2012 Forging New Frontiers:

"Keeping Children Safe at Home, at Play & on the Road"

The 17th Annual Conference of the Injury Free Coalition for Kids jointly sponsored with Cincinnati Children's Hospital Medical Center

The 2012 Injury Free Coalition for Kids® Conference in Kansas City, MO, is bringing together medical experts and community leaders from around the country to exchange information and techniques designed to prevent injuries, reduce violence, and better understand the economic difference injury prevention makes in a struggling economy. Lessons learned and best practices of programs developed around the country will be discussed through scientific abstracts, lectures, panel discussions and workshops presented by the country's leading experts in the field of injury prevention and epidemiology.

Attendees of Forging New Frontiers include principal investigators (physicians), and program coordinators (nurses, health educators, social workers, community leaders and researchers). In addition to renewing their convictions, the conference is an opportunity for these childhood injury prevention advocates to network with representatives from around the country.

The objectives of the 2012 Annual Conference are to provide participants with an opportunity to:

- Study and encourage research in the field of injury prevention.
- 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 trauma centers develop and improve injury prevention programs.
- Share information about innovative injury prevention best practices.
- Describe how trauma centers can develop and evaluate community-based injury prevention programs.
- Identify opportunities for multi-city projects and research as well as opportunities to learn more about translating research into practice in minority and resource-limited communities.
- Provide attendees with the opportunity to revitalize their creative energies in order to continue to innovate and sustain healthy communities.

Accreditation Statement

Sponsored by Cincinnati Children's, a designated provider of continuing education contact hours (CECH) i n health education by the National Commission for Health Education Credentialing, Inc. This program is designated for Certified Health Education Specialists (CHES) and/or Master Certified Health Education Specialists (MCHES) to receive up to 15.5 total Category I contact education contact hours. Maximum advanced-level continuing education contact hours available are 0.

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 Injury Free Coalition. Cincinnati Children's is accredited by the ACCME to provide continuing medical education for physicians. Cincinnati Children's designates this live activity for a maximum of 15.75 *AMA PRA Category 1 Credit(s)*™ . Physicians should claim only the 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. All planning committee members and/or faculty members were determined to have no conflicts of interest pertaining to this activity.

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Dear Friends:

Welcome to the 17th Annual Conference of the Injury Free Coalition for Kids®. We are excited to see you here in Kansas City for a weekend of networking, exchanging ideas, and sharing our passion for keeping kids safe. The Program and Scientific Committees have put together an extraordinary conference. During the next three days, we will hear from national experts on issues ranging from substance abuse to bullying and violence prevention, to the economics of injury prevention. We will also have panels devoted to current issues and challenges in the world of pediatric injury prevention. In addition, ample time has been set aside for participants to get to know one another and network.

The past year has been a busy one for the leadership of Injury Free. We have worked hard to strengthen the Committee structure of the organization. Both the Program and Scientific Committees have worked diligently to develop the Annual Meeting program and to enhance the academic rigor of materials submitted to the Journal of Trauma for publication. The Membership and Communications committees have also pursued ways to enhance the involvement of site and individual members of the coalition. An Individual membership category has been added to Injury Free, so that those who are interested in being a part of the Coalition, but are not affiliated with a site have a role. We are also working on developing a more standardized mechanism for the allocation of "mini-grant" funds, and to enhance collaborative research efforts.

From a financial standpoint, Injury Free is on stable footing. The core source of funding, and the primary means of funding the Annual Conference is through the Institutional Membership dues. Additional revenue to support the organization is through individual and corporate giving. I would like to take this opportunity to personally thank everyone who has donated to Injury Free. Your generosity allows us to continue to do the work that we do. For more information regarding giving to Injury Free, please see our website (www. Injuryfree.org). I am very excited to report that Dr. Barlow is the Associate Director of a CDC Injury Center grant at Columbia University, which will provide space and cover some salary support for the National Office. For more information about the state of Injury Free, please come to the Business Meeting on Sunday afternoon at 2:30pm.

Finally, this Conference could not have happened without the support of our sponsors. Our thanks to them, and a special thanks to Dr. Joseph Tepas, who continues to serve as the editor of the Injury Free supplement to the Journal of Trauma. Again, welcome to Kansas City and to the Conference. I look forward to meeting you, and sharing ideas and enthusiasm.

