

2010 Forging New Frontiers: “Making Communities Safe for Children and Their Families”







The 15th Annual Conference of the Injury Free Coalition for Kids jointly sponsored with
Cincinnati Children’s Hospital Medical Center
November 12 - 14, 2010



This year’s conference is jointly sponsored by the Injury Free Coalition for Kids® and Cincinnati Children’s Hospital Medical Center. The main support for this conference is conference registration fees and additional support from Little Tikes, SofSurfaces and the Allstate Foundation. For fifteen years, members of the Injury Free Coalition for Kids, located in Level I Trauma Centers, have met to collaboratively address ways to prevent injuries in communities across the country. Forging New Frontiers, the annual conference of Injury Free Coalition for Kids®, is a valuable meeting to foster collaborative research, develop best practices and address challenges in the field of injury prevention and epidemiology. This year, for the first time, the Conference will be opened to all who are interested in the development of best practices in the field of injury prevention.

The attendees are principal investigators (physicians), program coordinators (nurses, health educators, social workers, community leaders and researchers). The conference is designed to focus on ways to build best practice injury prevention programs that have sustainability and longevity. It examines resources for effective interventions and programs. Some specific areas to be explored include: Intentional and Unintentional Violence Prevention; Safe Teen Driving, Disaster Preparedness, Sports and Recreational Injury Prevention, and Child Passenger Safety Initiatives. Those in attendance will experience and explore intervention techniques, learn about the most current injury prevention research, and share the latest advocacy efforts.

The objectives of the 2010 Annual Conference are to provide participants with an opportunity to:

-  Learn about designing, planning and building healthy communities.
-  Share and explore challenges and successes in community-based injury prevention programming with a goal of helping other institutions develop and improve injury prevention programs.
-  Share information on innovative injury prevention programs promoting best practices.
-  Describe how institutions, particularly trauma systems can develop and evaluate community-based injury prevention programs.
-  Identify opportunities for cross site projects and research as well as opportunities to learn more about translating research into practice in minority and resource-limited communities.
-  Provides Injury Free members with the opportunity to revitalize their spirit, creative energies and stamina in order to continue to innovate and sustain healthy communities.

Accreditation Statement

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of Cincinnati Children’s Hospital Medical Center and The Injury Free Coalition for Kids. Cincinnati Children’s is accredited by the ACCME to provide continuing medical education for physicians.

Cincinnati Children’s designates this educational activity for a maximum of 12.0 (Saturday-6.5; Sunday-5.5) *AMA PRA Category 1 Credit(s)*™. Physicians should only claim credit commensurate with the extent of their participation in the activity

Disclosure Statement

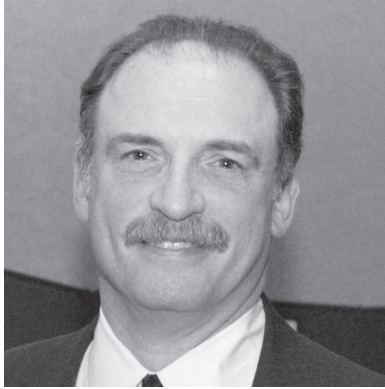
Cincinnati Children’s requires all clinical recommendations to be based on evidence that is accepted within the profession of medicine and all scientific research referred to, reported or used in support of or justification of patient care recommendations conform to the generally accepted standards of experimental design, data collection and analysis. All faculty will be required to complete a financial disclosure statement prior to the conference and to disclose to the audience any significant financial interest and/or other relationship with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in his/her presentation and/or commercial contributor(s) of this activity.

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Dear Conference Participants,

As President of the Injury Free Coalition for Kids I welcome you to our annual conference, Forging New Frontiers: “Making Communities Safe for Children and Their Families.” This year we are celebrating 15 years of coming together to address the issue of childhood injuries, the number one killer and cause of hospitalization of young people.

Each conference has presented a wonderful opportunity to network and exchange information about ground breaking studies, the latest intervention techniques, best practices and lessons learned. The conference this year will be no different. For the first time, we will have invited panels: one addressing violence prevention, and another that examines disaster preparedness. In addition, from a record number of submissions, we’ve selected 20 abstracts on some of the most significant injury prevention topics for presentation. I am certain that many of these are among the best we’ve ever had. I truly believe that some of the biggest contributions in the field of injury prevention begin at Injury Free Conferences.

Sponsors like Little Tikes, SofSurfaces, and the Allstate Foundation are to be commended for making these learning experiences possible. We must also acknowledge hospitals and institutions that have supported Injury Free with institutional dues. They too have helped to make this conference happen.

Serving as the first President of the Board of Injury Free has been not only an honor but a pleasure. Our newly formed board has been active and innovative, and very supportive. This year during our business meeting, I will be turning the reigns over into the very capable hands of Barbara Gaines, MD. I am confident that she will continue the growth and development that we worked to advance.

I would like to give special thanks to Joseph J. Tepas, MD, who has supported and fostered the publication of our conference proceedings in a Journal of Trauma Supplement for the last four years. This year could prove to be one of the finest supplements to date. You will understand what I mean as you listen to the presentations.

Enjoy the conference.

Sincerely,

Michael P. Hirsh, MD
UMASS Memorial Children’s Medical Center Surgeon-in-Chief
Injury Free Coalition for Kids Board President
Professor of Surgery and Pediatrics UMASS Medical School
Chief, Division of Pediatric Surgery and Trauma (UMMCMC)
UMASS Memorial Health Care System
Injury Free Coalition for Kids of Worcester Co-Principal Investigator



Dear Conference Attendees,

Welcome to the 15th Annual Forging New Frontiers conference of the Injury Free Coalition for Kids. This year's conference promises to be the best in the history of our organization. We've opened the submission of abstracts beyond members of the Coalition and we've had the largest number of submissions in organization's history. In addition, we've got the country's premier experts available to address two major threats to children: violence and disaster preparedness. We will also take a look at issues that continue to plague our young people: Teen Driving, Home Safety, Pedestrian Safety and Safety at Play.

Our 15th Annual Conference couldn't have come a moment too soon. Our country is at a critical juncture when it comes to the prevention of childhood injury. A number of health related issues have surpassed injury prevention when it comes to obtaining the funding and attention necessary to address the state of our children's health and wellbeing; however, injury remains the number one cause of hospitalization and death. We must stay focused and grounded in our effort to make a difference.

Please enjoy yourself, network with all of the health care professionals and community leaders here, and take away all that you can as you return to your communities across the country. Your work is critical when it comes to the future of our children.

Sincerely,

Barbara Barlow, MD
Professor Emerita of Surgery in Epidemiology
at the Columbia University School of Public Health
Injury Free Coalition for Kids Founder & Executive Director



Carden Johnston, MD
American Academy of Pediatrics
Violence Prevention Sub-committee Chair
Past President, American Academy of Pediatrics
University of Alabama at Birmingham
School of Medicine
Professor Emeritus Pediatrics
2010 Keynote Speaker

Dr. Carden Johnston, a Past-President of the American Academy of Pediatrics, (2003-04) created the Pediatric Emergency Medicine Division in the Department of Pediatrics, UAB School of Medicine where he enjoys the title of Professor Emeritus. He has served as chair of the Section of Emergency Medicine on the AAP and the Advanced Pediatric Life Support Task Force.

Experiences in lay education include the creation of health information videos for the news, called KidCheck, which ran weekly for ten years networked to up to 50 NBC stations. As prevention is his passion, these 600 short videos emphasize intentional and unintentional injury prevention, also they help parents recognize serious disease early, in order to recognize and manage common problems at home, and to make appropriate decisions about when to call their pediatrician.

Dr. Johnston has received the Jacobi Award from the AMA & AAP, Distinguished Service Award from the Section on Emergency Medicine and the Holroyd-Sherry Award from the Section on Media. He wrote, lobbied, testified, advised and negotiated the first Child Passenger Safety Law in the State of Alabama. He has been recognized internationally, being admitted as Fellow of the Royal College of Physicians in England.

Dr. Johnston and his wife Susie have three children, four grandchildren, and have been foster parents for 18 children.

Sandro Galea, MD, MPH, DrPH

**Gelman Professor and Chair
Department of Epidemiology
Mailman School of Public Health
Columbia University
2010 Keynote Speaker**

**Author:
Mental Health and Disasters**



Dr. Galea is a physician and an epidemiologist. He is the Anna Cheskis Gelman and Murray Charles Gelman Professor and Chair of the Department of Epidemiology at the Columbia University Mailman School of Public Health. Dr. Galea's primary research has been on the causes of mental disorders, particularly common mood-anxiety disorders and substance abuse, and on the role of traumatic events in shaping population health. His research program seeks to uncover how determinants at multiple levels of influence—including policies, features of the social environment, molecular, and genetic factors—jointly produce the health of urban populations.

Dr. Galea has conducted large population-based studies in several countries worldwide including the US, Spain, Israel, Ethiopia, Tanzania, and Liberia, primarily funded by the National Institutes of Health. Dr. Galea's interest in the complex etiology of health and disease has led him to work that explores innovative methodological approaches to population health questions primarily funded by a Robert Wood Johnson Health Policy Investigator Award.

Dr. Galea has published more than 250 scientific journal articles, 50 chapters and commentaries, and 5 books. He did his graduate training at the University of Toronto Medical School, at the Harvard University School of Public Health, and at the Columbia University Mailman School of Public Health. Prior to his arrival at Columbia, Dr. Galea was on faculty at the University of Michigan. Several media outlets including The New York Times, NPR, and NBC have featured Dr. Galea's work. He was named one of TIME magazine's epidemiology innovators in 2006.

Book review:

Since the attacks of September 11, 2001, disaster preparedness and response has developed into a discrete subspecialty in medicine, and the paramount health care initiative of the U.S. Government. The mental health component of disaster response is a serious subject of study, as trauma is associated with a substantial and long-lasting psychologic burden, both on an individual and community level. The psychopathologies associated with disaster are also quite broad, varying from several different types of post-traumatic stress and anxiety disorders to acute variations of grief-associated depression. This book is the definitive reference on mental health and disasters, focused on the assessment and treatment of the full spectrum of psychopathologies associated with many different types of individual disasters. The logistics for utilizing pre-existing community-based mental health services, as well as the development of new programs, are covered in depth. Case studies and perspectives for improving care, incorporating lessons from Hurricane Katrina and 9/11, are included in detail.



Gary Slutkin, MD

CeaseFire Founder and Executive Director

2010 Dinner Speaker

Dr. Gary Slutkin is an epidemiologist, an innovator in violence reduction, and the Founder/ Executive Director of CeaseFire, a scientifically proven, health approach to violence reduction using disease control methods. Heralded by the “The World in 2009” edition of the Economist as “the approach that will come to prominence,” CeaseFire has been statistically proven to reduce shootings and killings by 41% to 73% by an extensive, U.S. Department of Justice funded, independent three-year evaluation. In June 2009, U.S. Attorney General Eric Holder, Jr., head of the Department of Justice referenced CeaseFire as an example of “a rational, data-driven, evidence-based, smart approach to crime - the kind of approach that this Administration is dedicated to pursuing and supporting.”

Dr. Slutkin applied lessons learned from more than a decade fighting epidemics in Africa and Asia to the creation of a public health model to reduce violence through behavior change and disease control methods. He is an Ashoka Fellow, a Professor of Epidemiology and International Health at the University of Illinois at Chicago, a senior advisor to the World Health Organization and the 2009 Winner of the Search for a Common Ground Award.

Dr. Slutkin received his M.D. from the University of Chicago Pritzker School of Medicine, and did his internship and residency at San Francisco General Hospital. He served as Medical Director for the Tuberculosis Program for the San Francisco Health Department (1981 - 1985), where he learned infectious disease control methods, and from 1987 to 1994 worked for the World Health Organization reversing epidemics, including being principally responsible for supporting Uganda’s AIDS program—the only country to have reversed its AIDS epidemic. CeaseFire’s approach is driven by epidemic reversal methods developed at WHO. CeaseFire is currently being promoted by the National League of Cities, the National Governors Association, the White House, and the U.S. Foreign Relations Committee. The program is being replicated in 12 U.S. cities, with an additional 14 in the pipeline, as well as several cities abroad.

Dr. Slutkin’s work was featured in Studs Terkel’s *Will the Circle be Unbroken* and profiled in *Blocking the Transmission*, a New York “Times Magazine” cover story by bestselling author Alex Kotlowitz, which was selected as the Best American Science Writing of 2009. Dr. Slutkin is currently working on a book regarding these methods.

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Schedule at a Glance

Friday, November 12		Room
3:00 - 6:00 pm	Registration/Poster Set Up	Artist Foyer
6:00 - 7:00 pm	Welcome Reception	Warhol Room
7:00 - 9:00 pm	Board Meeting	Gallery 724
Saturday, November 13		
7:00 - 8:00 am	Breakfast/Posters	Artist Foyer
8:00 - 8:05 am	Welcome, Michael Hirsh, MD	Avedon D
8:05 - 8:15 am	Call to Action: Barbar Barlow, MD	Avedon D
8:15 - 8:20 am	Introduction of Keynote, Joseph Wright, MD	Avedon D
8:20 - 9:00 am	Keynote Speaker: Carden Johnston, MD, “Violence Prevention; Past, Present, and Future”	Avedon D
9:00 - 10:15 am	Spanning the Spectrum of Violence Prevention Panel	Avedon D
10:15 - 10:30 am	Break	
10:30 - 12:00 pm	Teens Behind the Wheel Panel	Avedon D
12:00 - 1:30 pm	Lunch	Avedon C
1:30 - 3:00 pm	Motor Vehicle Occupant and Pedestrian Injuries Panel	Avedon D
3:00 - 3:15 pm	Break	
3:15 - 4:45 pm	Injury Prevention Education Panel	Avedon D
6:00 - 7:00 pm	Reception	Artist Foyer
7:00	Dinner Keynote Speaker: Gary Slutkin, MD, CeaseFire Founder and Executive Director	Avedon C
Sunday, November 14		
7:00 - 8:00 am	Breakfast/Posters	Artist Foyer
8:00 - 8:10 am	Introduction of Keynote, Micheal Hirsh, MD	Avedon D
8:10 - 9:00 am	Keynote Speaker: Sandro Galea, MD, “Disasters and Mental Health”	Avedon D
9:00 - 10:15 am	Injury Prevention and Disasters Panel	Avedon D
10:15 - 10:30 pm	Break	
10:30 - 12:00 pm	New Topics Panel	Avedon D
12:30 - 1:30 pm	Lunch	Avedon C
1:30 - 2:30 pm	Business Meeting	Avedon D
2:30 - 4:40 pm	Injury Prevention and Sports Panel	Avedon D
2:30 - 4:30 pm	Special Sessions	
	Grantee Meeting for Translation of SBIRT to Pediatric Trauma Center Project	Pollock B
	Toys”R”Us Post Grant Meeting	Pollock C

Agenda

Friday, November 12, 2010		Room
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Saturday, November 13, 2010		
7:00 - 8:00 am	Breakfast and Posters	Avedon C
8:00 - 8:05 am	Welcome Micheal Hirsh, MD Injury Free Coalition for Kids Board President	Avedon D
8:05 - 8:15 am	Call to Action: Barbara Barlow, MD	
8:15 - 8:20 am	Introduction of Keynote Speaker: Joseph Wright, MD, MPH Injury Free Coalition for Kids of DC	Avedon D
8:20 - 9:00 am	Keynote Speaker: Carden Johnston, MD American Academy of Pediatrics Violence Prevention Sub-committee Chair Past President, American Academy of Pediatrics University of Alabama at Birmingham School of Medicine Professor Emeritus Pediatrics Violence Prevention; Past, Present and Future Dr. Johnston will examine the history of violence directed toward children. He will look at some successful and not-so successful programs aimed at preventing violence including some instituted by the AAP, the Injury Free Coalition for Kids, and Connected Kids: Safe, Strong and Secure. In addition he will discuss the impact of media on violence and the recent Supreme Court decision regarding an individual's right to bear arms. This session will enable participants to: 1) Be able to discuss the benefits of strength based counseling; 2) Identify violence prevention programs with which the AAP has been involved; and 3) Recognize opportunities with current strong community, professional and national commitment.	Avedon D
9:00 - 10:15 am	Spanning the Spectrum of Violence Prevention Panel Discussion Moderator: Joseph Wright, MD, MPH Children's National Medical Center Professor of Pediatrics (Vice Chair), Emergency Medicine and Health Policy George Washington University Schools of Medicine and Public Health Senior Vice President for the Child Health Advocacy Institute Injury Free Coalition for Kids of Washington, DC, Co-Principal Investigator	Avedon D

It's been two decades since youth violence in this country was declared a public health emergency. Strategic approaches to intentional injury intervention initiatives have employed a variety of programmatic and research methodologies steeped in the basic tenets of the public health approach to prevention. This panel presentation will explore several such initiatives that span the spectrum from the office to hospital emergency department to community-based settings, and discuss the efficacy and effectiveness of their implementation.

This session will enable participants to:

- 1) Apply the public health approach to the strategic design of intentional injury intervention/prevention programs;
- 2) Appreciate the critical value of collaborative linkage and community engagement to the programmatic success of youth violence prevention initiatives; and
- 3) Discuss the asset-based approach to building the self-efficacy of pediatric health professionals as agents of change in youth violence prevention.

Presenters:

Joseph Wright, MD, MPH: The Role of the Emergency Department in Youth Violence Prevention: a Systematic Review.

