grant Baldwin, as well as David Sleet -- the Associate Director for Science at CDC's Division of Unintentional Injury Prevention -- who's been a leader in transportation safety for decades, and will be retiring later this year -- or as he says moving to part-time -- after a 37-year career in injury prevention.

I'm now going to turn it over to our second Town Hall speaker, Lindsey Myers of the Colorado Department of Public Health and Environment.  
Lindsey?

Lindsey Myers: Thank you Erin, and thanks for asking us to join the Town Hall today.

I'm going to give you a little snapshot of some work that's going on in Colorado relative to motor vehicle safety across the board. So if we start on Slide 22, you'll see just a quick data snapshot of Colorado compared to the US in terms of motor vehicle fatality rate from 2005 to 2014. And as you can see, both have - we have decreased similarly to the nation, though we tend to have slightly lower motor vehicle fatality rates than the nation as a whole. Next slide.

So some of our work to address the burden of motor vehicle injury in Colorado -- both fatalities and our non-fatal injuries -- falls into the following five buckets - and I'm going to very briefly today outline some of our major activities in each of these areas. So first we spend a lot of time -- as many other states do -- building and maintaining partnerships at both the state and the local level to support the implementation of evidence-based programmatic and policy strategies.

We also have a large concentration on our work related to maintaining and monitoring data systems. We do a lot of educating about existing policies - so as an example, the graduated driver's license policy. We provide technical assistance to local communities that are trying to implement programs for motor vehicle safety in their local areas. And we try to educate about best practice policy strategies. Next slide.

So on Slide 24 here - and I know that the logic model there -- as much as we love logic models in public health -- is very hard to read on your slide there. I wanted to demonstrate here because what we've been doing a lot of work -- over the last five years in particular -- is really aligning work plans from various funding sources and across different agencies, so that we're all working in the same direction.

The picture of the logic model on your left is a picture of Colorado's Teen Motor Vehicle Safety logic model, just by way of an example. I'm showing it here to demonstrate how we have, you know, worked with other partners. So in Colorado for the last five years, motor vehicle - teen motor vehicle safety has been a priority of the Maternal and Child Health Program - funded through HRSA - so one of our state priorities, as well as a priority through the core Violence and Injury Prevention Program through CDC.

So Colorado selected motor vehicle safety -- in a broad sense -- as one of our four priorities to address through the base integration funding. And then we also received a special motor vehicle policy component for the last five years at about \$150,000 a year, to really, you know, bolster some of our efforts. And it's really enhanced our capacity to be able to spend the time aligning these different funding sources, and making things kind of make sense. So we made our logic model for MCH -- which is pictured here -- really the same thing as we were using for our CDC funding, etcetera.

We also spent time integrating with other state agencies. So the Colorado Department of Public Health and Environment also partnered closely with the Colorado Department of Transportation and various other state agencies -- like our State Patrol and planning agencies, etcetera -- to develop a Colorado Strategic Highway Safety Plan. From - if those of who are on the call from states are probably familiar and have similar plans in your areas.

It's a requirement through both the Federal Highway Administration and the National Highway Traffic Safety Administration to coordinate and try to get on the same page that really aligns nicely with the work that we're doing. Teen motor vehicle safety is -- again -- a priority area in that plan, and so - even though the language across different plans looks a little differently, we have really aligned our goals, our objective, and some of our measurement around our specific target areas - for teen driving safety as well as other motor vehicle issues, which has, you know, led to a lot of good leveraging of resources and partnerships across the board. Next slide on Slide 24 - 25 - sorry.

We also have been working -- in a different capacity -- with the Department of Transportation. In addition to kind of planning in and aligning work plans, we have a unique relationship in that the Colorado Department of Transportation funds a full-time motor vehicle epidemiologist at the Colorado Department of

Public Health and Environment. This is a relationship that going on about 3, 4 years now and has really been great, because we have been able to have a dedicated person focusing on motor vehicle data housed here at the health department which really informs our programming and allows us easy access to data.