Sincerely,

Barbara A. Gaines, MD
Director of Trauma and Injury Prevention
Clinical Director, Pediatric General and Thoracic Surgery
Program Directory, Pediatric Surgery Residency
Children's Hospital of Pittsburgh of UPMC

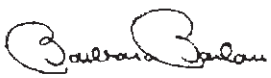
Dear Injury Free Coalition for Kids® members and Injury Prevention Advocates,

Welcome to Kansas City and the 17th Annual Forging New Frontiers Conference, "Keeping Children Safe at Home, at Play, and on the Road." Many excellent abstracts were submitted this year, and the Scientific Committee, under the direction of Dr. Michael Mello, reviewed them all and selected podium presentations, poster presentations and those for full journal articles. Their hard work produced a very interesting meeting agenda with extra emphasis on gun violence and the economics of injury prevention.

Kansas City is a special place for the Injury Free Coalition for Kids. Injury prevention sites funded as part of a national program of The Robert Wood Johnson Foundation together chose our name at the 1997 annual meeting in Kansas City. A bit of history – Dr. Denise Dowd arranged for Austin Knight Advertising Agency to run focus groups for us to choose a name for the national program and the agency developed our logo. At the meeting that year there were five funded sites in addition to the Harlem Hospital Injury Prevention Program and two additional sites which joined without funding. Injury Free grew over the years with The Foundations funding to 44 sites. The Foundation funding ended in 2008 and we all had to work hard to continue the mission of keeping children and families safe in their communities while we also worked to develop local funding support. Injury Free has survived the serious economic downturn and we can all look forward enthusiastically to brighter days.

There is still much to do to promote safe communities and to keep children safe from harm at home, at play and on the road. Each year, as we meet together, we recommit to sustaining the mission and keeping our network strong and vibrant. I hope that you enjoy this year's conference and that you return to your community armed with information about best practices and a renewed strength and zest for making a difference.

Warm Regards,



Barbara Barlow MD
Injury Free Coalition for Kids
Executive Director and Founder
Columbia University
Mailman School of Public Health

Paige Cahill

Social Media:
Rev Up Relationships and Results

Paige Cahill is the Constant Contact Regional Development Director for the states of Kansas, Missouri, Nebraska, & Arkansas. She is an email marketing and social media expert, a small business plus non-profit advocate, advisor, professional speaker, coach and trainer.

Ms. Cahill speaks to and coaches over 10,000 small businesses annually about traditional and non-traditional marketing campaigns. Her mission is to help them rev up their relationships, referrals and results" with online marketing best practices, strategies and tools. In her position, she coaches and connects both small businesses and non-profits to real world and strategies that help drive them to stellar results.

She has more than 20 years in speaking, technology, adult education, consulting, serial entrepreneur, traditional and non-traditional marketing experience. She has served as a national speaker for SCORE, the Small Business Development Corporation, countless Chambers of Commerce, non-profit and small business associations. She has published technology curricula and online marketing materials and is a frequent contributor and author for many small business and trade associations, and non-profit marketing publications.

Rebecca Cunningham, MD

Preventing Youth Violence: Emergency Department and Hospital Based Interventions

Dr. Rebecca Cunningham is an Associate Professor in the University of Michigan Department of Emergency Medicine, and the Department of Health Behavior and Health Education and serves as Director of the UM Injury Center, as well as the Associate Director of the CDC funded Flint Youth Violence Preventions Center. Her research focuses on violence prevention, on substance use/abuse, the relationship of substance use to injuries, the development and application of behavioral interventions in the Emergency Department setting.

Joseph L. Wright, MD, MPH

Bullying: Impact on Children's Health

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. Dr. Wright provides strategic leadership for the organization's advocacy mission, public policy positions and community partnership initiatives. Dr. Wright is 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 provides regional leadership within the Maryland Institute for Emergency Medical Services Systems as state medical director for pediatrics. He provides national leadership as principal investigator of the federally-funded Emergency Medical Services for Children (EMSC) National Resource Center.