Michael Hirsh, MD: Guns for Art - Goods for Guns Comes Full Cycle.

Rebecca Levin, MPH: Connected Kids Implementation Projects: Lessons Learned.

Marlene Melzer-Lange, MD: Healthy Youth: Strong and Connected.

10:15 - 10:30 am

Break

10:30 - 12:00 pm

Teens Behind the Wheel

Avedon D

Panel Discussion Moderator: Garry Lapidus PA-C, MPH

Trauma Institute, Injury Prevention Center Director

Connecticut Children's Medical Center/Hartford Hospital

Associate Professor of Pediatrics & Public Health, University of

Connecticut School of Medicine

Injury Free Coalition for Kids of Hartford, Program Coordinator

Motor vehicle crashes remain a leading cause of morbidity and mortality among teens. This session will describe 4 studies that address the problem. The first study will describe the results of implementing a teen safe driving classroom curriculum enhanced with e-learning activities. The second study will describe the use of computer simulation technology as a tool for ATV safety education. The third study will describe an evaluation of a state based graduated driving licensing system. The fourth study will describe the feasibility and effectiveness of an educational intervention conducted one year post licensure.

This session will enable participants to:

- 1) Describe e-learning technology and its application to influence safe teen driving behavior;
- 2) Discuss the process of creating a digital simulation of an ATV crash and how it might be used to promote ATV safety;
- 3) Describe the methods used to conduct an analysis of a state based graduated driver licensing system; and
- 4) Describe the feasibility of implementing an educational intervention designed to reduce unsafe driving behavior among one year post licensure teen drivers.

Presenters:

- Bridget Clementi: Alcohol, Tobacco and Other Drug Education, Influence on Self Reported Teenage Driving Behavior.
- Steve Rogers, MD: Impact of Connecticut's Graduated Driver Licensing System on Teenage Motor Vehicle Crashes.
- Janice Williams, MESd: Post Drivers Education Instruction: Is it Effective and Feasible?
- Shane Eoff: Developing a Digital Simulation of an ATV Crash.

12:00 - 1:30 pm

Lunch

Avedon C

1:30 - 3:00 pm

Motor Vehicle Occupant and Pedestrian Injuries

Avedon D

Panel Discussion Moderator: Mindy Statter, MD, MPH

University of Chicago Comer Children's Hospital
 Pediatric Trauma Program Director
 Injury Free Coalition for Kids of Chicago at
 University of Chicago, Co-Principle Investigator

In the United States during 2008, 968 children ages 14 years and younger died as occupants in motor vehicle crashes, and approximately 168,000 were injured. In 2008, one in every five children between the ages of 5 and 9 who were killed in traffic crashes was a pedestrian. Child occupant safety and pedestrian safety are complex problems. Effective prevention strategies for both must be multifaceted, incorporating social, behavioral, environmental, and educational factors, and must be culturally sensitive.

This session will enable attendees to:

- 1) Describe how spatial analysis of geographic information systems may be utilized to identify associations between pediatric pedestrian crash sites and the demographics of the neighborhoods where those crashes occur;
- 2) Describe the observed risk and protective behaviors of child and adult pedestrians;
- 3) Discuss how a brief intervention, targeting the family of the hospitalized pediatric trauma patient, impacts child occupant safety practices; and
- 4) Discuss a multi-component strategy, partnering with law enforcement, to increase child restraint use within the Latino community.

Presenters:

- Mindy Statter, MD, MPH: Targeting Pediatric Pedestrian Injury Prevention Efforts: Teasing the Information through Spatial Analysis.
- Dawn Marie Daniels PhD, RN: Protective and Risk Behaviors of Children Walking to School: Do These Behaviors Differ When Adults are Present?
- Peter F. Ehrlich, MD: Stages of Change is Predictive of Response to Brief Intervention to Improve Motor Vehicle Safety Practices for Injured Children at a Level 1 Trauma Center.
- Judy Schaechter, MD: Restraint Use Law Enforcement Intervention in Latino Communities.

3:00 - 3:15 pm

Break

3:15 - 4:45 pm

Injury Prevention Education

Avedon D

Panel Discussion Moderator: Chris Vitale, RN, MSN

Children's Hospital of Pittsburgh University of
Pittsburgh Medical Center
Injury Prevention Coordinator
Injury Free Coalition for Kids of Pittsburgh
Program Coordinator

Injury prevention is critical to reducing traumatic preventable injury and insuring the safety of children. Creativity is key to developing new and unique ways to educate families. The work of this panel illustrates four different styles of bringing the message to the people via physician counseling in an office setting utilizing a computerized risk assessment, a mobile injury prevention exhibit, a safety center modeled after the safety store concept except nothing is sold, and a collaboration between injury prevention and artists to bring the message of safety to English and Spanish speaking families. Each speaker shares the work so all can benefit from lessons learned and successes achieved

This session will enable participants to:

- 1) Assess the ability of replicating one of these programs at your institution;
- 2) Discuss one unique aspect of each program presented; and
- 3) List one challenge of each program that would need to be addressed in your institution.

Presenters:

Janice Williams, MEd: Does Physician Counseling on Injury Prevention Topics Reflect Self-Reported Injury Prevention Risks and Injury Incidence in Young Children?

Mariann Manno, MD: On the Road with Injury Prevention - An Analysis of the Efficacy of a Mobile Injury Prevention Exhibit.

Kira McGroarty Koon, MPH: Health Educators' and Artists' Collaboration Yields Innovative Educational Materials.

Christine Vitale, RN MSN: Kohl's Safety Center in a Safety Store World.

6:00 pm

Reception

Artist Foyer

7:00 pm

Dinner

Avedon C

Keynote Speaker: Gary Slutkin, MD

Cease Fire Founder and Executive Director

Sunday, November 14, 2010

7:00 - 8:00 am

Breakfast and Posters

Avedon C

8:00 - 8:10 am

Introduction of Keynote Speaker: Michael Hirsh, MD

Injury Free Coalition for Kids Board President

Avedon D

8:10 - 9:00 am

Keynote Speaker: Sandro Galea, MD, MPH, DrPH
Disasters and Mental Health

Avedon D

Disasters occur frequently, sometimes in multiple locations at the same time, and although they vary in terms of type, impact, and their consequences they are often life changing for large numbers of people. Although disaster forecasting has improved in recent decades, many disasters remain unforeseen, and even more disasters continue to exceed the response capacities of the communities that they affect. A number of large-scale human-made and natural disasters during the past decade have resulted in considerable popular and academic attention being paid to population effects of disasters, particularly in terms of mental health effects. Building on recent findings in the field this presentation aims to synthesize the state of the science, to identify crucial gaps in our knowledge, and to provide suggestions for future directions for improved research about the mental health consequences of disasters.

This session will enable participants to:

- 1) Summarize the state of the science about disasters and mental health;
- 2) Identify limitations in the field and clear gaps in our knowledge; and
- 3) Discuss potential areas of research and for intervention going forward.

9:00 - 10:15 am

Injury Prevention & Disasters

Avedon D

Panel Discussion Moderator Michael Hirsh, MD

UMASS Memorial Children's Medical Center Surgeon-in-Chief
Injury Free Coalition for Kids Board President
Professor of Surgery and Pediatrics UMASS Medical School
Chief, Division of Pediatric Surgery and Trauma (UMMCMC)
UMASS Memorial Health Care System
Injury Free Coalition for Kids of Worcester Co-Principal Investigator

This panel features an array of experts who will discuss the concept of preparing communities and larger surrounding regions for disasters in an effort to help mitigate mass casualties when possible. Several panelists have successfully received grants to outline not only disaster response for Southern California, Metropolitan New York, the S.F. Bay Area and Central Massachusetts, but are also exploring the best practices for dissemination of disaster preparedness training for populations of families in the affected areas. They will share these experiences.

This session will enable participants to:

- 1) Discuss various federal, state, regional resources for funding of disaster preparedness education (DPE) programs;
- 2) Describe how DPE programs can dovetail with IP programs; and
- 3) Prepare a needs assessment for their respective communities.

Presenters:

Art Cooper, MD: The New York City Pediatric Disaster Coalition: A Readily Replicable Model for Multidisciplinary Regional Pediatric Mass Casualty Planning.
Nathan Timm, MD: Pediatric Hospital Incident Command System (PHICS): Innovative Approach to Hospital Emergency Management.
Mary-Elise Manuell, MD: Creating a Regional Emergency Preparedness Training Center Using State and Federal Funding: One Institution's Experience.
Jeffrey Upperman, MD: Comprehensive Pediatric Disaster Preparedness.
James Betts, MD: Disaster Preparedness: Coping with a Catastrophic Natural Disaster: Perspectives, Systems, and a First Hand Account.

		Room
10:15 - 10:30 am	Break	
10:30 - 12:00 am	<p>New Topics</p> <p>Panel Discussion Moderator Joyce Pressley, PhD, MPH Columbia University Mailman School of Public Health Associate Professor Clinical Epidemiology and Clinical Health Policy and Director Injury Free Health Policy and Population Studies Injury Free Coalition for Kids National Program Office</p> <p>This session of special injury topics identifies and quantifies injury mechanisms in a newly emerging vulnerable population residing within the geographic area of many of our Injury Free sites. It highlights new developments in the ongoing struggle to further elucidate the relationships among social, environmental, and behavior factors and infant, child and adolescent injury risk. Topics covered include: alcohol and drug misuse in caregivers, differences in unintentional and intentional injury risk to children in military vs. nonmilitary families, a “community of practice” model for rural children and adolescents, and microwave oven risks to toddlers.</p> <p>This session will enable participants to:</p> <ol style="list-style-type: none"> 1) Identify and quantify injury mechanisms in newly emerging/newly recognized vulnerable population(s); 2) Discuss new findings on the relationship of social, environmental and adult caregiver behavior on child injury risk; and 3) Identify areas where injury prevention activities may benefit from cross-agency and cross-disciplinary collaboration. <p>Presenters:</p> <p style="padding-left: 40px;">Karla A. Lawson, PhD, MPH: Alcohol & Drug Misuse Among Injured Caregiver/Child Groups.</p> <p style="padding-left: 40px;">Joyce C. Pressley, PhD, MPH: Injury-Related Hospital Admissions of Military Dependents Compared to Similarly Aged Non-military Insured Infants, Children and Adolescents.</p> <p style="padding-left: 40px;">Erica Streit-Kaplan, MPH, MSW: Preventing Child and Adolescent Injuries in a “Community of Practice” Model.</p> <p style="padding-left: 40px;">Marla Robinson, MSc, OTR/L: Behaviors of Children Ages 15 Months to Five Years\Around Microwave Ovens.</p>	Avedon D
12:00 - 1:30 pm	Lunch	Avedon C
1:30 - 2:30 pm	Business Meeting	Avedon D
2:30 - 4:30 pm	<p>Injury Prevention and Sports</p> <p>Panel Discussion Moderator: Andrea Winthrop, MD Professor of Surgery, Medical College of Wisconsin Co-Director Education Core, Injury Research Center at MCW Children’s Hospital of Wisconsin Injury Free Coalition for Kids of Milwaukee Co-Principal Investigator</p> <p>Organized and recreational sports and physical activity improve physical fitness, coordination, self-discipline and teamwork, but participation in these activities is associated with risk of unintentional injury. Although deaths are rare, more than 3.5 million children ages 14 and under sustain sports and recreational-related injuries yearly. In fact, brain injuries associated with these activities account for 21 percent of all trauma brain injuries in children. Understanding which sports/recreational activities are associated with injuries, and how these vary with age, population, geographic region, season, and developmental maturity of the child is key to developing targeted</p>	Avedon D

education and prevention strategies. Interventions should include ensuring proper physical and psychological conditioning, appropriate safety equipment, safe play environments, adequate supervision, and enforcement of safety rules.

This session will enable participants to:

- 1) Demonstrate how using the ABC's of injury prevention approach can facilitate development of targeted prevention strategies for sports and recreational-related fall injuries in school age children;
- 2) Identify ways to increase the awareness of TBI associated with school sports participation;
- 3) Identify gaps in the knowledge and preparedness of school sports coaches with respect to prevention of and recognition/treatment of sports-related injuries; and
- 4) Describe the spectrum of injuries associated with motorized recreational vehicles.

Presenters:

Andrea Winthrop, MD: Falls Among School-Aged Children (6-14 Years) in an Urban County.

Kimberly Gran: Knowledge and Management of Sports Concussions Among Middle and High School Coaches in Alabama.

Courtney Baxley, MD: Motorized Vehicles for Recreation Associated Injuries in Children Presenting to the Emergency Department at Children's Hospital (Dirt Bikes, Golf Carts, Go Carts and Scooters).

Mary Beth Moran PT, MS, MEd: Injury Prevention Preparedness in Youth Football and Soccer Coaches: Are They Prepared to Identify and Manage a Potentially Catastrophic Injury?

2:30 - 4:30 pm

Special Sessions

Grantee meeting for Translation of SBIRT to Pediatric Trauma Centers Project, [Pollock A](#)
Michael Mello, MD

Toys"R"Us Post Grant Meeting, [Pollock B](#)
E. Lenita Johnson, MA

Accreditation Statement

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of Cincinnati Children's Hospital Medical Center and The Injury Free Coalition for Kids. Cincinnati Children's is accredited by the ACCME to provide continuing medical education for physicians.

Cincinnati Children's designates this educational activity for a maximum of 12.0 (Saturday-6.5; Sunday-5.5) *AMA PRA Category 1 Credit(s)*™. Physicians should only claim credit commensurate with the extent of their participation in the activity

Disclosure Statement

Cincinnati Children's requires all clinical recommendations to be based on evidence that is accepted within the profession of medicine and all scientific research referred to, reported or used in support of or justification of patient care recommendations conform to the generally accepted standards of experimental design, data collection and analysis. All faculty will be required to complete a financial disclosure statement prior to the conference and to disclose to the audience any significant financial interest and/or other relationship with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in his/her presentation and/or commercial contributor(s) of this activity.

2010 Forging New Frontiers: “Making Communities Safe for Children and Their Families”

*The 15th Annual Conference of the Injury Free Coalition for Kids jointly sponsored with
Cincinnati Children’s Hospital Medical Center
November 12 - 14, 2010*

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DISCLOSURE

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FACULTY	
Courtney Baxley, MD	NONE
James Betts, MD	NONE
Bridget Clementi	NONE
Art Cooper, MD, MS	NONE
Dawn Marie Daniels, PhD, RN	NONE
Shane Eoff	NONE
Peter F Ehrlich, MD	NONE
Kimberly Gran	NONE
Michael Hirsh, MD	NONE
Carden Johnston, MD	NONE
Karla A. Lawson, PhD, MPH	NONE
Rebecca Levin, MPH	NONE
Marlene Melzer-Lange, MD	NONE
Sandro Galea, MD, MPH, DrPH	NONE
Garry Lapidus, PA-C, MPHr	NONE
Mariann Manno, MD	NONE

FACULTY	
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Marla Robinson, MSc, OTR/L	NONE
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Judy Schaechter, MD	NONE
Mindy B. Statter, MD	NONE
Erica Streit-Kaplan, MPH, MSW	NONE
Nathan Timm, MD	NONE
Chris Vitale, MSN, RN	NONE
Jeffrey Upperman, MD	NONE
Janice Williams, MEd	NONE
Andrea Winthrop, MD	NONE
Joseph Wright, MD, MPH	NONE

None of the speakers intend to discuss unlabeled uses of a commercial product or an investigational use of a product not yet approved for this purpose.



2010 Forging New Frontiers:
“Making Communities Safe for Children and Their Families”

Abstracts

The Role of the Emergency Department in Youth Violence Prevention: A Systematic Review

Tiffani J Johnson, MD1 and Joseph L Wright, MD, MPH2,3. 1 Fellow, Division of Emergency Medicine, Children's Hospital Pittsburgh, Pittsburgh, PA; 2, Child Health Advocacy Institute and 3, Division of Emergency Medicine, Children's National Medical Center, Washington, DC

Introduction/Background:

Youth violence is a major cause of morbidity and mortality. Homicide is a leading cause of death among 10-24 year olds. Emergency departments (ED) in the United States see more than 750,000 young people annually for intentional injuries. While the ED's role in evaluating and treating violent injuries is clear, questions remain regarding the effectiveness of ED-based prevention efforts.

Methods:

A review of the literature from 1980 to present using electronic databases and bibliographic hand search. Eligibility included studies involving pediatric subjects with intentional injuries; excluded were child abuse, sexual assault and intimate partner violence. Interventions were categorized in accordance with a validated level of evidence tool.

Results:

Two randomized controlled trials (RCT) met inclusion criteria. Both studies linked participants to community resources through a case management model. The first demonstrated reduction in self-reported re-injury, but not population-based rates of recidivism. The second used a family-based intervention that trended towards, but did not significantly reduce risk factors for injury. A third RCT not limited to intentional injuries, included sub-analysis of behavioral change counseling for weapon-carrying with unfavorable outcomes.

Conclusions:

The ED is an important setting for the study of youth violence prevention. Controlled investigations are few, outcomes equivocal and efficacy is limited by adherence over time, subject perceptions, and study power. Further research is needed to assess the feasibility and potential effectiveness of ED-initiated interventions.

Objectives:

Attendees will learn:

- 1) How the emergency department can contribute to community-based youth violence intervention efforts based on systematic evidence;
- 2) How community resources can best be accessed through acute care point-of-contact opportunities; and

- 3) What is methodologically feasible in the design of hospital-based youth violence intervention activities.