But it also has really helped facilitate partnerships in a broader sense with our Department of Transportation. So one of the things as part of our agreement for housing that position here - we produce (CDOTS) or Colorado Department of Transportation's annual problem identification report, which is a requirement of their funding from the National Highway Traffic Safety Administration.

And so we're able to not only analyze crash data that's made available to us through CDOT and through the Department of Public Safety, but we also use, you know, the fatal analysis reporting system and then bring in our data sets from more, kind of, typical public health data sets -- like hospitalization discharge, emergency department discharge, and death certificate data -- to have a more comprehensive report. So it's really, you know, I think enhanced our ability to take the data to action, and has facilitated a more robust analysis of motor vehicle crashes from different sources. Next slide.

Slide 26 shows a complicated picture -- that I know is also difficult to read -- but I think demonstrates sort of the complexity of the data systems that exist in Colorado, and I know other states are similar. In Colorado, motor vehicle data is housed in five different state agencies and 264 local law enforcement agencies throughout the state. And over the last year Colorado motor vehicle partners have spent a lot of time mapping out all of these different data systems to understand how they relate to each other, where the gaps are, and we've discovered a lot of things.

Many of the data systems are incompatible or using outdated databases. We also have some outdated business practices such as paper data collection at some law enforcement agencies. We don't have a unique identification number, so you know, kind of looking through the lifespan of a crash -- or from someone getting a license all the way to a crash and through the judicial system -- is really hard to track. And there are some jurisdictional issue about who owns what data and how that data is shared.

And so we have really been exploring ways and have developed some very strong partnerships -- on the data side of things -- to try to integrate our crash data systems with EMS, hospitalization, emergency department, as well as judicial and treatment data. And this has become a main priority of our Colorado State Traffic Records Advisory Council -- which is run by our Department of Transportation -- to really kind of focus and figure out how we can do this, and ultimately hopefully lead to a linked, analytic data set that removes identifiers but still allows multiple agencies to analyze the data across the board.

You know, the emphasis for a lot of this work -- I have to be frank -- came from our marijuana legalization here -- for retail marijuana -- because we can't very easily answer the very simple question of - what has the legislation for retail marijuana done in terms of impacting motor vehicle fatalities or impaired driving in the general sense due to marijuana, because we can't separate out marijuana and alcohol-related crashes easily in our data. So you know, we're taking advantage of the momentum -- that exists in our state to understand this issue -- to do some data work. Next slide.

On Slide 27, you know, we're doing some other projects. Our data system -- that's housed at the Department of Revenue for our driver's license system -- is

being updated. We're updating our accident-reporting form to help differentiate some of the codes related to alcohol-and-drug DUIs, and really just focusing on how we can do better data-sharing across the agencies. Next slide.

On Slide 28 - another big focus of our TA - or of our work is TA to local communities. So through the Colorado Department of Public Health, we don't have a lot of funding that's going out to local communities as grantees to do work at the local level, but our Department of Transportation does. They fund between 40 to 60 grantees a year using National Traffic Highway Safety Administration funds.

And we -- as part of our work in collaboration with CDOT through the position that they house here, as well as our work through our Core Violence and Injury Prevention grant through CDC -- have worked with them to do a number of things in terms of enhancing their grant-making project.

This picture here on this slide is just demonstrating, you know, trying to come up with an action plan that our Department of Transportation can use with their grantees. We're working to strengthen their evaluation and, you know, our partners at Department of Transportation are a little less familiar with smart objectives and things like that, though they're on board with using them. So we've had a lot of good work together with local communities trying to strengthen both CDOTs grant-making process as well as the applications that come in to the Department of Transportation for funding. Next slide.

Slide 29 - just to touch on policies - we do a lot of work around educating about existing policies, such as graduated driver's licensing. And just by way of example, we coordinate the Colorado Teen Driving Alliance which has existed since 2005 when our most recent version of the graduated driver's

license law went into place. And since then we've seen really great reductions in teen motor vehicle fatalities - they've decreased by 69%.