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 contributed over 70 peer-reviewed articles, reviews and book chapters to the scientific literature. Dr. Wright has received recognition for his advocacy work including the Shining Star award from the Los Angeles-based Starlight Foundation, the Fellow Achievement Award from the American Academy of Pediatrics (AAP) in recognition of exceptional contributions in bullying prevention, and induction into Delta Omega, the nation's public health honor society.

Dr. Wright serves on several advisory bodies including the Board of Trustees of the new National Children's Museum, as an Obama administration appointee to the Pediatric Advisory Committee of the Food and Drug Administration, and as an advisor to the Sesame Street Workshop's anti-bullying programming. He has also served national appointments to study committees of the Institute of Medicine and the National Quality Forum, and is currently an appointed member of the AAP Committee on Pediatric Emergency Medicine. Dr. Wright regularly delivers invited expert testimony before Congress and state and municipal legislative bodies.

David Hemenway, PhD

Children & Guns

David Hemenway, Ph.D., is an economist and Professor at Harvard School of Public Health (HSPH) and a James Marsh Visiting Professor at Large at the University of Vermont. He is Director of the Harvard Injury Control Research Center and the Youth Violence Prevention Center. He received the Excellence in Science award from the injury and violence section of the American Public Health Association and fellowships from the Pew, Soros and Robert Wood Johnson foundations.

Dr. Hemenway has written more than 165 journal articles and is sole author of five books. Recent books include Private Guns Public Health (U Michigan Press 2006) and While We Were Sleeping: Success Stories in Injury and Violence Prevention (U California Press 2009). Dr. Hemenway has received ten HSPH teaching awards.

Ted Miller, PhD

How to Use Cost Data Effectively in Child Injury Prevention

Internationally recognized safety economist Ted Miller is a Principal Research Scientist and Program Director in the Maryland office of the Pacific Institute for Research and Evaluation. He founded the award-winning Children's Safety Network Economics and Data Analysis Resource Center. He has published more than 245 articles, books, chapters, and proceedings papers, primarily in injury economics and epidemiology. Mr. Miller received the Excellence in Science Award from the American Public Health Association's Injury Control and Emergency Health Services Section and the Vision Award from the State and Territorial Injury Prevention Directors Association and is a fellow of the Association for the Advancement of Automotive Medicine.

He earned his doctorate from the University of Pennsylvania in 1975 and began working in injury prevention in the early 1980s. The Washington Post called him a national oracle on the financial damage caused by substance abuse and injuries. His work shows convincingly that safety saves money as well as lives.

Welcome Back to Kansas City!

In 1997, Kansas City hosted the Injury Free Conference.
That year:
Princess Diana Killed in a car crash
Smoking banned in California bars & nightclubs
Women's National Basketball Association Begins
Movie Tickets: were $4.59
Gasoline: $1.22/gal.
US Postage Stamps: 32¢
Music: "Getting Jiggy Wit It" by Will Smith, "Men in Black" Will Smith
Movies: Titanic, Contact, LA Confidential
We named the Coalition The Injury Free Coalition for Kids®,
Austin Knight advertising agency began development of our logo,
PMS green 340 became our color,
& attendees displayed artistic talents making tiles.

2012 Forging New Frontiers:

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The 17th Annual Conference of the Injury Free Coalition for Kids jointly sponsored with Cincinnati Children's Hospital Medical Center
November 8 - 11, 2012