Healthy Youth: Strong and Connected

David Anderson, Barbra Beck, Patricia Kirby, Marlene Melzer-Lange, Toni Rivera, Dawn Zahrt

Introduction/Background:

Youth violence threatens the lives and well-being, both physically and psychosocially of our youth, families, and communities. Milwaukee youth are at risk for violent, intentional injuries as well as psychosomatic problems such as headaches, abdominal pain, post-traumatic stress and school avoidance caused by bullying and threats. By improving interpersonal communication and understanding of the roots of violence, we targeted these important health issues. We addressed our Wisconsin public health goals by addressing major health risks including intentional injury and mental health disorders, by focusing on urban, racially and ethnically diverse youth, and by building capacity and systemic programs in a school-based environment.

Methods:

A collaboration of firefighters from the Milwaukee Fire Department, teachers and violence prevention experts from Milwaukee Public Schools, and community liaisons from Project Ujima, a community-based violence prevention and intervention program developed a curriculum: Project Staying Alive. We trained 34 teachers and 36 firefighters in the curriculum. Beginning in 2007, five sessions, three taught by teachers and two 2-hour sessions team led by firefighters and Project Ujima community liaisons were provided to 6th graders in Milwaukee Public Schools. The curriculum included lessons in the causes of violence, risk factors for being injured, and ways to resolve conflicts. Students had the opportunity to discuss in small groups their attitudes and behaviors related to violence and then share their ideas with the entire classroom Utilizing a computer-based audience response system, students answered questions about violence before and after the sessions. Short-term outcomes include student responses via the audience response system and teacher evaluations of the program. Long-term outcomes include number of school suspensions and results of a school climate survey.

Results:

During the initial pilot year, 2007-2008, Project Staying Alive there were 128 student contacts. During the year 2008-2009, 1,318 student contacts were made. For the school year 2009-2010, 4,308 student contacts were made. Knowledge about violence for the student

Saturday, November 13, 2010

question, “ Violence usually occurs between people who know each other.” improved by 48% pre and post curriculum. Attitudes about preventing violence for the student question, “If I really want to, I can usually talk someone out of trying to fight with me.” improved by 34% pre and post curriculum.

Conclusions:

A violence prevention curriculum presented by teachers, firefighters and community liaisons from a community-based violence prevention organization effectively reached a large number of sixth graders in Milwaukee. Students had improved knowledge and attitudes related to violence.

Objectives:

Attendees will learn:

- 1) Discuss a multidisciplinary collaboration that addresses youth violence with 6th grade students;
- 2) Understand opportunities and challenges in presenting violence prevention in the school setting; and
- 3) Share outcomes of our project.

Guns for Art - Goods for Guns Comes Full Cycle

Hirsh, Manno, Rook, Borer, Yano-Litwin

Introduction/Background:

Most murders in the United States are committed with firearms, especially handguns. This is reflected in the injuries treated in trauma centers and hospitals at high cost to society. IFCK Worcester’s Goods for Guns Program (G4G) has collected 1,861 guns since 2002 at an average total annual cost of \$13,500/year (average \$54/weapon). The annual expense for a G4G buyback is estimated to be a fraction of the expense of hospitalization for one gun shot victim. However, gun buybacks remain controversial and funding to sustain them is challenging. In collaboration with the Worcester’s District Attorney, Police Department, Park Recreation Department and the Worcester District Medical Society, IFCK Worcester has expanded its G4G program this year to create an artistic monument from guns collected in our program. This will be in a centrally located park and serve as a permanent reminder of the cost of violence to the Worcester community. An additional driving force in this project is to recognize Dr. Leonard Morse, who will be retiring in September 2010, for his 40 years of medical service to Worcester, most recently as Commissioner of Public Health

Methods:

IFCK - Worcester has engaged the local vocational high school, Worcester Tech and artist, Boris Bally.

Worcester Tech has a large welding studio and students are required to participate in community service projects as part of their high school curriculum. Mr. Bally led a team of artists that created art from disabled guns collected in gun buybacks in Pittsburgh through a program called Artists of a Different Caliber. One of these pieces is a large obelisk created from weapons. It is publicly displayed in Providence, RI.

Results:

Using a design by Mr. Bally, Worcester Tech metal working department has created a prototype of a 14 foot tall catenary arch that will be located on a 30’ by 30’ plot of land in Elm Park, the nation’s first public park and one of the most recreational popular spots in Central Massachusetts. Approvals from Worcester’s Police Department, Public Schools, Department of Parks and District Attorney’s Office are being obtained. Following this, funds will be raised to sponsor the vocational students who will assemble and erect the structure. A portable “mini” version of the project will be simultaneously constructed. It could be transported to schools for use in programs that address nonviolent conflict resolution and to encourage youth visitation of the “macro” version at Elm Park.

Conclusions:

The overarching goal of IFCK -Worcester’s G4G program has been community outreach and education. We specifically teach the importance of safe storage of guns, particularly in home where children live and/or visit. Our hope is that by adding Guns for Art to our Goods for Guns program will help us further raise community awareness of the cost of gun related violence.

Objectives:

Attendees will learn:

- 1) How with community collaboration, an already existing, successful program can be expanded to help further increase awareness of the cost of gun related violence;
- 2) How to replicate this project in other communities that have Gun Buy Back programs; and
- 3) How to expand the scope of an injury prevention program into an educational center

Connected Kids Implementation Projects: Lessons Learned

Rebecca Levin, MPH

Introduction/Background:

The American Academy of Pediatrics’ Connected Kids: Safe, Strong, Secure (CK) program provides tools and strategies for health care providers to integrate

violence prevention into practice, take an asset-based approach to counseling, and help families raise resilient children.

Methods:

Two CK implementation projects have been conducted. In 2007, 27 pediatricians were recruited to implement CK in their practices for 6 months, with an emphasis on using the program with 5- to 10-year old patients. Data were collected through 3 surveys and telephone discussion groups/interviews. Evaluation focused on how successfully participants were able to use CK in practice to enhance their counseling on parental supervision and monitoring. In 2008, case studies were conducted in 8 pediatric practices that had not previously begun to implement CK. Data were collected during 2 site visits to each practice (through physical practice assessment, staff meetings, and individual interviews) and were reviewed and thematically coded. Each practice's approach to implementation was described, and data from all practices were used to characterize successful implementation of CK and to identify facilitators and barriers to implementation.

Results:

Findings from the 2007 project indicate that CK is appealing to pediatricians, implementation in practice is feasible, and use is sustainable over a period of 6 months; implementation is most successful when undertaken incrementally. The 2008 project revealed that different approaches to implementation could be successful, and a variety of facilitators and barriers to implementation were identified.

Conclusions:

The following are lessons learned regarding CK implementation:

1) Implementation can be undertaken in a variety of ways depending on the needs and capacity of the practice. For example, some practices emphasized extensive preparation while others began implementing immediately and adjusted along the way; some practices implemented CK for all patients while others focused on a specific age group.

2) CK can be implemented without requiring longer well-child visits, especially when integrated within existing approaches to anticipatory guidance. Providers can be selective in their incorporation of CK topics rather than trying to incorporate all recommended topics.

3) CK provides new approaches to discussing topics that are already covered and to prioritizing anticipatory guidance on violence-related topics. For practices that do not have systematic approaches to provision of anticipatory guidance, CK encourages practices to

improve structure and documentation of anticipatory guidance generally and provides a way to build on anticipatory guidance from visit to visit.

4) CK's asset-based approach helps providers discuss topics in a more open-ended way and address families' needs more specifically, lets parents know that their pediatrician cares about them and can be a resource on a wide range of psychosocial topics, and facilitates counseling on sensitive topics in a nonjudgmental way.

5) Successful implementation involves connecting with the right people and groups in the community because the pediatrician cannot and should not do everything.

Objectives:

Attendees will learn:

- 1) The findings from two Connected Kids (CK) implementation projects;
- 2) Lessons learned about implementation of Connected Kids in pediatric practice; and
- 3) How lessons learned about Connected Kids implementation can be applied to other settings or other violence prevention programs.

Alcohol, Tobacco and Other Drug Education, Influence on Self Reported Teenage Driving Behavior

Timothy E. Corden, MD; Richard O. Schafer, PhD; Deena Liska; Katie Horrigan, MPH; Bridget Clementi

Introduction/Background:

Motor vehicle crashes (MVC) remain a leading cause of teenage deaths and injuries. Alcohol and the high-risk behaviors exhibited by the teenage population are components that contribute to the burden of MVCs in this age group. The purpose of this research was to determine if an Alcohol, Tobacco and Other Drug (ATOD) intervention program conducted at school, via classroom and e-learning modules can positively impact self-reported teenage driving behavior.

Methods:

School districts within Wisconsin counties with a higher incidence of teenage MVC events were approached to participate in the program; 7 schools engaged in the study with 6 receiving the intervention and 1 serving as a control. An ATOD program, "It's Up 2 U", was developed using nationally validated standards. The program spanned 8-10 hours of didactic and e-learning classroom activities and was conducted over a 6-week period administered to 8th and 10th grade students. The study included 474 eighth grade students and 263

tenth grade students and a control group of 196 tenth grade students; no control group was identified at the eighth grade level. A pre-program test and a post-test given 6-12 weeks after the intervention, evaluating high-risk behavior was scored for each participant. In addition to driving behavior, attitudes regarding the influence of parents, peers, and negative consequences on decision-making were assessed. Data was collected through a secure format to maintain confidentiality. The study was approved by the Children's Hospital of Wisconsin's IRB.

Results:

Self-reported passenger seat belt use increased 4.5% for 8th grade students and 6.3% for 10th grade program participants while there was a 5% decrease for the 10th grade controls over the same time period. Driving 10th grade students completing the course reported wearing a seatbelt 92% of the time post intervention compared to 86% pre-intervention while reported seatbelt use among drivers in the control group was 88%. The reported incidence of recognition that riding in a car without a seat belt could have negative consequences increased 16% for 8th grade participants (48.5% to 65.1%), and by 21% for 10th graders (56.9% to 77.9%); an increase of 5.9% was noted in the 10th grade controls over the same time period.

Conclusions:

Preliminary analysis of data indicates ATOD education has the potential to positively influence attitude and behavior relating to teenage driving. The e-learning format allows for wide dissemination and was well received by teachers and students. The program can be replicated in any educational environment with access to the Internet.

Objectives:

Attendees will learn:

- 1) New ideas on how to use new technologies;
- 2) Data which supports the hypothesis that using ATOD education can affect the way students think about other risky behaviors, such as those related to teen driving; and
- 3) The successes and failures about how to effectively implement a technology-based injury prevention program.

Developing a Digital Simulation of an ATV Crash

Eoff S N, Thorbole C K, Miller B K, Graham C J, Aitken M E

Introduction/Background:

Injuries and deaths in children under 16 who operate all-terrain vehicles (ATVs) are increasing. Safety

practices such as always wearing a helmet, never carrying a passenger, completing rider training, and driving a proper sized ATV are factors that riders can control. A factor that riders cannot control is the design of ATVs. This factor contributes to the risk of injury for children. The purpose of this study is to create a realistic simulation of an ATV crash to educate on the design risks of ATVs.

Methods:

An ATV was purchased that is representative of the popular size that children are riding. The ATV was then digitized by engineers. Data was collected to determine the physical characteristics of the ATV. A tilt table test was used to determine the angle at which both tires lifted from the test bed along the longitudinal axis of the vehicle. The tilt table test was also used to compute the center of gravity of the ATV. A swing test was then conducted to determine the roll and pitch mass moment of inertia values. The digitized model and the data collected from the tests were then used to generate a computerized simulation of an ATV crash involving a child driver.

Results:

Four tests were conducted to determine the angle at which both tires lift off of a tilt bed, the height of the center of gravity, the static stability factor, the roll Mass Moment of Inertia and the pitch Mass Moment of Inertia. The angle at which both tires lifted from the tilt bed was 43.5°. The center of gravity was located 17.94 inches from the ground. The static stability factor was computed as 0.97. The Mass Moment of Inertia for roll and pitch was computed to be 2092.757 (lb-ft²) and 803.9184 (lb-ft²) respectively. A computer simulation is under development using the data collected in order to accurately depict the mechanics and injuries that children sustain during an ATV crash.

Conclusions:

With ATV deaths and injuries on the rise in many areas educational tools are becoming increasingly popular. Constructing a computer simulation of ATV crashes can accurately depict an ATV crash. Using this material can be a powerful tool for educators conducting ATV safety courses.

Objectives:

Attendees will learn:

- 1) The process that was used to create a digital simulation of an ATV crash; and
- 2) The mechanics involved in an ATV crash.

Impact of Connecticut's Graduated Driver Licensing System on Teenage Motor Vehicle Crashes

Steven Rogers, MD, George Bentley, MS, Brendan Campbell, MD, MPH, Kevin Borrup, JD, MPA, Garry Lapidus, PA-C, MPH

Introduction/Background:

Novice teen drivers younger than 18 have increased crash rates due to inexperience and risk taking behavior. In response, many states have enacted graduated driver licensing (GDL) systems which delay full licensure while allowing beginners to obtain experience under lower risk conditions. Connecticut's GDL system has undergone several upgrades since its inception in the late 1990's. In 1997, a 6 month minimum learner's permit period was introduced. In 2004 a passenger restriction went into effect. In 2005, a night restriction from midnight to 5AM was added. In 2008, passenger and night restrictions were extended, a 2 hour mandatory parent training class added, parent supervised teen driving was extended to 40 hours, and a 48 hour mandatory license suspension for GDL infraction was added. The purpose of this study is to evaluate the impact over the last 10 years to determine its effect on teen motor vehicle crashes.

Methods:

Connecticut motor vehicle crash (MVC) data from 1999-2008 were analyzed. Percent change in MVC crash rates per 10,000 registered drivers were calculated by age and year over the 10 year study period. Percent change in MVC related injury during the night restriction (23:00 and 05:00 hours) and MVCs with passengers was also calculated.

Results:

995,539 MVCs occurred during the study period resulting in an annual rate of 6,249 crashes per 10,000 registered drivers. MVC rates were highest for 18 year old drivers (1,225) and lowest for drivers 30-59 years of age (392). Over the 10 year study period the MVC crash rate decreased 41% for 16 year old drivers, and 30% for 17 year old drivers covered by the states GDL system. In comparison, rates among 18 year old drivers, 19 year old and 30-59 year old drivers were reduced by 16%, 7%, and 10% respectively.

During nighttime restricted driving times, MVC related injuries decreased 54% among 16 year old drivers, and 58% among 17 year old drivers. In comparison, injuries among 18 year old drivers, 19 year old drivers, and 30-59 year old drivers were reduced by 36%, 45%, and 29% respectively.

MVCs with passengers decreased 65% among 16 year old drivers, and 52% among 17 year old drivers. In comparison, MVCs with passengers among 18 year old drivers, 19 year old, and 30-59 year old drivers were reduced by 29%, 22%, and 14% respectively.

Conclusions:

Implementation of Connecticut's GDL system has resulted in significant reductions in MVCs (and injury). This time trend analysis provides a blueprint for other states to examine the impact of their GDL system.

Objectives:

Attendees will learn:

- 1) To understand the importance of evaluating state-based traffic safety laws;
- 2) To describe the methods used to conduct an analysis of a state-based graduated driver licensing (GDL) system; and
- 3) To understand the impact of GDL systems of teen motor vehicle crashes and injury.

Post Drivers Education Instruction: Is it Effective and Feasible?

Janice Williams, MSED; Joanna York, MD; Jeff Kline, MD; Robert Schafermeyer, MD.

Introduction/Background:

Teen driving is a significant injury risk for adolescents nationwide. In one local community, data shows that 41% of teen crashes are attributed to driver error. Hands on teen driving classes have risen in response to adjust skill level and impact risk taking, indeed, even NHTSA is recommending an additional 10 hours education post drivers education. Classes meant to raise confidence levels have been shown to be harmful especially to young male drivers. However, there is some evidence that "insight" classes meant to allow teens to experience how they and their vehicle react are beneficial. This study seeks to add to that literature by assessing Adverse Driving Events (ADE) in a control and intervention group taking such a class as well as document barriers and facilitators to implementation to lend to the translatability literature of public health initiatives.

Methods:

Injury staff at a local hospital assessed local crash data to identify skills that correlate with driver errors in order to choose an appropriate hands on class teaching the desired topics. Then 2000 families with teens from the same drivers education session one year post licensure were invited to participate free of charge in the study and class. Participants were divided into a control and intervention group. Data was collected at

the beginning and post study period pertaining to self reported attitudes of risk and (ADE) experienced using a modified Allstate Insurance Company survey. ADE's were also confirmed by motor vehicle driving records.

Results:

Prior to the intervention, there was no difference between ADE's reported by teen drivers groups. Post study, during the same time period, the control group had 17 ADE's and the intervention group had only three. The control groups largest areas of increased risk were racing and driving after drinking. In the intervention group, two of the three ADE's were texting while driving uncovering a new area for curriculum content in these type of classes that is driver distraction risk while driving. Facilitators for implementation include, dedicated vehicle track, volunteer police instructors, dedicated staff to market and enroll families. Barriers to implementation include teen's lack of desire, competition for weekend activities, parents lack of interest in class, city ordinances requiring tree placement in parking lots, and lack of highway safety priorities within local infrastructure.