So you know, the work of this group and really kind of educating law enforcement and parents and teens and the general public about these laws have been a big focus of our work, but we know we have a long way to go. The CDC's most recent prevention status report on motor vehicle issues, you know, was a really great tool for us - to show us where our Colorado laws are not aligned with best practice.

Our booster seat law only covers up to age 7, so there's some room for improvement there. Portions of our graduated driver's license law is, you know, not in line with best practice. And then we also don't have a primary seatbelt law in Colorado, and that's an issue that we've been working on for a long time.

On Slide 30 I just wanted to highlight - a recent policy that was enacted in Colorado is the felony DUI bill. This bill passed just in our most recent - our 2015 legislative session and just went into effect about a year ago. This was a big win for people in Colorado that have been working on this type of bill for a long time.

The legislation failed previously five times in other legislative sessions. And the law basically says that it's a felony - a felony occurs if you're pulled over for a DUI or a DWAI more than three times - three or more convictions. This also includes alcohol and drugs, which is important for us in Colorado given our concentration on looking at drug-impaired data as well.

And then lastly on Slide 31 - I just wanted to give a snapshot of where future efforts are aligned. Colorado has recently formed a new seatbelt task force

that is really looking at our unrestrained fatalities and unrestrained injuries and trying to work on messaging a little bit better around this issue. We've had -- as a state -- the primary seatbelt legislation introduced eight times, and it has failed by just a couple of votes each time.

And it's been awhile since there's been legislation introduced, but we feel the need to kind of get our partners kind of reengaged in the issue - and reframing the issue as a public health issue versus just a safety issue. And so we've been working in collaboration with lots of partners on how to use our data better and how to communicate it better to various partners - and our local grantees that we work with, so that they are - have the kind of reframed messages to use.

And we also think that it is likely that our Colorado Department of Transportation and Colorado State Patrol will put primary seatbelt legislation on their legislative agendas for the 2017 session. So we'll wait to see how that turns out, but there is talk of that now.

So I know that was super fast, and I apologize for having to speed through it, but we've got lots of great things going on in Colorado, and also a lot of room for improvement but I feel like our partnerships really help us, you know, get to where we need to go. And I'm looking forward to continuing our work.

So now I'm going to introduce the next speaker - Leah Shahum, the founder and Director of Vision Zero. Leah?

Leah Shahum: Hi. Thanks so much Lindsey and thanks Erin before that. Yes - my name is Leah Shahum, and I represent a new organization -- we are a non-profit -- called the Vision Zero Network. Real briefly, we've been around just a year - and really in response to the growing interest and momentum around Vision

Zero which I'm going to share more about. I do want to mention that our non-profit has generous funding from Kaiser Permanente - so really to emphasize the public-health basis of our founding.

First - what is Vision Zero? Let me just clearly state. It is a goal that was started in Sweden less than 20 years ago - it was about 18 years ago so still a relatively new concept. And what it is -- sounds very basic -- it is setting and reaching the goal of zero traffic fatalities and severe injuries among all road users - that's people walking, bicycling, driving, on the bus. So it sounds like a very simple concept and I'm going to share a little bit more about what it is. So next slide, which is 34.

What you'll see here is a map. This is showing -- in green - the dots show -- the 18 US cities that have committed to a Vision Zero goal. And what I mean by that is that their highest elected official -- usually a mayor in the case of these cities -- has said, "We are going to reach zero traffic fatalities and severe injuries by a certain date." Many of them have set them out in about 10, 12, sometimes 15 years - but quite -- I'd say -- aggressive and relatively near-term dates, which is a real mind-shift and I'll talk more about that. The yellow triangles are showing cities considering Vision Zero - and I'm sure there's more than that.