Schedule at a Glance

		Room
Thursday, November 8, 2012		
6:00 p.m. - 8:00 p.m.	Registration/Poster Setup	Seville Ballroom
Friday, November 9, 2012		
7:00 a.m. - 8:00 a.m.	Breakfast/Registration	Seville Ballroom
8:00 a.m. - 8:10 a.m.	Welcome: Board President, Barbara Gaines, MD	Grand E, F & G
8:10 a.m. - 8:15 a.m.	Social Media Introduction: E. Lenita Johnson, MA	Grand E, F & G
8:15 a.m. -10:00 a.m.	Social Media: Rev Up Relatinships & Results: Paige Cahill	Grand E, F & G
10:00 a.m. -10:05 a.m.	Rebecca Cunningham, MD, Introduction: Michael Mello, MD	Grand E, F & G
10:05 a.m. -10:45 a.m.	Preventing Youth Violence: Emergency Department and Hospital Based Interventions Keynote Speaker: Rebecca Cunningham, MD	Grand E, F & G
10:45 a.m.-11:00 a.m.	Break	
11:00 a.m.-12:30 p.m.	Implementation of SBIRT in the Pediatric Trauma Center, Panel Moderator: Michael Mello, MD	Grand E, F & G
12:30 p.m.- 1:45 p.m.	Lunch	Seville Ballroom
1:50 p.m.- 2:30p.m.	Joseph Wright, MD, Introduction: Michael Hirsh, MD Bullying: Impact on Children's Health, Speaker: Joseph Wright, MD,	Grand E, F & G
3:00 p.m.	Depart for an afternoon at the ranch: a look at some Kansas City area bullying prevention programs	
Saturday, November 10, 2012		
7:00 a.m. - 8:00 a.m.	Breakfast/Posters	Seville Ballroom
8:00 a.m. - 8:15 a.m.	Welcome & David Hemenway, PhD Introduction: Barbara Gaines, MD	Grand E, F & G
8:15 a.m. - 9:00 a.m.	Children & Guns, Keynote Speaker: David Hemenway, PhD	Grand E, F & G
9:00 a.m. – 9:15 .am.	Break	
9:15 a.m.-10:45 a.m.	Violence Prevention In Children's Hospitals, Panel Moderator: Denise Dowd, MD	Grand E, F & G
10:45 a.m. -11:00 a.m.	Break	
11:00 a.m. -12:30 p.m.	Preventing Head Injuries in Sports and Recreation, Panel Moderator: Beverly Miller, MEd	Grand E, F & G
12:30 p.m. - 2:00 p.m.	Lunch	Seville Ballroom
2:00 p.m. - 3:30 p.m.	Being Safe in the Home, Panel Moderator Kathy Monroe, MD	Grand E, F & G
3:30 p.m. - 3:45 p.m.	Break	
3:45 p.m. - 5:15 p.m.	Practical Applications of Injury Prevention, Panel Moderator: Garry Lapidus, PA-C, MPH	Grand E, F & G
6:00 p.m. - 7:30 p.m.	Reception	Seville Ballroom
7:30 p.m. - 9:00 p.m.	Board Meeting	Brush Creek
Sunday, November 11, 2012		
7:00 a.m. - 8:00 a.m.	Breakfast/Posters	Seville Ballroom
8:00 a.m. - 8:15 a.m.	Welcome & Ted Miller, PhD Introduction: Michael Hirsh, MD	Grand E, F & G
8:15 a.m. - 9:00 a.m.	How to Use Cost Data Effectively in Child Injury Prevention, Keynote Speaker: Ted Miller, PhD	Grand E, F & G
9:00 a.m. - 9:30 a.m.	Program Sustainability Proven, Speaker: Wendy Pomerantz, MD	Grand E, F & G
9:30 a.m. - 9:45 a.m.	Break	
9:45 a.m.-11:15 a.m.	Motor Vehicle Safety: Using epidemiologic analysis, educational and collaborative programs to achieve further improvement, Panel Moderator: Joyce Pressley, PhD	Grand E, F & G
11:15 a.m. -11:30 a.m.	Break	
11:30 a.m. - 1:00 p.m.	Tackling the Challenges of Child Passenger Safety, Panel Moderator: Steve Rogers, MD	Grand E, F & G
1:00 p.m. - 2:30 p.m.	Lunch	Seville Ballroom
2:30 p.m. - 3:30 p.m.	Business Meeting	Grand E, F & G
3:30 p.m. - 4:30 p.m.	Toys"R"Us Children's Fund Projects	Plaza
4:30 p.m. - 5:30 p.m.	Kohl's Group Discussion: Barbara Gaines, MD	Plaza

Agenda

Thursday, November 8, 2012 — Room

6:00 pm - 8:00 pm	Registration/Poster Set Up	Seville Ballroom

Friday, November 9, 2012

7:00 am - 8:00 am	Breakfast/Registration	Seville Ballroom
8:00 am - 8:10 am	Welcome: **Barbara Gaines, MD** Injury Free Coalition for Kids Board President	Grand E, F & G
8:10 am - 8:15 am	Keynote Speaker Introduction: **E. Lenita Johnson, MA** Injury Free Coalition for Kids Marketing & Communications Director	Grand E, F & G
8:15 am - 10:00 am	Keynote Speaker: **Paige Cahill** Rev Up Relationships and Results	Grand E, F & G