Conclusions:

This study showed differences in adverse driving events with a select insight based teen driving class (as opposed to a skill based class which has been shown to have a negative effect). These findings do correlate with NHTSA's advanced education recommendation for future interventions but significant barriers exist to implementation. Potential may exist for other use of the outcomes such as key skills emphasized in classrooms, importance of teachers understanding of content, and parent guidance of discussion with teen.

Objectives:

Attendees will learn:

- 1) The different types of advanced education classes for teens;
- 2) The efficacy in reduction of adverse driving events in teens post advanced education; and
- 3) To assess the local feasibility of hosting such a class as an outreach activity for their community.

Targeting Pediatric Pedestrian Injury Prevention Efforts: Teasing the Information through Spatial Analysis

Mindy Statter MD, Todd Schuble MS, Michele Harris-Rosado RN, Donald Liu MD, PhD, Kyran Quinlan, MD, MPH

Introduction/Background:

Pediatric pedestrian injuries remain a major cause of childhood death, hospitalization, and disability. Racial disparities have been noted in the rates of

pediatric pedestrian death and injury. In order to target injury prevention efforts it is imperative to identify those children at risk. As previously reported in other cities, we hypothesized that children from low-income families living in dense, urban residential neighborhoods have a higher risk of sustaining pedestrian injury.

Methods:

Utilizing E-codes for pedestrian-motor vehicle crashes, children < 16 years of age were identified from the trauma registry, who received acute care and hospitalized at the University of Chicago Medical Center, a Level 1 pediatric trauma center, after being struck by a motor vehicle from 2002-2009. By retrospective chart review and review of the Emergency Medical Services (EMS) run sheets, demographic data, and details of the crash site were respectively collected. Crash sites were mapped. In addition, maps were generated using geographic information systems (GIS) from census data to evaluate race, employment, income, density of public and private schools, density of parks, and density of children living in the neighborhoods surrounding our medical center where crash sites are identified.

Results:

There were 3,521 children admitted to the University of Chicago Medical Center for traumatic injuries from 2002-2009; 27.7% (974) of these children sustained injuries in pedestrian motor vehicle injuries. From 2002-2009, there were a total of 106 traumatic deaths; 29 due to pedestrian motor vehicle crashes (27.4%). (Figures 1-9 are maps) Figure 1: All crashes 2002-2009 Figure 2: Crash hot-spots + parks Figure 3: Density of African-American families Figure 4: Unemployment Figure 5: Average income Figure 6: Child density Figure 7: Crash sites + all schools Figure 8: Crash sites + private schools Figure 9: Crash sites + public schools

Conclusions:

Spatial analysis using GIS identified associations between pediatric pedestrian motor vehicle crash sites and the neighborhoods served by our pediatric trauma center. Pediatric pedestrian motor vehicle crash sites occurred predominantly within low-income, African-American neighborhoods. Crash sites occur where urban children have a high level of exposure to traffic, often related to routine play. The relationship of crash sites to public parks will allow for targeted park and playground builds. A lower prevalence of crash sites was observed in the predominantly higher income, non-African-American neighborhoods. The disparity in prevalence of crash sites is somewhat attributable to the lower density of children living in the latter referenced neighborhoods. The prevalence of crash sites is less in the vicinity of private schools compared

to public schools. Future efforts will include exploring the factors contributing to fewer pediatric pedestrian motor vehicle crashes around private schools compared to public schools. Templates for injury prevention strategies need to encompass cultural differences and need to be community based.

Objectives:

Attendees will learn:

- 1) To assess disparities in pediatric pedestrian motor vehicle crash rates utilizing spatial analysis of geographic information systems (GIS);
- 2) To identify associations between pediatric pedestrian motor vehicle crash sites and the neighborhoods served by our pediatric trauma center; and
- 3) To target injury prevention strategies based on the associations noted between crash sites and the demographic features of the respective neighborhoods.

Protective and Risk Behaviors of Children Walking to School: Do These Behaviors differ when Adults are Present?

Dawn Marie Daniels, PhD, RN, PHCNS-BC, Wendy St. John, BSN, RN, Nena Ray, Serifatu Walton, MAMFT

Introduction/Background:

Decreasing pedestrian injuries is a complex issue that requires a multi-faceted approach which includes environmental/engineering changes, law enforcement, motorist behavioral changes, as well as changes in child and adult pedestrian behaviors. A child walking to school with adults has long been cited as a method to decrease pedestrian injuries while increasing the number of children who walk to school. As part of a larger program focusing on pedestrian safety to and from school, we conducted an observational study to identify pedestrian behaviors and to determine if these behaviors differed between adults and children. An environmental assessment was also conducted to identify (and correct if possible) those environmental risk factors in the area.

Methods:

Environmental and pedestrian behavior observations were conducted by trained pairs of observers placed at intersections and midblock within a one block radius of three elementary schools located in a densely populated urban neighborhood. All pedestrians observed during the observation times (30 minutes before and after arrival and dismissal time) were included in the study. Environmental variables observed included traffic conditions (flow, traffic speed, direction, and number of lanes); environmental hazards such as sight obstructions and sidewalk condition;

and traffic/pedestrian signals. Pedestrian behaviors observed included demographic variables (age category; gender); adult presence (crossing guards; adults walking with child); group dynamics (size and interaction); crossing behaviors (use of crosswalk, type of intersection; scanning behaviors before and during crossing, gait); and use of pedestrian tools (traffic signals, pedestrian buttons).

Results:

A total of 1505 pedestrians (64% children; 36% adults) were observed within the study timeframe. Forty-eight percent of the children were walking to school with an adult. Children were less likely than adults to cross the street against the traffic light ($p > .0001$). There was no statistical difference between children and adults in their use of crosswalk intersections (66.7% and 62% respectively) vs. midblock crossings. Neither children nor adults scanned appropriately for traffic before leaving the curb with only 21% of adults scanning and 10% of the children. Only 16.8% of the adults and 5.6% of the children continued to scan for traffic once they entered the multiple lane heavily traveled roadways. There were a total of 19 “near miss” pedestrian vs. car crashes, all occurring from children departing motor vehicles into the flow of traffic while arriving at school.

Conclusions:

In spite of conventional thought that children are safer when walking with adults, we identified very few differences in pedestrian protective and risk behaviors between adults and children. While the presence of an adult may provide protective factors that we did not measure, programs and efforts to improve pedestrian safety for children must also focus attention on improving pedestrian behaviors of the adults who are walking with the children. Further examination of these variables is recommended for further study.

Objectives:

Attendees will learn:

- 1) To identify the risk and protective factors for pedestrians;
- 2) To identify three environmental risk factors present for children walking to school; and
- 3) To identify differences between risk and protective factors of child pedestrians and adult pedestrians.

Stages of Change is Predictive of Response to Brief Intervention to Improve Motor Vehicle Safety Practices for Injured Children at a Level 1 Trauma Center

Peter F Ehrlich MD, Bethany Buschmann MS, Lynn Massey MSW, Maureen Walton PhD, and Rebecca Cunningham MD

Introduction/Background:

We conducted a randomized controlled trial comparing a brief intervention to a pamphlet intervention to improve safety belt and other motor vehicle safety practices in hospitalized trauma patients at level 1 trauma center. The intervention improved part time to full time seat belt use in 54% of participants; part time to full time placing children less than 13 in the back seat of a car in 56% of participants; and part time to full time booster seat use in 33% of participants. The purpose of this study was to examine those factors that predicted change in behavior.

Methods:

A brief tailored selected age appropriate intervention was developed and beta tested. Hospitalized trauma patients between the age of 7- 14 and their parents were eligible. A selected safety screen identified patients. There were three entry criteria:(1)not always using a seatbelt; (2)sitting in the front seat of a car if under 13 and (3) not using a booster seat if less than 8. A child could have more than one reason to enter the study. Eligible patients were randomized to one of the two interventions. Injury and demographic data was collected. At baseline and one month follow up readiness to change, self efficacy, behavior intentions and parenting sense of competency was assessed.

Results:

Between April and October 2009, 238 children and their parents were screened and 166(70%) met criteria. One hundred and thirty were randomized and 115(90%) completed follow up. There were 84 males and 46 females with average age of 9.8+/-2. The average injury severity score was 6.2. Both interventions improved behaviors but a significantly higher rate of change towards good safety practices was seen in the brief intervention group as opposed to the pamphlet intervention(12%, $p<0.01$).Readiness to change at baseline ($p<0.001$) was the strongest predictor followed by the brief intervention in predicting a desired change in safety practices. Readiness to change correlated significantly with lower age, gender(female) and parents not on public assistance. $P<0.00001$.

Race and injury severity had no impact. After the intervention positive attitude changes towards safety practices was seen in both the parent and the youth group. ($p<0.05$). The use of the brief intervention, younger age, readiness to change, all predicted change from a negative to a positive attitude. These were also similar in the knowledge and commitment to changes $p<0.05$. Improvement in self efficacy and behavior intentions were seen both groups but the pamphlet group showed better results than the booklet/brief intervention group. Parent knowledge about safety belt practices especially related to placing children

under 12 in the back seat of a car. (0.03)Parent sense of competency scale did not correlate to behavior change, attitude or knowledge acquisition or increase self efficacy

Conclusions:

A brief family center intervention improved safety restraints practices in a high risk group of patients. Readiness to change and the factors that influence it appears to be the most important factor to enhance positive safety practices. Further testing with a larger more diverse population with longer follow up is needed.

Objectives:

Attendees will learn:

- 1) The factors that influence behavior change in injured children; and
- 2) The stages of behavior change.

Restraint Use Law Enforcement Intervention in Latino Communities

Judy Schaechter, MD, Susan B. Uhlhorn, Ph.D.,

Introduction/Background:

Motor vehicle crashes are the leading cause of death for U.S. Latinos aged 1-35 years of age. Restraint use is an effective means of prevention of motor vehicle crash injury. Effective interventions to raise restraint use include: legislation, law enforcement, education and equipment distribution. The effects of law enforcement interventions in Latino immigrant communities are under studied. We measured the community-level effect of a combined intervention which included warnings and citations phase enforcement in Latino communities.

Methods:

We designed and implemented in two of three Latino-majority communities a multi-component intervention consisting of a community awareness campaign, restraint use education with equipment distribution, and a two-staged law enforcement intervention. Restraint use observations were conducted in all three communities at baseline, after the warnings phase and again after the citations-phase of the intervention was completed.

Results:

The combined intervention of community awareness, education, child passenger restraint distribution and law enforcement focused on educational traffic stops with incentives and warnings was associated with a significant rise in driver and child passenger restraint use in both intervention communities. The citations-

phase of the intervention did not result in a significant increase in driver restraint use and gave mixed results in child restraint use. Citations also resulted in complications including interruption of events due to drivers having no valid license.

Conclusions:

The combined effort of community awareness, education, equipment distribution and law enforcement intervention that included incentives and warnings was effective at increasing seat belt use in Latino communities without the need for citations.

Objectives:

Attendees will learn:

- 1) To conduct a multi-faceted restraint use intervention in diverse Latino-majority communities;
- 2) The results of the project, as well as the successes, challenges, and unique considerations in an intervention targeting the Latino community and partnering with law enforcement; and
- 3) To understand the heterogeneity in safety practices among Latino communities.

Does Physician Counseling on Injury Prevention Topics Reflect Self-Reported Injury Prevention Risks and Injury Incidence in Young Children?

Janice Williams, MSED; Carolinas Medical Center
Nancy Weaver, PHD; St. Lois University
Tonja Nansel, PHD; Katherine Wilson; Julia Tse,
National Institutes of Child Health and Development

Introduction/Background:

Injury counseling has been recommended in pediatric offices as a strategy for reducing childhood injuries. Currently there are no standard tools that providers can use to prioritize counseling areas which is problematic given time limitations in pediatric offices. Safe 'N Sound is a computerized risk assessment for children age 0-4 years designed to guide guidance in well visits by identifying the two highest priority risks for each child based on the caregivers home and vehicle safety practices. The purpose of this paper is to examine caregivers' reported injury risks and injury incidence data with actual anticipatory guidance topics during well child visits in pediatric offices in one community.

Methods:

Safe N Sound was placed in five pediatric clinics in one community for an average of nine months. Parents of children ages 0-4 completed the voluntary assessment in the waiting room; 11,884 users utilized the program. Chart audits were conducted at each site to determine the frequency and types of injury counseling at those practices. The incidence of relevant injuries was

obtained from ICD-9 E - codes for emergency room and inpatient visits along with mortality incidences for the community. Injury types as documented from each source were ranked and then compared to assess their agreement.

Results:

In analysis of broad injury risk categories, the risk areas identified by the Safe N Sound program were similar to consensus agreement of priority by injury specialists and by injury data regarding the leading causes of child death. Lead categories identified through the assessment included Motor Vehicle 36.8%, Burns, 25.9%, and Suffocation 17.3%. However, site and topic specific results show promise for identifying specific risks. In two of the settings, burn risk exceeded motor vehicle risk as the top risk for that population, and in one site four of the injuries were equally represented making the case for broader content at that site. Results also indicated the need to adjust risk content delivery within injury areas as well. Accidental suffocation risks were large in both the self reported and injury mortality data. However, when examining risks in that category, the largest self reported risk factor was soft items in the crib, while the most frequent content of provider counseling was "back to sleep". Deficits in risk counseling were identified such as in the case of burns, with lower rates of counseling compared to the actual risk levels in the population.

Conclusions:

Results indicate that there is agreement between injury risk data, self report data, and provider counseling on broad categories of child injury risks, but that differences exist in counseling content of preference, clinic specific risk factors, and specific messages within injury risk area. Safe n Sound may be an effective tool to guide selection of injury prevention topics.

Objectives:

Attendees will learn to:

- 1) Identify the utility of having a prioritization method for identifying family injury risks for young children;
- 2) Identify differences in messaging most commonly seen in broad injury topics that may lead to a difference in injury impact; and
- 3) Identify differences in self reported injury risks and counseling on risks as they both compare to injury incidence.

Health Educators' and Artists' Collaboration Yields Innovative Educational Materials

Kira McGroarty Koon, MPH, CHES; Eileen M. McDonald, MS; Stephanie Parsons, BS, CHES, Andrea C. Gielen, ScD, ScM

Introduction/Background:

The CARES Safety Center is a mobile injury prevention center that aims to be a “one-stop shop” for safety for low-income, urban families in Baltimore City. Developed and implemented through a partnership between the Johns Hopkins Center for Injury Research and Policy (CIRP) and the Baltimore City Fire Department (BCFD), the CARES Safety Center promotes the safety of children and families by providing life-saving education and access to affordable safety products. This 40 foot “house on wheels” contains 22 fun, interactive exhibits that safety educators utilize to teach parents and caregivers how to prevent injuries in their home.

In response to the growing Latino population in Baltimore, the need emerged to develop new or adapt existing educational materials and exhibits tailored to both English and Spanish speaking families who visit the CARES Safety Center. Thus, CARES Safety Center educators and faculty collaborated with faculty and students at a local art college to create and pilot-test materials and exhibits for both English- and Spanish-speaking families. This presentation will provide an overview of this collaboration, the resulting six new or adapted injury prevention materials and exhibits, and how artists and injury prevention educators can work together to develop materials for low-literate audiences.

Methods:

Health educators and graphic designers/artists met over a 3-month period to: 1) Confirm and clarify injury prevention, literacy and design needs of both English and Spanish speaking families, 2) Brainstorm approaches, and 3) Create and revise material prototypes. Two focus groups were conducted with English- and Spanish-speaking adults to pilot test the material and solicit feedback about them from adults.

Results:

Six new or adapted injury prevention materials and exhibits were created and will be presented. Each product followed a design protocol that used universal icons to depict injury prevention content. The use of diagrams and a consistent color system reduce the need for written language. Focus group results will be shared that document participants' overall positive response. Most participants reported that they found the materials both aesthetically appealing and culturally relevant. In addition, the injury prevention content was

accurately interpreted and understood by participants.

Conclusions:

Collaborations between public health and design professionals can be successful in developing innovative and effective health education materials. Such innovative partnerships should be further studied and implemented.

Objectives:

Attendees will learn to:

- 1) Explain three benefits of a health educator & artist collaboration to develop health educational materials for the public;
- 2) Describe two design elements that reduce the need for language in educational materials; and
- 3) Explain six innovative educational materials that facilitate home safety education for parents.

On the Road with Injury Prevention - An Analysis of the Efficacy of a Mobile Injury Prevention Exhibit

Mariann Manno, MD, Allison Rook, MPS, EdM, Andrew Burr, DO, Amanda Yano-Litwin, Michael Hirsh, MD

Introduction/Background:

To assess the effectiveness of a mobile injury prevention vehicle (Mobile Safety Street (MSS)) with a comprehensive hands-on curriculum on instruction and retention of safety knowledge when compared to traditional classroom safety curriculum among grade 5 elementary school children within a large central Massachusetts city.

Methods:

All Grade 5 students (n=1,692) were asked to participate in the study as either the intervention group (who received the MSS experience) or the comparison group (who received traditional classroom safety education). Each student in the intervention group was asked to complete a series of 3 surveys. The first survey was given prior to the MSS visit (Fall '09) followed by a survey given immediately following the MSS visit (Fall '09), and a final one given 6 months after the MSS visit (Spring '10) to measure knowledge retention. Students in the comparison group were asked to complete 2 surveys. One baseline survey given at the same time as the treatment group (Fall '09) and one given after the completion of the traditional classroom safety education curriculum (Spring '10). Descriptive statistical analyses were then conducted to determine if significant differences existed between the various treatment and comparison groups.