I do want to empathize that our work at the network -- at way point -- is focusing more at the local level. That is not to discount the great work happening -- and more needed to happen at state levels and of course at the federal level -- but what we are seeing is tremendous momentum at the local level. That's both from political leaders, and agency directors and leaders, as well as community folks.

I want to give credit to New York City that really started this just 2 1/2 years ago. So since New York started -- or committed -- to Vision Zero just 2 1/2 years ago, we're already up to 18 US cities that have made this commitment. Next slide is Number 35.

These are just laying out some of the key principles of Vision Zero, and I'm going to quickly go through these. I was to emphasize this is really highlighting simply - how does Vision Zero differ as a concept from traditional traffic safety approaches? Because obviously traffic safety is not a new priority. It's not a new goal - we've always cared about this. But what does Vision Zero bring to the table that is different?

And here's what I'd say. Number 1 - it acknowledges that traffic losses are preventable. And I want to really thank CDC for calling this a winnable battle. Frankly, that's not what I would say most people think - particularly outside of the public-health field. There's a sense of inevitability around traffic deaths and traffic violence. It's as if this is an unfortunate but, you know, irresistible kind of cost - or unavoidable cost of doing business. And we're saying is, "No. That's not the case. These losses are preventable."

Number 2 - Vision Zero takes a systems approach to prevention. So I'll talk a little bit more about how this is really trying to help build traffic safety up as a public health challenge that needs public health solutions. Number 3 - Vision Zero is very much data driven. And kudos to Colorado. Thank you Lindsey for giving so many examples of how that state is using data in a more -- I think -- focused and effective way than probably many have traditionally done that.

Vision Zero is about all road users. This isn't just a pedestrian movement, or isn't just drivers -- it's everyone. So really moving out of those silos I think

we've been in a little bit too much - particularly at the local level around advocacy.

Vision Zero engages diverse critical stakeholders. I really want to highlight the public-health field here -- given this audience -- but it's really the case in so many cities I'm talking with. What I'm hearing is, "We've always known the public health community has a role to play -- not only in data collection and analysis etcetera -- but of course also in framing the issue, and bringing that health-in-all-policies lens to this public health issue. But frankly, public-health hasn't had a seat at the table as strongly or as fully as it should." I'm hearing that over and over again.

So part of what Vision Zero is doing is -- I think -- helping in that case bring more diverse stakeholders and needed stakeholders to the table and then bringing new urgency. I really want to highlight that, you know, sometimes a catchy slogan can grab people's attention. We've got to do what we can with that, and that's partly what we're doing here. But Vision Zero is about much more than a catchy slogan. Next I'm going to - next slide please - Number 36.

Just highlighting this - if there's maybe one take away I'd ask from everyone on this call is thinking about your language. Back to that idea that traffic - severe traffic losses are preventable - even changing our language around this matter is important. And I really appreciate that the people on the call have been calling them crashes or collisions or incidences or, you know, fatalities -- rather than accidents.

And I think that's something in just kind of the common lexicon -- for whatever reason - historically, here in our country and elsewhere -- we've called these traffic accidents, when in fact most are not accidents. There is

some behavior or environmental condition or policy that could have changed that. Perhaps there would be a crash, but not as severe.

So even thinking about our language here, I want to highlight that a lot of advocates are really working on trying to officially change this lexicon - so whether that's, you know, the mayor, or the police chief, or the media. I'll highlight that the AP -- the Associated Press nationally -- has recommended a change from traffic accident to crash. That's not insignificant because what this is showing is that we do have agency. We do have control, whether that's us as individuals -- in the choices we make and in our behavior -- but also as institutions as government - as society. Next slide - Number 37.

Moving into that - I'm sure many of you from the public-health field are very familiar with this image - the spectrum of prevention. This is not something historically we've looked at a lot around the range of traffic safety. I would say -- again - historically - not trying to brush with too broad a stroke -- but historically we have spent a lot of time on this - those lower items - of strengthening individual skills and knowledge, providing community education - we've spent a lot of time going out and telling people, "Don't drink and drive. Don't do this. Do this."