During this interactive session attendees will participate in a discussion about how the Injury Free Coalition for Kids can use online marketing tools and social media to "Forge New Frontiers" and externally extend its brand, mission, communications, relationships, and cause as well as get feedback about what is working and not working in communities being served. In addition, discussions will center on internal use of those same mediums to enhance communications within local coalitions across the country, between sites, and between the National Program Office and sites.

This session will enable participants to:
1) Recognize why small businesses and non-profits are using social media to grow their business and organization.
2) Identify what social media marketing really " is" and " is not".
3) Recognize 10 social media tips & best practices.
4) Describe tips on how to grow and promote social media channels.

10:00 am - 10:05 am	Keynote Speaker Introduction: **Michael Mello, MD** Injury Free Program Publications Committee Chairman	Grand E, F & G
10:05 am - 10:45 am	Keynote Speaker: **Rebecca Cunningham, MD** Preventing Youth Violence: Emergency Department and Hospital Based interventions	Grand E, F & G

The speaker will give background on the current knowledge base of substance use and youth violence, including epidemiology, interventions and studies that have explored prevention initiatives in the health care setting. Interventions at both the community and individual level will be discussed, with special attention paid to the speakers' involvement with an Emergency Department based intervention (SafERTeens) that aimed to reduce youth violence and substance use using technology to aid feasibility of delivery and implementation, and a longitudinal Emergency Department based study (Flint Youth Injury Study) which tracks youth for two years following an ED visit seeking care for assault.

This session will enable participants to:
1) Identify the epidemiology of youth violence and substance use.
2) Discuss the background of youth violence and substance use using a public health model.
3) Describe current and past interventions at both the community and individual level including the Emergency Department.

Agenda, cont.

Room

4) Recognize the barriers that practitioners face when implementing interventions in health care settings and explore some solutions to overcoming these that have been implemented.
5) Describe future interventions focused on youth violence at both the individual and community level.

10:45 am - 11:00 am

Break

11:00 am - 12:30 pm

Grand E, F & G

Panel Discussion: **: Implementation of SBIRT in the Pediatric Trauma Center**

As part of the American College of Surgeons verification to be a level 1 trauma center, centers are required to have the capacity to identify trauma patients with risky alcohol use and provide an intervention. The alcohol screening, brief intervention and referral to treatment (SBIRT) model is a possible way to gain capacity and satisfy these requirements. With funding provided by the CDC's National Center for Injury Prevention and Control, the Injury Prevention Center at Rhode Island Hospital partnered with seven Injury Free sites: (Children's Hospital of Wisconsin; Children's Hospital of Michigan; Children's Hospital of Pittsburgh of UPMC; Cincinnati Children's Hospital; Connecticut Children's Medical Center; Rady's Children's Hospital and Health Center and Riley Hospital for Children) in 2009 to translate SBIRT to the adolescent trauma patient.

This group, known as the Pediatric Trauma SBIRT Workgroup, was engaged in a multi-year process, which involved measurement of SBIRT services through medical record review, participation in SBIRT technical assistance activities, creation of institutional SBIRT policies, monitoring the opportunities and barriers to implementation and examining sustainability. The experience and data accumulated from the seven sites was utilized to produce recommendations for the development and implementation of a SBIRT program at pediatric trauma centers.

During this session, the Pediatric Trauma SBIRT Workgroup will present implementation recommendations related to a variety of topics including: SBIRT Site Leaders & Support Team, Target Population, Methods of Alcohol Screening, Integrating within Electronic Medical Records, Brief Interventions, Referral to Treatment, Confidentiality Issues and Sustainability.

This session will enable participants to:
1) Discuss the issue of alcohol use and the adolescent trauma patient
2) Describe components of the SBIRT model;
3) Identify effective methods for adopting, implementing and sustaining a SBIRT policy;
4) Recognize barriers to SBIRT implementation in a pediatric trauma center; and,
5) Identify strategies for overcoming barriers to SBIRT policy adoption, implementation and sustainability.