Saturday, November 13, 2010

Results:

Of the 1,692 5th grade students eligible to participate in the study, 1,417 students (84%) completed the baseline survey in September/October 2009 (pre-intervention group) averaging 9.12 correct responses out of 14 questions (64% correct). The intervention group (444/1,417; 31%) took an immediate post test in October/November (post group) averaging 10.7 correct responses (76% correct) and a six month (April/May 2010) (delayed post group) delayed post test averaging 10.5 correct responses (75% correct). Within the intervention group significant differences were noted between the pre-intervention and post-MSS group (9.12 vs. 10.7, $p < 0.0005$). No significant difference was noted between the post-MSS and delayed-post MSS group ($p = 0.06$). The comparison group (155/1,417; 11%) completed a post test (February/March 2010) averaging 9.7 correct responses (69% correct). Significant differences were noted between the comparison group's pre and post scores (9.7 vs. 9.12, $p = 0.0005$) as well as the comparison group's post scores and the intervention groups' post-MSS scores (9.7 vs. 10.7, $p < 0.0005$).

Conclusions:

Injury prevention is critical to reducing traumatic preventable injury and deaths within the modern trauma system. Hands-on programs such as Mobile Safety Street are shown to be more effective than traditional methods for providing young children with the necessary safety knowledge.

Objectives:

Attendees will learn:

- 1) How hands-on curriculum can impact the efficacy of safety and injury prevention education curriculum;
- 2) About the challenges in developing and implementing a novel interactive exhibit; and
- 3) About adapting traditional classroom safety curriculum into an interactive model.

Kohl's Safety Center in a Safety Store World

Christine A. Vitale MSN, RN; Barbara A. Gaines, M.D.

Introduction/Background:

For eight years we diligently worked to bring a safety store to our hospital to provide families with education, resources and hands-on skills necessary to keep their children safe at home. After many changes in leadership, location, style and process we opened the Kohl's Safety Center in February 2010. Unlike our original plan, and the first of its kind, this center is not a store and nothing is sold. We have six months to program information to share.

Methods:

Families come to the center by referral or as walk-ins from inpatient and outpatient areas of the hospital or from the community. Each family completes a home safety assessment, signs a waiver as part of participation, and agrees to a follow up call. Staff review the assessment, provide education, prioritize resources needed and allow for hands-on practice. Data is collected on referral patterns, inventory patterns, home safety concerns, family misconceptions, and demographics. In the first three months of operation 95 families have been served in an increasing number over time. Follow up calls are just beginning; we will have five months of follow up at the conference and many more families. Follow up consists of product usage, ease of use, issues, additional safety measures taken by the family, and injury occurrence.

Results:

We will be looking at who is coming to the center and from where, what are the needs they report vs. the needs identified in their assessment, what resources are being provided, are they being used, are they working as expected, and are families taking steps to further the level of safety in their homes? We will be reporting additional recommendations of families, cost of operating and sustaining a center and future plans for growth.

Conclusions:

We learned that through persistence and flexibility programs will come to fruition. Families believe the safest place is home, even though most injuries to their children occur in the home. Our goal is to make their belief a reality. We have creatively designed a center to meet the needs of the hospital, the needs of our program, the needs of our funder and most importantly the needs of our families and community.

Objectives:

Attendees will learn:

- 1) Compare two similarities and two differences of a safety center and safety store;
- 2) Discuss three positive effects of a safety center in the institution; and
- 3) Explain the importance of having all three in place - education, hands-on skill practice, and resource provision.

The New York City Pediatric Disaster Coalition: A Readily Replicable Model for Multidisciplinary Regional Pediatric Mass Casualty Planning

Arthur Cooper, MD, Michael Frogel, MD; Mayer Sagy, MD; Katherine Uranek, MD, Lewis Soloff, MD, Dana Meranus, MPH, Michael Tunik, MD, Stephan Kohlhoff, MD, Bruce Greenwald, MD, Katherine Biagis, MD, Michael Ushay, MD, Steven Pon, MD, Edward Conway, MD, David Prezant, MD, Dario Gonzalez, MD, Mordechai Goldfeder, MPA, EMT-P, Nicholas Lobel-Weiss, BA, EMT, Avram Flamm, B.EMS, Marsha Treiber, MPS, George Foltin, MD

Introduction/Background:

Children frequently are the victims of disasters due to natural hazards and acts of terrorism. However, there is a lack of specific, comprehensive, pediatric, emergency preparedness planning worldwide. A disaster or mass casualty event (MCE) in the New York City (NYC) metropolitan region that involved pediatric patients could overwhelm existing pediatric resources. The New York City Department of Health and Mental Hygiene (NYCDOHMH) recognized the need to plan for a MCE with a large number of pediatric victims and funded a project called the NYC Pediatric Disaster Coalition (PDC). The PDC's primary goal is to create a coalition that addresses gaps in the ability and infrastructure of the NYC Regional Health Care System to provide effective and timely large-scale pediatric care during a MCE.

Methods:

The PDC was created and includes 11 of 43 NYC Pediatric and Children's Hospital programs, experts in pediatric emergency preparedness, emergency medicine, critical care, and surgery, the NYCDOHMH, the NYC Office of Emergency Management (OEM), and the NYC Fire Department (FDNY) Office of Medical Affairs (OMA), which provides medical oversight of the municipal emergency medical services (EMS) agency. The participants formed two committees to develop Prehospital Triage/Transport and Hospital Surge Capacity plans. The committees met twice per month to develop plans using an iterative process.

Results:

After an extensive literature review and multiple draft revisions, Prehospital Triage/Transport and Hospital Surge Capacity plans were formulated. The former utilizes novel pediatric modifications of the START algorithm, a two-tiered Pediatric Disaster Receiving Hospital system, and Virtual Pediatric Consultation Center. The latter utilizes a four-stage plan to expand existing pediatric critical care services to provide pediatric mass critical care (MCC), including education of pediatric hospitalists in Pediatric

Fundamental Critical Care Support (PFCCS). These plans provide pediatric specific triage and transport, matching severity of illness to the appropriate level of resources, and additional hospital surge capacity for critically ill or injured pediatric patients.

Conclusions:

The PDC project has proven itself an effective multidisciplinary approach to planning for a large-scale MCE involving pediatric patients in a major metropolitan area. This structure could be used as a replicable model for other large urban centers.

Objectives:

Attendees will learn:

- 1) The importance of multidisciplinary participation in regional pediatric disaster planning;
- 2) A regional model for triage and primary and secondary transport of ill or injured children to pediatric disaster receiving hospitals; and
- 3) An all hazards approach to mass critical care of ill or injured children in the event of a disaster involving multiple pediatric casualties.

Pediatric Hospital Incident Command System (PHICS): Innovative Approach to Hospital Emergency Management

Nathan Timm, MD, Matthew Gneuchs

Introduction/Background:

Hospitals must prepare and respond to various emergencies including natural and man-made disasters that exceed capacity. Furthermore, hospital emergency management has taken on greater importance for national accreditation agencies over the past few years. Development and maintenance of an emergency management system that is simple, rapid and flexible, is a challenge for all hospitals.

Methods:

In 2008 our hospital developed and adopted an innovative hospital emergency management system called the Pediatric Hospital Incident Command System (PHICS). The goals of this program were the following: (1) provide a cohesive approach between the preparedness and response components of a hospital emergency management plan, (2) simplify training and implementation of emergency management concepts to hospital leadership, and (3) reflect emergency management priorities established for hospitals by accreditation agencies.

Sunday, November 14, 2010

Results:

As a result of this initiative, numerous changes were made to our emergency management program with an emphasis on the six critical areas of PHICS: Communication, Safety & Security, Staff Support, Patient Clinical Support, Facilities and Resources & Assets. Based on these priorities the following changes were made: (1) Reorganization of the hospital Emergency Preparedness Committee to include critical hospital leadership and departments, (2) Implementation of PHICS structure by our incident management team to respond to hospital-wide emergencies - both simulated and real, and (3) Utilize consistent format for after-action reports and performance improvement measures in the context of the six critical priorities.

Conclusions:

(1) PHICS capitalizes on the design of daily operations to limit confusion and uncertainty thereby increasing the system's reliability during crisis, (2) This system integrates preparedness measures with response activities, thus ensuring a more coordinated effort during a hospital emergency, (3) The structure allows for the integration of emergency management regulatory guidelines to naturally follow everyday function while being flexible.

Objectives:

Attendees will learn:

- 1) A cohesive approach between the preparedness and response components of a hospital emergency management plan;
- 2) To simplify training and implementation of emergency management concepts to hospital leadership; and
- 3) Emergency management priorities established for hospitals by accreditation agencies.

Creating a regional Emergency Preparedness Training Center using state and federal funding: one institution's experience.

Mary-Elise Manuell, MD, MA; Andrew Milsten, MD, MS;
John Broach, MD, MPH, Michael Hirsh, MD

Introduction/Background:

Healthcare agencies are under pressure to ensure that their staff receive training on certain emergency preparedness topics in order to comply with various state and federal regulations. Challenges to accomplishing this training include lack of a standardized healthcare emergency preparedness curriculum and difficulty in accessing courses due to location, cost, and availability constraints. Recognizing the need for increased availability of high quality,

standardized emergency preparedness training, the Massachusetts Department of Public Health Emergency Preparedness Bureau has recently provided funding for the development of two regional training centers.

The University of Massachusetts Medical School was one of two institutions recently awarded funding through the Massachusetts Department of Public Health Emergency Preparedness Bureau. In response to this, the Division of Disaster Medicine & Emergency Management created the Center of Excellence for Emergency Preparedness Education and Training (CEPET). The grant award specified the target audiences (staff members of hospitals, community health centers, EMS agencies and long-term care facilities) for the training as well as the focus topics for the curriculum (Incident Command System, HazMat and decontamination, risk communication, developing and implementing emergency plans for at-risk populations, and updating and revising emergency preparedness plans).

Methods:

Faculty members from the Medical School with expertise in various areas related to the target topics were recruited to participate in the CEPET initiative. A leadership team was identified and includes a Director, Associate Director, Curriculum Development Director and Subject Matter Expert consultant. Recognizing the need for a standardized approach throughout the state, CEPET has collaborated extensively with the MA DPH and the other state-funded training center. This collaboration has included the development of a statewide needs-assessment tool, short- and long-term curriculum planning and information-sharing on previously developed courses and certain areas of expertise.

Results:

The training needs of our state will be assessed using a survey created by the two training centers. Information obtained from this survey will then be used to fine-tune and finalize the curriculum. Preliminary investigation suggests that pediatric-specific disaster training is in high demand.

Conclusions:

We hope that the creation of a regional Emergency Preparedness Training Center using state and federal funding will improve access to and the quality of emergency preparedness training for healthcare providers. The opportunity to collaborate with other regional training centers should strengthen this initiative. Interpreting the data from a statewide needs assessment tool and follow-up surveys after courses are offered may provide the framework for the development of a standardized emergency

preparedness healthcare curriculum that may be applicable in other states.

Objectives:

Attendees will learn:

- 1) How to describe the development of a regional emergency preparedness training center;
- 2) The topics of focus in emergency preparedness training for healthcare agencies and providers;
- 3) Methods for collaboration between independent disaster preparedness training agencies; and
- 4) The process for development of an emergency preparedness training needs assessment tool for healthcare agencies.

Comprehensive Pediatric Disaster Preparedness

J Upperman, R Burke, B Berg, K Stevenson, N Blake, R Neches, R Wetzel, A Nager and H Ford.

Introduction/Background:

Many gaps exist in pediatric emergency preparedness. We hypothesized that a multi-disciplinary program focused on pediatric disaster planning and education would improve awareness and pediatric presence in a large urban county. To demonstrate this, we employed a federally-funded novel partnership between a private non-profit healthcare organization and a government emergency services agency.

Methods:

With IRB approvals, we created an organization to address pre-determined gaps in pediatric disaster education, research, information sciences, and hospital response. The functional-based structure included: (1) Disaster Resource Core; (2) Education and Training Core; (3) Drill and Evaluation Core; (4) Informatics Core; and (5) Administrative Core. We identified faculty and staff Core Leaders to develop strategies and direct the workflow. The Administrative Core provided overall project and financial management. The Core leadership identified 30 deliverables. Each core leader was responsible for reporting the status of their project results on a bi-weekly basis.

Results:

We recruited and hired seven faculty/staff leaders and 20 support staff over the two year period. We successfully completed 25 of 30 deliverables. The Center produced one national symposium and two national consensus forums with over 70 invited faculty and 350 participants. The family reunification summit produced a set of 44 recommendations. The national summit produced 24 manuscripts that were published in the Journal of Trauma supplement. In

addition, the Center partnered with local government and community organizations to coordinate three conferences: Grant Funded Disaster Preparedness Efforts, Pediatric Medical Surge, and Emergency Preparedness and Disaster Planning for Children with Special Health Care Needs. These meetings were attended by approximately 350 participants. The Center developed two web-based software programs: Pediatric Emergency Decision Support System (PEDSS), designed to support disaster planners in preparing for a surge of children, and SurgeWorld, which is a serious simulation game supporting real-time pediatric triage. The Education and Training Core trained over 300 individuals in person. The Center conducted research and published eleven manuscripts and eight abstract and poster presentations.

Conclusions:

Our findings indicate there are continued gaps in pediatric disaster preparedness, especially for children with special needs. More work is needed to help prepare emergency planners and responders for pediatric medical needs and a surge of children.

Objectives:

Attendees will learn:

- 1) Gaps in pediatric emergency preparedness;
- 2) Techniques for closing educational gaps in pediatric emergency preparedness; and
- 3) The role of informatics in preparedness.

Coping with a Catastrophic Natural Disaster: Perspectives, Systems, and a First Hand Account

James Betts, MD

Introduction/Background:

The Bay area has made great strides, as individual “systems” and communities, but more important as a unified Bay Area response coalition, to be better prepared to respond to a future devastating natural disaster. Discussion of specifics of the actions taken in 1989, as well as the Oakland Urban Fire of 1991 which destroyed 3200 homes in the Oakland Hills, and took the lives of 25 individuals, laid the ground work for the current integrated EMS, rescue, and health care response.

Methods:

Review of previous disasters

Results:

The devastation in Haiti most recently portrays the vulnerability of the human species to the scope of destruction and loss of human life. Most recently Hurricane Katrina demonstrated just how

fragile our cities and residents can be when the aftermath of the event and what's left in its path far exceed the ability of the "system" to properly deal with such an event.

Earthquakes have been recorded for thousands of years. Throughout the US there are faults, some inactive for decades, perhaps hundred's of years, awaiting movement-decompression, slippage, which can simply ravage entire regions, leaving everything in its "confines" destroyed, and thousands injured or dead.

In 1989 the Bay Area experienced a 15+ second, 7.1 magnitude temblor. Buildings collapsed. Roads warped, cracked, sunken and were impassable. The venerable Bay Bridge, constructed in 1937, had a section fall due to the failure of a set of 4"x 10" pins. Overall, there were 67 deaths in the Bay Area, 44 of them in the collapse of an elevated highway in the east bay, constructed in 1957 and known to be at risk for collapse in such an event. Even with thousands of buildings damaged or destroyed, the total cost for repair at 3 billion dollars, this was a small event given the location, and risk of a truly major earthquake.

Conclusions:

EMS, rescue, and health care responses have been extraordinary, given that the "system" has not fully been prepared to deal with even the modest number of injured and trapped relative to what would be expected with "The Big One". Rescues have been haphazard at some scenes, well coordinated at others. Yet with the entire calamity at that time, systems were not truly overwhelmed, and those in need received the full "compliment" of diagnostics and care that would be offered during less disruptive events. In the event of a sustained, much greater magnitude shaker, most hospitals in the bay area would be rendered inoperable. Loss of life will be in the thousands-tens of thousands, with many times more than that injured and trapped: Truly an event on the scale of a Haiti. Healthcare workers will need to make decisions to care for the least and lesser injured victims, for to use valuable resources on those not expected to survive will quickly deplete the supplies which could be used on those more likely to survive their injuries.

Objectives:

Attendees will learn:

- 1) How to define "austere medical care" as it relates to the 2010 advances utilized in daily practices;
- 2) Some basic "preparation guidelines" for those health care workers, both in the hospital and at home? and
- 3) How an integrated system prepares us for dealing with a lesser event, such as a multi-casualty incident, and smaller surge of patients?

Alcohol & Drug Misuse among Injured Caregiver/ Child Groups

Karla A. Lawson, Paula Yuma-Guerrero, R. Todd Maxson,MD; Kirk von Sternberg, Mary M. Velasquez,

Introduction/Background:

Trauma centers are required to provide patients with screening and brief intervention (SBI) for problem drinking. Caregiver's misuse of alcohol is related to child injury, however the scope of the problem is not known, and SBI with caregivers of pediatric trauma patients has not been evaluated. The purpose of this study is to examine alcohol and drug misuse by caregivers presenting with children to a hospital after injury in a common motor vehicle accident (MVA).

Methods:

We reviewed medical records for groups of caregivers and children who presented to an emergency department for injuries sustained in a common MVA from July 1, 2005-June 30, 2006. Alcohol or drug use at the time of vehicle collision was defined by blood alcohol screen, urine drug screen, and/or suspicion by the clinical team of acute intoxication. Alcohol and drug misuse was defined as positive responses to alcohol or drug "habitual" use intake questions. Groups were compared using Student's t-test for continuous variables and Chi2 analysis for categorical variables.