Around the individual behavior change - that it's still important and that is still needed. What I would say -- from a Vision Zero perspective -- that we have underemphasized and need to bump up in a more upstream approach of these higher items or top items of influencing policy and legislation, changing organizational practices - so really thinking about how do we move beyond the individual behavior question and focus more on the societal organizational policy-level questions. Next slide - Number 38.

To me, the best example of this is to bring more attention to the importance of speed -- and managing speed for safety. I really want to thank the CDC -- in their Vital Signs report just released -- that they have really empathized speed as obviously one of the major primary risk factors in severe injuries and death.

And this image -- if you're not familiar with it - pretty self-explanatory -- if someone is walking and is hit by a vehicle moving at 20 mph we have a 90% chance of survival. At just double that speed -- or a car moving at 40 mph -- our odds flip dramatically and we now have only a 1 in 10 chance of survival. This is dramatic.

So I really want to emphasize - Vision Zero is not claiming that we can reach zero crashes. This is not about crash prevention. It is about injury prevention and we do have more control over that. People will still make mistakes. There will be lights or sun in someone's eyes, and crashes will happen. But with the right policies -- with the right street design, with the right education and enforcement priorities -- we can lower the severity of the injuries happening in those crashes. And I just want to highlight the speed is one of the most important ways.

And I would say that, you know, this is where we know evidence supports the fact that certain policies -- such as lower speed limits - such as automated speed enforcement - such as our certain design solutions - such as separating out car - vehicles moving at a faster speed than, say, people walking or bicycling at a lower speed -- these are proven, evidence-based solutions to lowering injury levels and rates.

These are not unknowns, yet we do not -- at this point - I would across the country -- have the kind of political and policy leadership on these issues that we need. So I'll just highlight that. That's one of our big takeaways at Vision

Zero - is - how do we build up support for speed management? Next slide is Number 39.

And kind of stepping back to the data picture. This is just one city's example. This is San Francisco, California - where I live. And we were the second city to commit to Vision Zero about two years ago. And what this is showing is that 70% of injury crashes -- this should say injury crashes -- are actually happening on 12% of streets. It's a relatively small number of streets for a big number of injuries.

What we're seeing -- in major city after major city that - where we're analyzing data -- is that this is a common theme - that there is a disproportionate number of severe injury crashes happening on a relatively small number of streets. Now it's disconcerting in some ways, but it's actually helpful in other ways because we know where we need to emphasize our energy, in terms of resources - that's redesigning streets - that's education - that's policies like lowering speed limits and better enforcing speed, etcetera. So this is very manageable and we need to follow that data. Next slide is Number 40.

I also want to highlight some trends that the data is showing us. Really troubling - probably not surprising to many of you - especially in the public-health field. But what this is showing is -- not surprising -- but traffic safety - traffic injuries have a disproportionate negative impact on low-income communities. This slide is specifically showing where the big red dots are -- the bigger - the greater the problem -- but where a red dots are - are showing where there's the heaviest disproportionate impact on low-income communities.

I'll highlight here that I don't have a slide for this. We also know traffic injuries have a disproportionate impact on people of color, on children, and on seniors, and on people with disabilities. And so Vision Zero is very much aiming to bring an equity lens to this work of traffic safety. And I wish I could spend more time there but - going to move quickly. On to the next item - Number 41.

Too much to read here, but I'll use this as a teaser to please come check out our Web site. This is showing the nine components of a strong Vision Zero commitment at the local level, but I would say this absolutely has crossover to state and other efforts - regional efforts, etcetera. What I'm really sharing here is that Vision Zero is not about a very specific toolbox. It's not about, "Oh - if you do exactly this, you know, width of a street, and this exact speed."