Panel Discussion Moderator: **Michael J. Mello, MD, MPH**
Injury Prevention Center Director
Rhode Island Hospital
Associate Professor of Emergency Medicine
Associate Professor of Health Services, Policy & Practice
Alpert Medical School of Brown University
Providence, Rhode Island
PI Injury Free Providence

Panelists:

Julie Bromberg, MPH, Injury Prevention Center, Rhode Island Hospital
Dawn Daniels, PhD, RN, PHCNS-BC, Riley Hospital for Children at Indiana University Health
Lynn Haas, RN, MSN, Cincinnati Children's Hospital
Donica Kulwicki, RN, BSN, CPN, Children's Hospital of Michigan
Gary Lapidus, PA-C, Connecticut Children's Hospital
Chris McKenna, MSN, RN, CRNP, Children's Hospital of Pittsburgh of UPMC

Agenda, cont.

		Room
12:30 pm - 1:45 pm	Lunch	Seville Ballroom
1:45 pm - 1:50 pm	Introduction of Keynote Speaker: **Michael Hirsh, MD**	Grand E, F & G
1:50 pm - 2:30 pm	Keynote Speaker: **Joseph Wright, MD, MPH** Bullying: Impact on Children's Health	Grand E, F & G

There has been much recent attention directed at the relationship between normative and low level aggression in children, and the development of more serious violent behavior. Despite the establishment of public information campaigns on the part of government and organized medicine, there is a dearth of information on bullying, being bullied, retaliation and the risk for involvement in more serious violence. This session will examine the prevalence of bullying in the United States and explore intervention strategies.

This session will enable participants to:
1) Recognize the importance of attention to bullying as part of intentional injury prevention.
2) Describe and define the emerging frontiers of bullying behavior in the United States.
3) Discuss the health consequences of bullying behavior and its potential long term impact.
4) Identify intervention opportunities for bullying prevention by child health professionals.
5) Summarize the types of activities and behaviors that characterize and define bullying.

3:00 pm — Depart for an afternoon at the ranch: A look at several Kansas City Area Bullying Prevention Programs

Saturday, November 10, 2012

7:00 am - 8:00 am	Breakfast/Posters	Seville Ballroom
8:00 am - 8:15 am	Keynote Speaker Introduction: **Barbara Gaines, MD** **Injury Free Coalition for Kids Founder & Executive Director**	Grand E, F & G
8:15 am - 9:00 am	Keynote Speaker: **David Hemenway, PhD** Children and Guns	Grand E, F & G

Compared to other developed nations, children in the United States have broadly similar rates of bullying and fighting. But we have more guns per capita and more permissive gun control laws—and also higher rates of gun homicide and overall homicide, gun suicide and overall suicide, and fatal gun accidents. Within the United States, children are at higher risk for such violent deaths if they live in states with more guns and weaker gun control laws. There are many ways to reduce our violence problem, and many groups can help—including physicians, reporters, clergy, foundations, gun dealers, law enforcement and even Hollywood writers. Creating and maintaining a comprehensive data system for firearm injuries is an important step in addressing the problem.

This session will enable participants to:
1) Recognize that the US is exceptional among developed nations in terms of guns and gun violence.
2) Discuss how a public health approach can reduce the problem.
3) Recognise that good data systems that help describe the problem are a key component of the public health approach.

Agenda, cont.

Room

9:00 am - 9:15 am — Break

9:15 am - 10:45 am — Panel Discussion: **Violence Prevention in Children's Hospitals** — Grand E, F & G

"The Facts Hurt" from the Trust for America's Health published by The Robert Wood Johnson Foundation show there are more than 740,000 children and teenagers seen in the nation's emergency rooms for injuries related to violence. Child abuse and neglect, teen dating violence, school and gang related violence, and bullying all contribute to the number of violence related injuries. "Experts from the medical community and public health" have developed evidence based ways to help reduce violence and violence related injuries which need to be discussed and instituted across the country.

This panel will focus on innovative violence prevention initiatives from a sample of children's hospitals, and include: 1) Creation of a community violence prevention collaborative. 2) Development of an intimate partner violence screening and intervention program 3) Leadership development for violence prevention via an inter-professional administrative council. 4) Emergency department assessment of males for dating violence.