Results:

We identified 278 incidents of caregivers (n=363, age >16) and children (n=426, age <16) presenting together after a common MVC. Twenty seven (9.7%) groups contained a caregiver with a blood test positive for alcohol/drugs or who was suspected of intoxication; an additional 30 (10.8%) groups contained a caregiver admitting to alcohol or drug misuse. Positive intoxication at the time of car crash was significantly related to being male (p < 0.001), vehicle rollover (p = 0.008) with ejection (p 0.02), and lack of seat belt use (p = 0.003). Children in the vehicle with a positive caregiver were more likely to be admitted to the hospital (p = 0.001) and slightly more likely to be unrestrained (p = 0.06). There was no significant relationship between admission of past substance misuse and these parameters.

Conclusions:

A substantial portion of our patients' caregivers are risky alcohol and drug users. Caregiver intoxication at the time of motor vehicle collision was related to crash severity, hospital admission and safety device use. Results from this study led to a pilot screening program for caregivers of pediatric trauma patients. Over seven months, 295 caregivers were interviewed: 32.5% (n=96) admitted to risky alcohol use within the past year and

0.0% (n=0) to use of illicit drugs. Further research evaluating SBI for caregivers' use of alcohol and drugs in pediatric settings is needed.

Objectives:

Attendees will learn to:

- 1) Identify vehicle collision outcomes associated with caregiver alcohol use in this study population;
- 2) Discuss the need for the screening for risky alcohol use among caregivers of pediatric trauma patients; and
- 3) Identify the association between safety device utilization and caregiver alcohol use in this study population.

Injury-Related Hospital Admissions of Military Dependents Compared to Similarly Aged Non-Military Insured Infants, Children and Adolescents

Joyce C. Pressley, Ph.D., M.P.H., Barbara Barlow, M.D. and Rebekkah Robbins

Introduction/Background:

Children in today's military families have well-recognized physical, educational and mental health needs. Risks to mental health in fragile family relationships associated with deployment of one or both parents and single parent caregivers have been documented, but less is known about the injury risks in child and adolescent military dependents.

Methods:

The Kid Health Care Cost and Utilization Project (KID) 2006 database containing 3,131,324 hospitalizations from 38 states was used to identify the study population. Inclusion criteria included states that reported insurance payment status that allowed classification as a military dependent through expected payor being CHAMPUS, Tricare, or CHAMPVA (CTC) as either a primary or secondary source of payment; age at hospitalization 0 to 17 years; and being insured through any means: private; CTC, other government; or other insurance. KID reporting states that did not report CTC coverage or that combined CTC with other government (including Department of Defense) were excluded. To identify individual child and adolescent exposure to out-of-hospital injury mechanisms, we excluded cases with admission type 'newborn', age at hospitalization zero or 1 day old; transfer to another short term hospital (to avoid double counting cases); and admission type missing. Of the final study population of 742,811, 12,305 were classified as military dependents with 77.8% of dependents hospitalized in a state containing an IFCK site (AZ, FL, CT, GA, KY, NC, NY, SC, TX, and WI) and 22.2%

in a state without an IFCK site (CO, KS, NJ, OR, TN, VA. Univariate proportions for categorical data are presented in percent of total hospitalizations and used chi square or Fishers exact tests of significance. Odds ratios (OR) are presented with 95% confidence intervals. All data are unweighted. SAS 9.2 was used to process the large data set.

Results:

Injury-related admissions from all cause injury was higher in CTC insured (military dependents) than in other insured patients (15.5% vs. 13.2%, $p < 0.0001$). Except for ages 5 to 9 years, military dependents exhibited higher odds of total injury in all age groups. Military dependents were more frequently white, less likely to be in the lowest income quartile, more likely to be classified as urgent vs. emergent upon admission, and tended to have higher all cause mortality ($p = 0.052$). Although the n and the risk difference were generally small, very young children had significantly higher odds of hospitalization for multiple trauma, intercranial injury, poisoning, suffocation and homicide. All military dependent age groups had a higher proportion of hospitalizations with a mental health diagnosis; older age groups had multiple mental health diagnoses. Except for 5 to 9 year olds, poisoning hospitalizations were higher in all military age groups. Age, gender and race adjusted suicide ORs were higher in the 3 oldest age groups, beginning with 10-14 year olds. There were no significant differences in the proportion of hospitalizations associated with motor vehicle traffic, driver, passenger or pedestrian injury.

Conclusions:

This study suggests that military dependents comprise a special needs population and identifies several mechanisms where injury prevention professionals might begin to address their needs.

Objectives:

Attendees will learn to:

- 1) Identify unintentional injury mechanisms for which preschool, elementary, and high school aged military dependents may be at increased or decreased compared to other similarly aged youth;
- 2) Identify intentional injury mechanisms for which preschool, elementary, and high school aged military dependents may be at increased or decreased compared to other similarly aged youth; and
- 3) Discuss areas where and ways in which injury prevention programs might be better able to address this vulnerable population.

Preventing Child and Adolescent Injuries in Rural Areas: Using a “Community of Practice” Model

Erica Streit-Kaplan

Introduction/Background:

Injury rates are higher in rural areas than urban due to many leading injury mechanisms. As a result, rural populations are more likely to die from injuries - such as motor vehicle crashes, drowning, fires, unintentional firearm injuries and suicide - than their urban counterparts. This may be attributed to several factors, including rural road design, inconsistent enforcement of safety laws, distance from first responders and medical care, and social norms that promote riskier recreation - such as all-terrain vehicles (ATVs) and snowmobiles. Through cross-agency collaboration, planning, and adaptation of best practices that focus on rural injury prevention, this disparity can be reduced.

Methods:

The Children’s Safety Network (CSN) formed a Community of Practice (COP) in April 2009 to assist six New England states in preventing rural injuries. The COP has a multifaceted membership of state Maternal and Child Health, Injury Prevention, and Rural Health staff. The National Highway Traffic Safety Administration, the New York Center for Agricultural Medicine and Health, and the Injury Prevention Center at Arkansas Children’s Hospital also participate. The group meets monthly via conference calls to learn about rural injury issues, share resources, and develop prevention strategies. CSN also recently launched a social networking web site so states can discuss pressing issues and share key information in a larger context. In September 2010 CSN will start a new national Community of Practice for 5-10 additional states to learn about data and prevention strategies and to take action on rural injury prevention.

Results:

The COP offers a model of multi-state, cross-agency collaboration to address a major health disparity, focusing on four key injury issues: 1) teen motor vehicle crashes, 2) teen suicides, 3) ATV injuries and 4) farm injuries. Each state convened a team to work on one of these issues. Six teams developed action plans to adapt evidence-based interventions for use in rural communities. Two states are addressing ATV injury prevention - one in providing information for proposed legislation to increase minimum rider age, the other working with the ATV rider association to promote education. Another two states are examining community-level data to assure that rural interventions reach at-risk populations. As part of

the COP, the fifth state was introduced to a key rural farm health organization which is now their new partner for education efforts. Finally, the sixth state is transforming their existing teen driving coalition to emphasize rural crash prevention. The COP facilitated collaboration both within states - multi-disciplinary teams strategized solutions and developed action plans - and also between states - sharing ideas, resources and feedback.

Conclusions:

Rural injuries are often overlooked since populations are larger in non-rural areas. However, particular attributes of rural life contribute to higher injury rates, leaving children at risk. Successful injury prevention in rural areas often requires different approaches than those for urban communities. Participating in the COP helps states learn, strategize and take action to successfully prevent injuries to children and youth, and promote healthier rural families and communities.

Objectives:

Participants will:

- 1) Understand the rural/urban injury disparity;
- 2) Learn how the multi-state Community of Practice model can increase collaboration and reduce rural injuries; and
- 3) Adapt injury prevention best practices for use in rural areas.

Behaviors of Children Ages 15 months to Five Years Around Microwave Ovens

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Introduction/Background:

Scald burn injuries are the leading cause of burn related emergency room visits and hospitalizations for young children. Studies have shown that scald burns are largely related to food preparation and consumption and generally occur in the kitchen or dining areas of the home environment. Many of these injuries occur when children are removing items from microwave ovens. Currently, safety controls are in place for most microwave ovens to prevent it from being started; however there are no safety controls for preventing the opening of the microwave once heating has occurred.

These safety concerns along with the observed scald injuries in young children operating and/or removing hot liquids from microwave ovens lead to this study. The purpose of this study was to assess the ability of

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typically developing children ages 15 months to 5 years to operate, open and remove the contents from a microwave oven.

Methods:

Subjects were recruited ranging in age from 15 to 59 months. Eligibility criteria included a microwave oven in the child's home environment, age appropriate development and English speaking. The Denver Developmental Screening Test II was administered to confirm normal development. Children were observed for interest in the microwave, ability to open both a push and pull microwave oven door, to remove a cup from the microwave and to start the microwave. Sessions were videotaped.

Results:

40 subjects without developmental delay were recruited. All four children aged four years were able to start the microwave, open both types of doors and remove a cup. Of eight children aged three years, all could start the microwave, seven (87.5%) could open both types of doors and all could remove a cup. Of 10 children aged two years, nine (90%) could start the oven, nine (90%) could open both types of doors, and all could remove a cup. Of 10 children aged 19-23 months, five (50%) could start the microwave oven, eight (80%) could open both types of doors, and nine (90%) could remove a cup. Of eight children aged 15-18 months, three (37.5%) could start the oven, two (25%) could open the pull door, one (12.5%) could open the push door, and two(25%) could remove a cup.

Conclusions:

We found that children as young as 17 months can start a microwave oven, open the door and remove the contents putting them at significant risk for scald burn injury. Passive prevention efforts to improve supervision and caregiver education have not lead to a significant reduction in scald injuries in young children. Therefore, consideration for redesigning safety controls on microwave ovens to not only prevent them from being started but also prevent them from being opened once heating has occurred needs to be addressed to help prevent this mechanism of scald injury.

Objectives:

Attendees will learn:

- 1) About the abilities of children 15 to 59 months in operating, opening and removing the contents from microwave ovens;
- 2) About the implications for scald injury to an at risk population with these abilities; and
- 3) About prevention efforts for this mechanism of scald burn injury.

Falls Among School-Aged Children (6-14 years) in An Urban County

Erica Flores BA and Andrea Winthrop MD, Department of Surgery, Medical College of Wisconsin and Children's Hospital of Wisconsin

Introduction/Background:

Falls are the leading cause of non-fatal unintentional injuries in children 6 to 14 years of age. Identification of fall-injury patterns and risk factors are essential to the development of injury prevention strategies to reduce these injuries in children at higher risk. Using the ABC's of injury prevention, this is the first step in designing a comprehensive falls prevention program in the targeted community.

Methods:

Data was abstracted from all inpatient charts and a 10% randomized sample of outpatient charts for children ages 6 to 14 years with a County zip code of residence, and with an E-code for a fall injury during a 3 year period. County zip codes were separated into inner city (Injury Free Coalition for Kids 7 zip codes with the highest injury frequency at the regional Children's hospital) and the surrounding county (county group).

Results:

The mean age was 9.8 years, with 72% in elementary school (6-11 years), and 62.5% males. Inner city vs county were 39.4% vs 60.6% respectively, similar to the proportion of children in the population in these 2 groups (43% vs 56% respectively). Odds Ratio analysis included: male: female OR 1.6; age 6-11:12-14 OR 1.3; and inner city:county OR 0.86. The most common cause of falls in the study was sports activity (27.6%). The 2nd leading cause in outpatients was slipping/tripping (25.6%), and for inpatients it was playground activity (18.7%). Severity of injury and cause of fall differed by age and gender. The younger children (6-11) were more severely injured, representing 78% of the inpatients, with sports injuries the most common cause (20.9%) in this younger inpatient group. The middle school age children (12-14) that required admission had more falls from bikes (35.7%). For males, the most common cause of falls was due to sports (26.1%). Although females treated as outpatients were most commonly injured during sports (28%), playground falls were the leading cause of female patient admission (29%).

Conclusions:

Our data suggests that elementary school children in this urban county have a greater risk for falls, and a greater likelihood of serious fall injuries requiring admission. While the majority of falls are due to sports

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activities, the 2nd leading cause of falls causing serious injury was from playground equipment. Further, the causes of falls leading to admission differed with age and gender. Although the inner city group was not identified at higher risk, the causes of falls and location where these events occurred differed from the county, more suburban children. Additional risk factor analysis including season, time of day, socioeconomic status, injury patterns and geographic location within the county will be completed and used to facilitate development of targeted prevention interventions by the IFCK Community Coalition.

Objectives:

Attendees will learn:

- 1) How to use the ABC's of Injury Prevention approach to develop an epidemiologic profile of falls injuries in school age children in a targeted community;
- 2) How this analysis can be used to facilitate the development of targeted prevention strategies by the local Injury Free Community Coalition; and
- 3) To identify opportunities to provide education to schools and sports recreation organizations about the risks of falls during these activities.

Injury Prevention Preparedness in Youth Football and Soccer Coaches: Are They Prepared to Identify and Manage a Potentially Catastrophic Injury?

Mary Beth Moran PT, MS, M.Ed.

Introduction/Background:

Each year 3.5 million children under the age of 14 receive medical treatment for sports related injuries. The majority of these injuries involves head injury, spinal cord injury, heat related illness and overuse injury. Currently the California Senate is reviewing an existing law which requires that school districts mandate that all coaches maintain CPR and First Aid Certification and complete a coaching education program. The proposed amendment, commencing December 31, 2011 would require all coaches take or renew a first aid certification that includes a basic understanding of the signs, symptoms and appropriate emergency action steps regarding potentially catastrophic injury. Including but not limited to concussion, second impact syndrome, head and neck injury, heat stroke, asthma attacks and cardiac arrest.

To support this legislation a survey was developed and distributed to obtain baseline information on preparation, knowledge and current practice of regional youth football and soccer coaches. The outcome of the survey will assist in the development of

future educational and advocacy programs as well as demonstrate the effectiveness of current programs.

Methods:

A literature search was conducted to evaluate prevalence and mechanism of injury of common sports related injury. Reports of best practice were compiled according to recognized and evidenced based organizations such as the National Athletic Training Association and the American Academy of Orthopedics. Survey data was extrapolation from various pre-tested surveys such as the CDC "Heads Up" survey and Stop Sports Injuries campaign. The survey was tested with a pilot group for validity and reliability. The survey was distributed and collected at a county wide Pop Warner Youth Football training and at the registration of a county wide youth soccer tournament. Data was collected and analyzed use ACCESS software. Proportions of responses were collected and evaluated

Results:

The results indicate that many current nationwide educational programs might have changed the knowledge and practice patterns of coaches as 90% -98% correct responses on recognizing and managing signs and symptoms of concussion, including disallowing a return to same day play. However many coaches (47%) did not know the signs of overuse injury and 23% did not know the signs of heat related illness and only 43% responded correctly with a potential spinal cord injury. Only 50% of the respondents had any CPR certification and only 26% had First Aid certification. Yet, 65% felt confident or very confident that they knew when to withdraw a child from play.

Conclusions:

This survey demonstrates that educational efforts and national campaigns such as the CDC Heads Up campaign might have impacted youth coaches as many recorded correct responses to the survey. However, additional injury specific programs need to be developed to address spinal injury, heat related and overuse injuries.

Objectives:

- 1) Participants will identify gaps in knowledge in coaches surveyed and appreciate the significance of this finding;
- 2) Participants will value the need to advocate for legislative change to enforce advanced education to coaches; and
- 3) Participants will judge the best mechanism for distribution and collection of surveys based on response rate of this survey.

Knowledge and Management of Sports Concussions Among Middle and High School Coaches In Alabama

Gran KA, Yust EM, Nichols MH, King WD, Davis D.

Introduction/Background:

Sports concussions have been a hot topic in recent years. This issue has prompted media attention and legislation in several states. Efforts are also under way in the state of Alabama to improve the identification and management of concussions. The purpose of this study therefore was to determine the current knowledge and management of sports concussions among middle and high school coaches of contact sports in Alabama.

Methods:

A cross-sectional survey was distributed electronically using SurveyMonkey™ to 2668 middle and high school coaches of contact sports in Alabama. Four hundred and two (16%) were returned, and these respondents were used for data analysis. Survey questions focused on coaches' demographic information, experiences, and knowledge of concussions based on the 2008 Zurich consensus statement.

Results:

The majority of participants (n=402) were male (n=327; 81.3%) with median age of 40 years and had coached for 13.3 +/- 8.6 years. Responses were obtained from coaches representing 47 of 67 (70.1%) Alabama counties, with 80.6% urban and 19.4% rural. While 245 (61.3%) coaches had formalized training in concussions and 83 (20.8%) coaches had viewed the "Heads Up: Concussion in Youth Sports" tool kit from the Center for Disease Control, 345 (86.3%) coaches were interested in further training. Of respondents, only 126 coaches (21.5%) provide preseason information on concussions to parents, yet 325 (81.3%) would support more regulatory guidelines from the state to improve proper identification and management of concussions. Overall, 124 middle school coaches (52.4%) and 276 high school coaches (76.8%) have some access to a certified athletic trainer, yet among all coaches 254 (63.5%) rely on physicians to make return to play decisions. Importantly, the most common referral site for athletes with ongoing concussion symptoms is their primary care provider for 174 (43.7%) coaches.