Obviously there are best practices around that. People smarter than me have been working on this for a long time. What Vision Zero is bringing is more of an approach and -- I would say -- a philosophy and a multidisciplinary approach. You'll see here - some of the leadership aspects around leadership, equity, collaboration, using data, transparency - engaging the community. Vision Zero is much more about how are we going to prioritize traffic safety. And I would say -- very much again -- bringing that public-health lens - that health-in-all-policies lens. Next slide.

This is just one example. One city -- Boston -- who has committed to Vision Zero. And this is showing you the diversity of city stakeholders in it on its Vision Zero task force. So again - really thinking about how to move out of our unintentional silos of, "Oh - this is a Transportation Department problem. Oh - this is purely a police enforcement problem." Absolutely not. This includes the public-health field. This includes senior services and emergency medical services. How do we all set the exact same and measurable goal --

that goal of zero -- and really work toward the measure of that together? Next slide is second to last - Number 43.

You know, I realize that sometimes I just have too many slides of numbers and graphs and data to really want to bring it home with people. Vision Zero - - like all of our work around traffic safety -- is about keeping people safe - making sure that people have equitable, safe, healthy options to move about their communities. And that we know that at 90 people per day -- roughly -- dying in this country - just moving around to school, to work, to the playground -- that's too many, and we obviously need to bring great urgency to this.

And final slide - is my contact information. Please check us out. Again - we're a non-profit, and we're eager to help communities think about whether they're interested in a Vision Zero commitment and how to do that meaningfully. So I will stop there. Thanks so much for this opportunity.

Susan Hardman: I want to thank the speakers for their excellent presentations today. Remember you can get in the queue to ask a question or make a comment by pressing Star 1. Say your name when prompted the operator will announce you when it's your turn. Please address your question to a specific presenter, or indicate that it's a question for all the presenters.

I encourage you to take advantage of this opportunity to share your strategy - lessons learned, challenges, and success stories. You can pose questions to our presenters or to each other. We have quite a few states and organizations on the call. This is a forum for you all to discuss, collaborate and question different methods, practices and experiences with motor vehicle injury prevention.

Operator - we are ready for questions. Is there anyone in the queue?

Coordinator: Not at this time. I'd like to remind all participants, if you have a question please press Star 1.

Susan Hardman: Well to get us started, I have a question for Dr. Erin Sauber-Schatz. Other than the overall death rate, how else does the US stand out?

Dr. Erin Sauber-Schatz: Right. So in addition to the death rates, the United States also had a high percentage of alcohol-impaired driving crashes compared with the other countries, as well as low front and rear seatbelt use. So those were really some of the areas that we have known effective interventions for -- that can be put into place -- to help really bring us up to par with some of the other countries.

Susan Hardman: Thank you. So something that's always been troubling for folks working in the field is - the seatbelt use is fairly high in the US. Do you have some strategies in how we can increase use in that hard-to-reach population?

Dr. Erin Sauber-Schatz: Sure. So overall - so the 87% and the 78% for front and rear seatbelt use - that's observed seatbelt use. So those are really the surveys that National Highway Traffic Safety Administration does standing at controlled intersections and recording seatbelt use. But if you look among the deaths, that's when we see that only see that half of the people who die in crashes are restrained.

And so it's really learning more about the people. So for instance, we know that young adults - teens and young adults have the highest percentage of non-restraint use in death - and so really trying to target those groups to get them to increase their seatbelt use.

Susan Hardman: Thank you. And Operator - I see we have some questions in the queue?

Coordinator: Yes. Our first question is from Bill Lynch. Your line is open.

Bill Lynch: This question is for Lindsey Myers. Lindsey - I'm familiar with information from your Impact Report from the Department of Public Health in Colorado -- with regards to increased incidence with regards to traffic fatalities and injuries from marijuana. Can you elaborate on how that's being tracked in Colorado to share with the country?

Lindsey Myers: Well, to be honest I think it's a really trippy - tricky question to answer, and I think we don't yet have our data systems set up to be able to track it fully. And so we are collaborating across multiple state agencies and -- as I mentioned -- really trying to get both the reporting systems, where law enforcement pulls over - an officer as well as on the toxicology side. One of the issues is that the, you know, the toxicology information is separate from the crash record.