This session will enable participants to:
1) Describe the role of executive administrators in hospital-based violence prevention initiatives.
2) Identify the challenges and natural life cycle of a hospital based violence prevention program.
3) Recognize the importance of collaborative relationships between the hospital and community based violence prevention advocates.
4) Describe risks for dating violence among adolescents who present to the emergency department
5) Recognize various roles for a children's hospital in community violence prevention.

Panel Discussion Moderator: **Denise Dowd, MD, MPH**
Director of Research,
Division of Emergency and Urgent Care
Children's Mercy Hospital
Kansas City, MO

Panelists:

Rebecca Levin, MPH Creation of a Hospital-Based Violence Prevention Collaborative
Kimberly A. Randell, MD, MSc The Life Cycle of an Intimate Partner Violence Program in a Children's Hospital
Donna O'Malley, PhD, RN: Violence Prevention in the Children's Hospital: Leadership by a Multi-Disciplinary Council
Brian Wagers, MD Adolescent Dating Violence in the Pediatric Emergency Department—A Male Perspective

10:45 am - 11:00 am — Break

11:00 am - 12:30 pm — Panel Discussion: **Preventing Head Injuries in Sports and Recreation** — Grand E, F & G

Sports and recreational activities pose inherent risks for traumatic brain injuries (TBIs). According to the CDC, emergency room visits for non-fatal TBIs among persons <19 years increased 62% from 2001 – 2009. This session will address three activities in the categories that made up one-third of these visits – football, all-terrain vehicle riding, and other specified causes that included snow skiing. This session will illustrated primary strategies for reducing inherent risks of these three recreational pastimes through the use of protective equipment (i.e. helmets approved for the sport) and

Agenda, cont.

Room

properly engaging in the activity.

This session will enable participants to:
1) Identify perceived areas of low risks toward which future educational efforts can be targeted.
2) Discuss evidence-based injury prevention strategies to reduce the risk of head injuries in sports and recreation.
3) Describe the implementation of a locally-driven helmet intervention in collaboration with privately-owned recreational venues.
4) Discuss the role of engineering in injury prevention education and products
5) Identify resources within the Injury Free network to obtain implementation

Panel Discussion Moderator: **Beverly Miller, MEd**
Associate Director, Injury Prevention Center
Arkansas Children's Hospital & the University of Arkansas for Medical Sciences
Injury Free Coalition for Kids of Little Rock, Program Coordinator

Panelists:

Hope Mullins, MPH Computational Modeling of Multiple Riders in All-Terrain Vehicle Crash Scenarios
Carol Mannings, MD Knowledge Assessment of Sport-related Concussion among Parents of Children Aged 5-15 years Enrolled in Recreational Tackle Football
Amy Teddy, BS Protect UR Brain - Wear a Helmet - On the Slopes

12:30 pm - 2:00 pm — Lunch — Seville Ballroom

2:00 pm - 3:30 pm — Panel Discussion: **Being Safe in the Home** — Grand E, F & G

Unintentional injury is the leading cause of death for children under the age of fourteen. 45 % of these injuries occur in and around the home. this session will focus on common home injuries and methods of prevention. This panel will discuss a variety of home safety topics. We will review home safety issues including safe sleep, fire safety and safety during natural disasters. We will also describe a home safety program and how to create one.

This session will enable participants to:
1) Describe safe sleep practices.
2) Describe appropriate safety device use in natural disasters.
3) Identify home fire safety practices.
4) Recognize how to build a home safety prevention program.
5) Identify common safety issues found in the home.

Panel Discussion Moderator: **Kathy Monroe, MD**
Professor of Pediatrics
Medical Director ED
Childrens Hospital of Alabama

Panelists:

Hope Mullins, MPH, Grandmothers and Infant Safe Sleep
Christine Campbell, MD, MSPH Prevention of Child Injuries During Tornadoes: A Case Series From The 2011 Tornado Outbreak In Alabama
Leticia Manning Ryan, MD Smoke Detector Installation Program Awareness and Home Fire Safety Practices in an Urban Pediatric Emergency Department Population
Mary Beth Moran PT, MS, MEd, Getting the Biggest Bang for Your Buck- How to Build a Comprehensive Home Safety Education Program

Agenda, cont.