In hypothetical scenarios involving an athlete with a head injury, the most conservative management plans were chosen for athletes with loss of consciousness by 377 coaches (95.2%) and least conservative management plans chosen for athletes with isolated dizziness by 264 coaches (66.7%). Loss of consciousness, headache, and dizziness were most

recognized as symptoms of concussion whereas only 170 (43.0%) coaches recognized personality changes and 137 (34.7%) coaches recognized trouble sleeping as symptoms. Though coaches correctly answered 88.2% of questions assessing knowledge of current concussion guidelines, 41.6% of coaches were not aware that strenuous mental activities can delay recovery from concussions.

Conclusions:

Improving recognition and proper management of concussions requires education and teamwork between athletes, parents, coaches, and various medical providers. These results capture coaches' variability in knowledge and practices. Levels of training, available local resources, and recent changes in concussion guidelines may account for knowledge and practice differences. Increased usage of the CDC tool kit, preseason distribution of educational materials to parents, focus on 'return to activity' instead of return to play, state regulatory guidelines, and targeted education of coaches and primary care providers are needed in our state.

Objectives:

Attendees will learn:

- 1) The current status of knowledge and management of concussions among coaches in Alabama;
- 2) How the previously mentioned information is being used in Alabama to further develop concussion education, programs and legislation, with the hope that it will spur progress in other states; and
- 3) To understand the most common misconceptions held about concussions by coaches, and furthermore, the need to provide education to coaches, athletes, parents, and medical providers.

Motorized Vehicles for Recreation Associated Injuries in Children Presenting to the Emergency Department at Children's Hospital (Dirt Bikes, Golf Carts, Go Carts and Scooters)

Courtney Baxley, MD; WD King RPh, MPH, DrPH; Kathy Monroe, MD

Introduction/Background:

Children and adolescents often use motorized vehicles for recreation (MVR's). Much has been written about motor vehicle and ATV (all-terrain vehicle) related injuries. This study evaluates MVR related injuries involving dirt bikes, golf carts, go carts and scooters.

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Methods:

After IRB approval, a retrospective chart review was performed on MVR injuries involving dirt bikes, golf carts, go carts and scooters during the time period of 1/2006 through 12/2009. Charts were identified by external and anatomic type of injury using an emergency department “E-coded”- medical record database. One reviewer gathered information from the electronic medical records using a standard data collection sheet and entered data into Microsoft Excel. A one way analysis of variance was performed with bonferonni t tests to detect differences in mean age and length of stay by MVR. The National Electronic Injury Surveillance System (NEISS) was also utilized to evaluate national trends of MVR injuries during 2006-2008.

Results:

A total of 196 charts were reviewed (102 dirt bike, 27 golf carts, 26 motorized scooters and 34 go carts, 3 motorized toy cars, 2 lawnmowers, 1 treadmill, 1 farm equipment). Overall, 30 patients (15%) required hospitalization, a higher admission rate than the average for the Emergency Department. Mean length of stay for all MVR types was 3 days. 81% were male and 49% reported helmet use. 61% of the injuries were in children less than 13 years with a min and max age of 15 months and 17 years, respectively. Children with dirt bike injuries were older than children with injuries of other MVR's, ($F=7.8$, $p<0.001$).

There was no association between mean lengths of hospitalization and MVR detected. Anatomic sites of injuries included: 13% closed head injuries, 36% fractures, 19% lacerations, 32% others, including soft tissue injuries, splenic rupture and renal / urinary tract trauma . 96% of patients received a triage level in the emergency department of urgent/acute. All types of MVR visits to our emergency department increased from 2006-2009 and the NEISS data showed an increase in the number of golf cart and scooter related injuries and a slight decrease in dirt bike and go cart related injuries from 2006 to 2008.

Conclusions:

In this study we describe the types of injuries sustained both nationally and locally at The Children's Hospital in Birmingham, Alabama from motorized vehicles including dirt bikes, golf carts, motorized scooters and go carts. The number of young children involved in MVR related injuries was surprising with injuries reported in as young as 15 months of age. These results will help guide interventions for injury prevention in our state. We plan to use this information to educate the public about injuries arising from motorized vehicles for recreation.

Objectives:

Attendees will learn:

- 1) About injuries sustained by motorized vehicles for recreation in children;
- 2) To describe injuries sustained by these vehicles; and
- 3) About National Electronic Injury Surveillance data.



2010 Forging New Frontiers:
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Faculty

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*The 15th Annual Conference of the Injury Free Coalition for Kids jointly sponsored with
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Bios

Bios

Courtney Baxley, MD University of Alabama

Courtney Baxley, MD is a third year Pediatrics resident at the University of Alabama in Birmingham. After graduating from Auburn University with degrees in Biomedical Science and Spanish, Courtney received her Doctorate of Medicine at the University of South Alabama. She is married and has two sons, Harrison and Everett. During her intern year, Courtney was selected by the faculty and fellow residents to receive the Dr. Joseph LaRussa Outstanding Intern Award and Scholarship. After residency, Courtney plans to practice as a General Pediatrician in Birmingham, Alabama. It is her desire to foster a safe environment for the children of her community.

James Betts, MD Children's Hospital Oakland

James Betts, MD is the Surgeon-in-Chief and Director of Trauma Services for Children's Hospital Oakland, where he has served for almost 30 years. The hospital has been a designated Level 1 Pediatric Trauma Center since 1986. A native of rural Vermont, he matriculated at the University of Vermont, for both his undergraduate and medical degrees. Trained in adult surgery and urology, he also completed fellowships in pediatric surgery, and pediatric urology at The Children's Hospital of Philadelphia. Long active in local and state EMS activities, he and his team work closely with local, regional, and state authorities regarding disaster preparedness. The hospital's and region's response system was first challenged during the 1989 bay area earthquake, and again in the 1991 Oakland hills urban fire, which destroyed 3200 homes. More recently, the hospital provided first line response for a child injured during the first two weeks of the Iraq invasion, taking a 9 year old boy gravely injured by the explosion of a cluster bomb. This required a 36 hour direct air transport from a front line US Air Force combat field hospital. On a daily basis Children's Hospital Oakland and the 3 East Bay regional adult trauma centers coordinate efforts with treating high volumes of injured adult and pediatric patients. Children's Hospital Oakland serves as the "safety net" pediatric trauma and critical care center for all of Northern California. Dr. Betts will share some experiences from those events, and present some protocols and systems which might be employed during future catastrophic incidents. He is a fellow of the American College of Surgeons, the American Academy of Pediatrics, the American Association for the Surgery of Trauma, and the American Trauma Society.

Barbara Barlow, MD Founder & Executive Director, Injury Free Coalition for Kids National Program Office

Dr. Barbara Barlow, is a Professor Emerita of Surgery in Epidemiology at the Columbia University School of Public Health and the Injury Free Coalition for Kids Founder & Executive Director. She is also the Founder and Director of the Injury Free Coalition for Kids, developed as a National Program of the Robert Wood Johnson Foundation of Princeton, New Jersey. Injury Free is a coalition of Injury Prevention Programs in Pediatric Trauma Centers located in major cities in the United States. The Injury Free Program reduces injury through education, construction of safe play areas, and the development and support of safe supervised activities with strong adult mentors. Major injury admissions of community children in Harlem have decreased by more than 60% since the program started in 1988. The Program and Dr. Barlow have received awards from the American Hospital Association, the American Academy of Pediatrics, the U.S. Department of Transportation, the National Highway Traffic Safety Association, the National Safety Council, the American Trauma Society, the National Association of Public Hospitals, Society of Public Health Educators of the American Public Health Association, Johnson and Johnson Foundation, Allstate Foundation, the Hospital Association of New York, the American Association of Medical Colleges' David E. Rogers Award, the Renaissance Woman Award from the Foundation for Women in Medicine, the Distinguished Career Award from the American Public Health Association Section on Injury Control and Emergency Health Services, and the Sloan Public Service Award from the Fund for the City of New York. Dr. Barlow's research has focused on traumatic injury to children and on injury prevention for the past twenty-five years. She is a former member of the American College of Surgeons Committee on Trauma and the American Academy of Pediatrics Committee on Pediatric Emergency Medicine. Dr. Barlow received a B.A. from Vassar College, an M.A. in Psychology from Columbia University and an M.D. from Albert Einstein College of Medicine where she was elected to Alpha Omega Alpha. Her general surgical training was completed at Bronx Municipal Hospital followed by a Fellowship in Pediatric Surgery at Babies Hospital, Columbia Presbyterian Medical Center.

Bridget Clementi

Injury Free Coalition for Kids of Milwaukee

Bridget Clementi has more than a decade of experience in implementing and providing oversight for community-based prevention initiatives. As the Executive Director for Children's Health Education Center (CHEC), Bridget not only oversees day-to-day operations, but also provides direction and vision for the center as it develops and delivers engaging, interactive and impactful health education and safety programs to communities throughout Wisconsin. Bridget has presented to a variety of age groups, backgrounds and organizations at many area conferences on all areas of childhood injury prevention; however, she specializes in "childproofing your home" and proper booster and child safety seat usage.

As a health professional, Bridget has over a decade of experience in prevention. She is currently a member of the Governor's Public Health Council and the Waukesha County Fatality Review Team. In addition, Bridget was a child passenger safety instructor for over five years. In 2006, Bridget received the Traffic Safety Advocate award for her work toward the passage of Wisconsin's booster seat law.

Art Cooper, MD, MS

Injury Free Coalition for Kids of New York at Harlem Hospital Center

Art Cooper, MD, MS was born in Brooklyn, New York in 1949. He obtained his baccalaureate at Harvard College and his doctorate at the University of Pennsylvania School of Medicine. He was trained in general surgery at the Hospital of the University of Pennsylvania and in pediatric surgery and surgical critical care at the Children's Hospital of Philadelphia - and is certified by the American Board of Surgery in all three specialties. He is also certified in disaster medicine by the American Board of Disaster Medicine, of which he is a founding member. He is currently Professor of Surgery at the Columbia University College of Physicians & Surgeons - from which he also holds a master's degree in human nutrition - and is both Director of Pediatric Surgical Services and Director of the Regional Trauma Center, as well as Medical Director of the Injury Prevention Program and Co-Director of the Child Protection Team for the Columbia University Medical Center Affiliation at Harlem Hospital. He is a member of numerous professional and academic societies, by which he has been frequently honored for his work in the fields of pediatric trauma, emergency medical care, critical care, and disaster medical care and education. He has co-edited eight books and resources, authored or coauthored more than two hundred scientific articles, textbook chapters, and policy statements, serves on a variety of national and regional expert and advisory committees, both public and private, and is a recognized authority in the fields of pediatric surgical nutrition, critical care, trauma, and emergency medical services for children - particularly pre-hospital emergency care, trauma systems development, and disaster management and emergency preparedness - as well as physical child abuse, and the surgical care of children with human immunodeficiency virus infection.

Dawn Daniels, PhD, RN

Injury Free Coalition for Kids of Indianapolis

Dawn Daniels, PhD, RN, is a public health clinical nurse specialist for pediatric trauma services at Riley Hospital for Children and clinical faculty at Indiana University School of Nursing. She serves on the national advisory council for the Institute for Quality, Safety, and Injury Prevention of the Emergency Nurses Association and chairs the Indiana Injury Prevention Advisory Council for the Indiana State Department of Health. She has a Bachelor of Science degree in Nursing from Pensacola Christian College in Pensacola, Florida and a Master's and Doctorate from Indiana University. In her current role, Dawn works with community groups to implement and evaluate evidence-based injury prevention strategies that focus on behavioral, environmental, and social changes to decrease the incidence and severity of injuries.

Shane Eoff

Arkansas Children's Hospital

Shane Eoff is an All-terrain vehicle research coordinator in the Injury Prevention Center at Arkansas Children's Hospital. He received his Bachelors of Science in Civil Engineering from the University of Arkansas. Shane is currently working on a federally funded grant to develop and evaluate targeted ATV strategies for rural children. He is also conducting formative research around barriers to helmet use for ATV users.

Peter Ehrlich, MD

Injury Free Coalition for Kids of Ann Arbor

Director of Pediatric Trauma, Dr. Ehrlich earned his medical degree from University of Toronto Faculty of Medicine. He completed his General Surgery residency at the University of Toronto. In addition he completed a Master of Science in Molecular Pathology from the Institute of Medical Sciences at the University of Toronto. He also completed a fellowship in Pediatric Surgery at Children's National Medical Center in Washington DC. After he completed his fellowship Dr. Ehrlich spent 5 years at West Virginia University Children Hospital as the director of pediatric surgery. He came to Ann Arbor in 2003 and currently is an Associate Professor of Surgery. Dr. Ehrlich is board certified in Pediatric Surgery and General Surgery and is a Fellow of the Royal College of Physicians and Surgeons of Canada. Dr. Ehrlich serves as Director of Pediatric Trauma at CS Mott Children's Hospital at the University of Michigan.

Kimberly Gran, MD

Injury Free Coalition for Kids of Birmingham

Kimberly Gran, MD is completing her last year of Pediatric Emergency Medicine fellowship at the University of Alabama at Birmingham. Dr. Gran attended the Georgia Institute of Technology in Atlanta, Georgia, where she received a Bachelor of Science in Mechanical Engineering. She received her MD from the Medical College of Georgia and then completed her residency in Pediatrics at Vanderbilt University Medical Center. She has a strong interest in sports concussions, and is actively involved in research and advocacy in this area.

Michael Hirsh, MD

Injury Free Coalition for Kids of Worcester

Dr. Michael Hirsh was born in New York City. After attending Bronx High School, he matriculated at Columbia College of Columbia University where he obtained a BA in 1975. He graduated summa cum laude and Phi Beta Kappa. He then went to Harvard Medical School where he graduated in 1979. He then began surgical residency training at Columbia Presbyterian University Medical Center from 1979 to 1984 and completed a pediatric surgical fellowship at St. Christopher's Hospital for Children of Temple University in Philadelphia in 1986. Thereafter, he spent six years at the University of Massachusetts Medical Center and from 1988 to 1992 was co-director of the Trauma Center there. He was also co-director of the Pediatric Critical Care Unit. In 1992, Dr. Hirsh left Worcester, Massachusetts, to take a position first at Allegheny General and later at Mercy Hospital of Pittsburgh. He worked there from 1992 to 1997 where he began directing a program of consortium of injury prevention sites led by Robert Wood Johnson Foundation, based in New York City. In 1997, Dr. Hirsh transferred his work to Mercy Hospital of Pittsburgh where he worked until he returned to University of Massachusetts Memorial Medical Center in 2000. He is a Professor of Pediatrics and Surgery at the University of Massachusetts Medical School and Director of the Divisions of Pediatric Surgery and Trauma of the University of Massachusetts Memorial Children's Medical Center. He also became Associate Director of Pediatric Critical Care. He became President of Injury Free Coalition for Kids in January, 2009. Dr. Hirsh has been Co-Director of the Trauma Program as well and served as overall Trauma Director for patients of all ages from 2004-2007. During this time, UMMHC received its accreditation as a Level 1 Adult and Pediatric Trauma Center (2005). Dr. Hirsh currently serves as President of the Injury Free Coalition for Kids, a consortium of 42 Injury Prevention sites based at Level 1 Pediatric Trauma Centers. He is also serving as the Secretary of the Worcester District Medical Society. He was recently appointed Surgeon-In-Chief for the UMass Memorial Children's Medical Center. He has been happily married for 30 years to wife, Julianne and has 2 children, Scott, 27 and Esty, 22.

Marlene Melzer-Lange, MD

Injury Free Coalition for Kids of Milwaukee

Marlene Melzer-Lange, MD Professor of Pediatrics at Medical College of Wisconsin, a pediatric emergency medicine specialist at Children's Hospital of Wisconsin, and has expertise in injury prevention, risk-taking behaviors of adolescents, and the medical and psychosocial care of youth, trauma victims and adolescent parents. She serves as medical director for Project Ujima, a youth violence prevention and intervention program, and as medical director of the Emergency Department/Trauma Center at Children's Hospital of Wisconsin. Dr. Melzer-Lange is active in community coalitions including the State of Wisconsin Emergency Medical Services for Children Injury Prevention section, Injury Free Coalition for Kids-Milwaukee, and the American Academy of Pediatrics Section on Injury, Violence

and Poisoning Prevention. She has published research articles on emergency care of children, adolescent utilization of emergency services, coalition building, and adolescent violent injury. She is a graduate of Custer High School in Milwaukee. She received her BS in Chemistry from Marquette University in 1971, her MD from the Medical College of Wisconsin in 1975, and completed her pediatric residency at Children's Hospital of Wisconsin in 1978. She is board certified in Pediatrics and Pediatric Emergency Medicine. She is a native of Milwaukee, is married and has two children and a two granddaughters.

Kira McGroarty-Koon, MPH

Johns Hopkins

Kira McGroarty Koon, MPH is Project Director of the CARES Safety Center at the Johns Hopkins Bloomberg School of Public Health Center for Injury Research and Policy. In this role, Mrs. Koon provides overall coordination of CARES and collaborates with the Baltimore City Fire Department to implement the program. Mrs. Koon received her Masters of Public Health in Behavioral Sciences and Health Education from Emory University Rollins School of Public Health and is a Certified Health Education Specialist.

Garry Lapidus, PA-C, MPH

Injury Free Coalition for Kids of Hartford

Garry Lapidus, PA-C, MPH, is the Director of the Injury Prevention Center at the Trauma Institute, Connecticut Children's Medical Center/Hartford Hospital. He is a physician assistant in the Emergency Department at Connecticut Children's and an Associate Professor of Pediatrics and Public Health at the University of Connecticut School of Medicine.