And so we're trying to figure out how to link those things together so that we can better share that information with the rest of the country. I think that, you know, we've got some law enforcement agencies that are tracking that information on their own and sharing it. But, you know, it's a complex issue. And without a per-say law and with some nuances related to, you know, how the body metabolizes marijuana, etcetera - it makes it a really complicated issue.

So you know, our intent is certainly to share that information as it becomes available. We have an entire marijuana team and impaired-driving task force that's focused on this issue and trying to use the data to the best of our ability to answer that exact question. But I think it's premature to tell just yet honestly.

(Bill Lynch): Thank you.

Coordinator: Next question is from (Ornice Simon). Your line is now open.

(Ornice Simon): Good afternoon and thank you all for the presentation. I was wondering in the campaigns and interventions - is there more of an emphasis on the behaviors that are causing the crashes themselves or on the survival of individuals in crashes? And would there be -- if you have to emphasize one or focus on one or the other -- do you recommend making any decisions about that?

Dr. Erin Sauber-Schatz: Right. So this is Erin. I can start with -- Erin from CDC -- I'll start with an answer for that. So for CDC, we really focus on the behavioral aspects of the crash versus the infrastructure or the environment or the specific vehicle. And so we know that if we can increase safe-driving behaviors -- as well as prevention efforts -- that we can prevent crashes as well as reduce injuries and death.

So our main focus is preventing crashes in the first place. And then, if and when crashes happen, by having somebody restrained you reduce your risk of dying in a crash by half. So it's a little bit of everything. You know, it's primary prevention -- preventing the crash from happening in the first place -- and secondary prevention - from if the crash happens to try to reduce the injury and the death from that crash. I don't know if others want to talk about it.

Leah Shahum: Yes. This is Leah with the Vision Zero network. And thanks for asking that question. I would say part of the emphasis that Vision Zero recommends is a greater emphasis on the environment -- the built environment -- and on the systems and policies in place. Again - that doesn't mean that we should

dismiss and not spend time and attention on influencing individual behavior, but basically that we should be moving upstream -- frankly -- more aggressively - more pointedly around the factors -- literally the environment and the policies -- that influence people's decision-making.

So, you know, obviously a great example is our seatbelt laws. That has had a huge influence. How do we do that in many other ways, and I mentioned a lot in the speed management piece. I would say - well, maybe another example is drunk driving. Obviously - huge change in thinking -- culturally - societally -- around drunk driving. Still a problem - but if you go back and look -- you know, change-wise -- 40 or 50 years ago - huge difference - or even more recently.

So you know, we would look and say, "Okay. How do we bring a similar emphasis -- from, say, governmental and community resources and kind of community taboos -- to speeding?" And we would do that not just by telling people not to speed, because that's frankly not going to be enough. It is bringing more of the policy and street design framework. So how do we redesign our streets to encourage a certain speed that is safer, and set policies, and use -- I would say particularly -- technology - automated speed enforcement more actively to discourage speeding.

So yes - just more of an upstream approach on that. Thanks.

(Ornice Simon): Thank you.

Susan Hardman: So again - I want to thank the speakers today. And thank you for your questions - those of you who called in. Before we close - please let us know how we can improve these teleconferences. Email your suggestions to

ostltsfeedback@cdc.gov. That's O-S-T-L-T-S feedback -- all one word --  
@cdc.gov.

We hope you'll be able to join us for next month's town hall, on Tuesday  
August 30, when we focus on Sepsis, the body's overwhelming and life-  
threatening response to an infection.

Thank you to our presenters and everyone who attended the call. I'd like to ask  
our presenters to please remain on the line, and I'll turn this back over to the  
operator.

Coordinator: This now concludes today's conference. All lines may disconnect at this time.  
Thank you.

END