Karla A. Lawson, PhD, MPH

Dell Children's Hospital

Karla A. Lawson, PhD, MPH is the head of the Trauma and Injury Control Research Program at Dell Children's Medical Center in Austin, Texas. She is an assistant professor at both the University of Texas School of Public Health and the Department of Pediatric Surgery at UT Southwestern Medical School. Her research interests include the epidemiologic, clinical, and behavioral study of childhood injury, injury prevention, and trauma clinical care. Her studies focus on child abuse recognition, treatment and prevention, behavioral determinants of injury including caregiver alcohol consumption, interventions for injury prevention, as well as developmental and psychological outcomes of pediatric trauma. She currently mentors both medical students at The University of Texas Medical Branch and graduate students at the University of Texas School of Public Health.

Rebecca Levin, MPH

American Academy of Pediatrics

Rebecca Levin, MPH, is the Senior Manager of Injury, Violence, and Poison Prevention Initiatives at the American Academy of Pediatrics; she has worked at the AAP for 11 years, addressing injury and violence prevention for the last 9 years. In her current role she oversees a number of programs that help pediatricians and families keep children and adolescents safe. Ms. Levin helped create the AAP violence prevention and parenting program Connected Kids: Safe, Strong, Secure and has led several projects to promote its implementation. She is a doctoral candidate in the Department of Health Systems Management at the Tulane University School of Public Health and Tropical Medicine; her dissertation will focus on child health care providers' counseling parents of young children on risk and protective factors for youth violence. Ms. Levin received her bachelor's degree in Integrated Science and Biology from Northwestern University and her master's degree in Health Policy and Administration from the University of Illinois at Chicago.

Mariann Manno, MD

Injury Free Coalition for Kids of Worcester

Mariann Manno, MD is an Associate Professor of Clinical Pediatrics and Emergency Medicine at the University of Massachusetts Medical School and Division Director, Pediatric Emergency Medicine at UMass Memorial Children's Medical Center, Worcester MA. Dr. Manno has received numerous honors in the area of medical education. Dr. Manno has received several grants, the most recent of which is from The Allstate Foundation for the purpose of educating teens about the risks associated with distracted driving. She is Co-director of Injury Free Coalition for Kids-Worcester.

Mary-Elise Manuell, MD, MA

University of Massachusetts Medical School

Mary-Elise Manuell, MD, MA is an Assistant Professor at the University of Massachusetts Medical School and an Emergency Medicine Attending Physician at UMass Memorial Medical Center . She has over fourteen years experience in emergency medicine and has a Master's degree in Disaster and Emergency Management through the American Military University. As Director of the Division of Disaster Medicine & Emergency Management, she has coordinated several educational conferences and developed a Disaster Medicine & Emergency Management Fellowship program. One of only two fellowship programs in the United States dedicated entirely to Disaster Medicine, the program currently is training two fellows.

Dr. Manuell serves as the chair of the Worcester Metropolitan Medical Response System Hospitals and Clinical Committees as well as the Co-Chair of the UMass Memorial Medical Center Emergency Management Steering Committee. She has served as Physician Liaison for several disasters and mass casualty incidents, including a 2007 contaminated water incident that sent more than ninety people to area hospitals, and a 2008 carbon monoxide exposure that hospitalized nineteen. Dr Manuell established and serves as coordinator for the National Disaster Life Support Certified Training Center at the University of Massachusetts Medical School. She previously served as Clinical Director, and as Associate Chief, of the Emergency Department of Saint Vincent Hospital at Worcester Medical Center .

Mary Beth Moran, PT MS M.Ed

Injury Free Coalition for Kids of San Diego

Mary Beth, Mary Beth Moran, PT MS M.Ed joins the injury prevention community at Rady Children's Hospital from a clinical background as a physical therapist. After 20 years of treating injuries after the fact she decided to use her background in health care, education and evaluative sciences toward preventative interventions. Mary Beth uses all aspects of her educational and employment background to provide a well rounded injury prevention program. She holds a BS degree in Biology from Regis College, BS in Physical Therapy from New York University, MEd in Education from George Washington University and MS in Evaluative Clinical Sciences from Dartmouth College.

Mary Beth has used her three year tenure at Rady Children's hospital to expand and support a robust child passenger safety program including programs for children with special needs, further develop a hospital based and mobile community Safety Store, and expand the sports injury prevention program with an emphasis on concussion, overuse injury and heat related illness. Mary Beth is the Program Coordinator for The Injury Free Coalition of San Diego and the Coordinator of Safe Kids San Diego. Mary Beth also participates in the APHA Sports and Recreation Injury Prevention Task Force.

Joyce Pressley, PhD, MPH

Injury Free Coalition for Kids National Program Office

Joyce Pressley, PhD, MPH is Director of Injury Free Health Policy and Population Studies and an Associate Professor of Clinical Epidemiology and Clinical Health Policy and Management at The Mailman School of Public Health at Columbia University. Her research interests include the study of injury-related disparities across the age span. She has examined a number of injury issues affecting child health, including window falls; home safety issues for burns, falls, poisoning, suffocation; motor vehicle injury including occupant protection and infant and child restraint systems; pedestrian injury; graduated driver licensing laws for teenagers; laws governing teenage drinking and driving laws and other related injury issues.

Marla Robinson, MSc., OTR/L

Injury Free Coalition for Kids of Chicago at Children's Memorial Hospital

Marla Robinson, MSc., OTR/L has been practicing as an Occupational Therapist for the past 16 years in acute care with a focus on Burn Care and Rehabilitation for the past 11 years. She received her BSc.OT in 1994 and then 10 years later her Master of Science in Health Promotion from the University of Alberta. She is currently the Assistant Director of Inpatient Therapy Services at the University of Chicago Medical Center. Her primary area for clinical practice is working with both adult and pediatric burn patients.

Steve Rogers, MD

Injury Free Coalition for Kids of Hartford

Steve Rogers, MD, is an attending emergency medicine physician at Connecticut Children's Medical Center and an Assistant Professor of Pediatrics and Emergency Medicine at the University of Connecticut School of Medicine. Dr. Rogers is the Co-PI for Injury Free Coalition for Kids and Research Scientist at the Injury Prevention Center. He is the Co-PI for the randomized control trial to determine the efficacy of driving simulator training for novice teen drivers.

Judy Schaechter, MD

Injury Free Coalition for Kids of Miami

Judy Schaechter, MD is a practicing pediatrician, associate chair and associate professor of pediatrics at the University of Miami Miller School of Medicine. She earned her BA in religious studies at Brown University. She completed medical school and pediatric residency at Stanford University. She is founder and director of Injury Free Coalition for Kids -- Miami, dedicated to injury prevention research and community-based programming. She initiated numerous community prevention projects including: home safety education reaching 2000 families and 40 practitioners annually, car and booster seat clinics in 3 languages, reaching 3000 families annually, multi-media educational tools on firearm safety, infant suffocation, adolescent driving, and community capacity-building through partnerships with child care centers, law enforcement and firefighters.

Dr. Schaechter leads the community engagement efforts of Florida's four-county NIH National Children's Study and developed. She developed the Children's Health Fund crisis plan to address outpatient health and mental health needs of Haitian earthquake refugees. Her research interests focus on injury prevention, preventive health and health disparities.

Dr. Schaechter is active in child and health policy; she serves as the child health policy expert on Florida Healthy Kids Corporation and was reappointed to both Florida's Children and Youth Cabinet and the Governor's Physical Fitness Council. As Chair of The Children's Trust's Health Committee, she led a child health initiative that placed nurses and social workers in 165 schools, outreach workers in neighborhoods to increase insurance enrollment, and established a universal newborn home visitation program. Currently, she is working with a bipartisan leadership group to provide health coverage and universal access to developmental screening to all Florida's children.

Mindy B. Statter, MD

Injury Free Coalition for Kids of Chicago at University of Chicago Comer Children's Hospital

Mindy Statter, MD is the director of the pediatric trauma program at the University of Chicago Comer Children's Hospital, a Level 1 trauma center. She obtained her medical degree from Emory University in Atlanta, Georgia. She completed the general surgery residency at the University of Illinois in Chicago and subsequently completed a fellowship in Pediatric Surgery at the C.S. Mott Children's Hospital at the University of Michigan in Ann Arbor. In 1992, she joined the faculty at the University of Chicago Pritzker School of Medicine and is currently an Associate Professor of Surgery and Pediatrics. She is board certified in general surgery, surgical critical care, and pediatric surgery. Through the American Pediatric Surgical Association Committee on Trauma, she has participated in multicenter studies on blunt intestinal injuries and pancreatic injuries in children. She completed a one-year fellowship in clinical medical ethics in 2010 and joined the faculty at the MacLean Ethics Center at the University of Chicago in 2010. Her research focuses on pediatric injury prevention; specifically pediatric pedestrian-motor vehicle crashes.

Erica Streit-Kaplan, MPH, MSW
Children's Safety Network

Erica Streit-Kaplan, MPH, MSW is a Technical Assistance Specialist for the Children's Safety Network, a national injury and violence prevention resource center serving staff in state health departments around the nation. In this role, Ms. Streit-Kaplan provides expert guidance and training around topics including best practices, on-line learning, data analysis and strategic planning. As coordinator of two "Communities of Practice" - groups of states addressing rural injury prevention -- she has been instrumental in facilitating collaboration and communication both within and between states.

Prior to her work with Children's Safety Network, Ms. Streit-Kaplan developed and implemented outreach and social marketing campaigns for low-income, uninsured women. She has also worked in on a range of public health topics including domestic violence prevention, child passenger safety and midwifery health services.

Ms. Streit-Kaplan received her Master of Public Health and Master of Social Work degrees from Boston University.

Nathan Timm, MD
Cincinnati Children's Medical Center

Nathan Timm, MD is an attending physician in the Division of Emergency Medicine at Cincinnati Children's Hospital Medical Center in Cincinnati, Ohio. He has also been responsible for the hospital's emergency management program since 2003. Dr. Timm completed his undergraduate degree at Grinnell College in Iowa and went on to medical school at the University of Iowa. He completed a three year residency in pediatrics at the Children's Hospital of Philadelphia followed by a three year fellowship in Pediatric Emergency Medicine in Cincinnati. He has been on the faculty of the Division of Emergency Medicine since 2003. Dr. Timm has published numerous articles in the field of ED surge capacity and ED utilization and has a special interest in Hazmat/Decon planning and response. In addition to preparing and responding to emergencies at the hospital, his favorite past time is cleaning up the disasters left behind by his two children, ages 3 and 5.

Jeffrey Upperman, MD
Injury Free Coalition for Kids of Los Angeles at Childrens Hospital Los Angeles

Jeffrey Upperman, MD, CHLA Director of Trauma is an Associate Professor of Surgery at the University of Southern California and an Attending Pediatric Surgeon at the Childrens Hospital Los Angeles. Dr. Upperman graduated from Stanford University in 1987 with a bachelor's degree in Human Biology and a master's degree in Sociology. He earned his medical degree from New Jersey Medical School in 1991 and completed his surgical residency at the same institution. He completed his fellowship training in pediatric surgery at Children's Hospital of Pittsburgh and served on the faculty at the University of Pittsburgh School of Medicine at Children's Hospital of Pittsburgh until 2006 where he was interim Director of Benedum Pediatric Trauma Program at Children's Hospital of Pittsburgh in 2005. He was recruited to Childrens Hospital Los Angeles in January 2006 and assumed Directorship of Trauma in 2007.

Dr. Upperman's disaster and trauma research focuses on the organizational level preparedness of health care workers, intestinal inflammation, sepsis and pediatric trauma. His funding has included the Department of Health and Human Services, National Institute of Health and the Robert Wood Johnson Foundation. He publishes clinical work in the area of pediatric disaster preparedness, pediatric trauma and computerized physician order entry. He is currently the Director of the Pediatric Disaster Resource and Training Center.

Dr. Upperman has extensive community involvement by serving on committees in national academic societies. He is a permanent member of the Pediatric Study Section at the National Institute of Child Health and Development. He serves his country as a US Army Reservist and he saw combat duty during Operation Iraqi Freedom 2 in a region outside of Baghdad, Iraq.

Chris Vitale, MSN, RN

Injury Free Coalition for Kids of Pittsburgh

Chris Vitale is the injury prevention coordinator for Children’s Hospital of Pittsburgh of UPMC and the program coordinator for Injury Free Coalition for Kids for the past eight years. She has over 30 years of experience in trauma care, including clinical, education, administrative and community outreach. Chris developed and coordinates the “Reality Education for Drivers” teen driver program as well as “RED - Before the Crash,” “Hard Heads” and “FOCUS - Teen Distracted Driver Initiative.”

Janice Williams, MEd

Carolinas Center for Injury Prevention

Janice Williams is the Director of the Carolinas Center for Injury Prevention at Carolinas Medical Center in Charlotte North Carolina. She has served in that position for almost 10 years. In that position she leads research, programming and evaluation, advocacy and outreach for the piedmont area of North Carolina.

She currently chairs or serves on boards for the local and state Safe Kids, child fatality, trauma, and injury groups. She serves nationally on the Children’s Hospital Associations Injury Prevention board and is adjunct faculty at UNC Charlotte. Recently published or presented work includes the areas of childhood injury prevention in general, along with the areas of safe sleep, prescription drug poisoning, teen driving, senior falls prevention and alcohol screening.

Andrea Winthrop, MD

Injury Free Coalition for Kids of Milwaukee

Andrea Winthrop, MD is a Pediatric Surgeon and Co-PI of Injury Free Milwaukee. She is the former Medical Director of Trauma at Children’s Hospital of Wisconsin, and Professor of Surgery, Medical College of Wisconsin. Dr. Winthrop has been involved in pediatric trauma care for over 20 years, and has a long-standing commitment and involvement with Injury Free and community-based injury prevention efforts. She is also the co-director of the Education Core of the CDC funded Injury Research Center at the Medical College of Wisconsin, and has mentored students and other trainees conducting injury control research. Dr. Winthrop’s work with Injury Free has focused on the high risk inner city of Milwaukee. She has presented her injury control research and program development at local, regional and national meetings.

Joseph L. Wright, MD, MPH

Injury Free Coalition for Kids of Washington, DC

Joseph L. Wright, MD, MPH is Senior Vice President and head of the Child Health Advocacy Institute, a newly established center of excellence at Children’s National Medical Center in Washington, DC. In that capacity, Dr. Wright provides strategic leadership for the organization’s advocacy mission, public policy positions and community partnership initiatives. He also serves as Vice President for Medical Affairs at the Hospital for Sick Children Pediatric Center, a sub-acute care affiliate of Children’s National. Academically, Dr. Wright is a Professor and Vice Chairman in the Department of Pediatrics, as well as Professor of Emergency Medicine and Health Policy at the George Washington University Schools of Medicine and Public Health. He is among the original cohort of board-certified pediatric emergency physicians in the United States, and has been attending faculty in the Division of Emergency Medicine at Children’s National since 1992. As founding director of the division’s Institute for Pre-hospital Pediatrics and Emergency Research, Dr. Wright provides state-level leadership as the EMS Medical Director for Pediatrics within the Maryland Institute for Emergency Medical Services Systems (MIEMSS), and national leadership as senior investigator and medical director of the federally-funded Emergency Medical Services for Children (EMSC) National Resource Center based at Children’s National.

Dr. Wright’s major scholarly interests include emergency medical services for children, injury prevention and the needs of underserved communities, areas in which he has authored or contributed over 70 articles and book chapters to the scientific literature. Dr. Wright has received recognition for his advocacy work throughout his career, including the Shining Star award from the Los Angeles-based Starlight Foundation, and induction into Delta Omega, the nation’s public health honor society. Dr. Wright serves on several boards and commissions including the Board of Trustees of the National Children’s Museum, the National EMS Advisory Council, and as an Obama administration appointee to the Pediatric Advisory Committee of the Food and Drug Administration (FDA). He has also been appointed to several leadership positions within the American Academy of Pediatrics (AAP) including as inaugural chair of the Academy’s Violence Prevention committee, and currently as a member of the national Committee on Pediatric Emergency Medicine.



2010 Forging New Frontiers:
"Making Communities Safe for Children and Their Families"

Evaluation & CME Certification

Evaluation

We continually strive to make this conference the best that it can be. Your evaluations help us with that process. This year's evaluations will be done online. Please go to the Injury Free Coalition for Kids website located at: www.injuryfree.org and share your comments.

Accreditation

Attendees of this year's conference are eligible for up to 12 *AMA PRA Category 1 CME Credit(s)*[™]. Upon completion of the evaluation, those needing a CME certificate will be able to access them at the end of the conference when evaluations are completed online. If you have questions, please contact E. Lenita Johnson at 816-651-7777.

Accreditation Statement

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of Cincinnati Children's Hospital Medical Center and The Injury Free Coalition for Kids. Cincinnati Children's is accredited by the ACCME to provide continuing medical education for physicians.

Cincinnati Children's designates this educational activity for a maximum of 12.0 (Saturday-6.5; Sunday-5.5) *AMA PRA Category 1 Credit(s)*[™]. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Disclosure Statement

Cincinnati Children's requires all clinical recommendations to be based on evidence that is accepted within the profession of medicine and all scientific research referred to, reported or used in support of or justification of patient care recommendations conform to the generally accepted standards of experimental design, data collection and analysis. All faculty will be required to complete a financial disclosure statement prior to the conference and to disclose to the audience any significant financial interest and/or other relationship with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in his/her presentation and/or commercial contributor(s) of this activity.