Room

3:30 pm - 3:45 pm — Break

3:45 pm - 5:15 pm — Panel Discussion: **Injury Prevention Education** — Grand E, F & G

Each year more than 9,000 children die and nearly 9 million children aged 0-19 are seen in emergency departments as a result of being injured. Injury treatment is the leading cost of medical spending for children, about $11.5 billion annually. Injury prevention programs have a role to play in reducing morbidity and mortality and reducing medical costs for those 0-19 years of age. This "Injury Prevention Education" panel will include four presentations. The first presentation will describe a summer student internship program designed to expand program capacity and provide a venue to train future practitioners. The second presentation shares the results from a prospective study comparing the use of home safety equipment after installation by an injury prevention specialist versus home safety equipment given to daycare centers and installed by families. The third presentation describes the impact of an interactive pedestrian safety exhibit among elementary school children. The final presentation presents the results of a study designed to reduce car seat misuse among newborns.

This session will enable participants to:
1) To describe the role of education in community based injury prevention programs.
2) To describe the development, implementation, and evaluation of a summer student internship program.
3) To identify the effectiveness of different methods of distributing and installing home safety equipment
4) To describe the impact of an interactive child pedestrian safety exhibit.
5) To recognize the challenges and limitations of implementing a comprehensive nurse education and training program designed to reduce car seat misuse among newborns.

Panel Discussion Moderator: **Garry Lapidus, PA-C, MPH**
Director, Injury Prevention Center,
Connecticut Children's Medical Center/Hartford Hospital
Associate Professor of Pediatrics & Public Health
Univ. of Connecticut School of Medicine
Injury Free Coalition for Kids of Hartford

Panelists:

Helen Arbogast, MPH, CHES Pediatric Injury Prevention Scholars (PIPS) Summer Internship Program
Dawne Gardner-Davis, MBA An Effective Way to Utilize Daycare Organizations to Distribute Home Safety Equipment
Anyah Land, MPH Increasing Injury Prevention Knowledge among Children through an Interactive Pedestrian Safety Exhibit
Steve Rogers, MD Can Nurse Education in the Post-partum Period Reduce Car Seat Misuse among Newborns?

6:00 pm - 7:30 pm — Reception — Seville Ballroom

7:30 pm - 9:00 pm — Board Meeting — Brush Creek

Sunday, November 11, 2012

7:00 am - 8:00 am — Breakfast and Posters — Seville Ballroom

8:00 am - 8:15 am — Keynote Speaker Introduction: **Michael Hirsh, MD**
Injury Free Coalition for Kids Past President — Grand E, F & G

8:15 am - 9:00 am — Keynote Speaker: **Ted Miller, PhD** — Grand E, F & G

Agenda, cont.

Room

How to Use Cost Data Effectively in Child Injury Prevention

This presentation will cover childhood injury costs and savings from prevention. It will use data on economic burden of injury and violence to educate participants about policy issues and prevention priorities. It will discuss the range of proven preventive measures and availability of data on the cost savings they offer. It will teach participants how to use available economic analyses in evaluation, fund-raising, and policymaking. A major emphasis will be on communicating cost data effectively to sell your program.

This session will enable participants to:
1) Identify six uses for data on cost of injury.
2) Describe basic injury cost components and how they are measured.
3) Recognize to access estimated return on investment for more than 160 injury prevention and treatment measures.
4) Identify cost-effectiveness estimates in fund-raising and policymaking.
5) Describe communicate cost and return-on-investment data effectively.

9:00 am - 9:05 am

Introduction of Speaker: **Barbara Barlow, MD**
Injury Free Coalition for Kids Founder and Executive Director

Grand E, F & G

9:00 am - 9:30 am

Speaker: Wendy Pomerantz, MD
Can the Reduction of Pediatric Injury Rates Be Sustained Using a Community-Based Approach?

Grand E, F & G

Community-based interventions are effective in reducing injuries. Using this approach, investigators significantly reduced injuries in Avondale, Ohio between 1999 and 2004 compared to 3 control communities (42% vs 15%, respectively). To our knowledge, no previous study has looked at sustainability in injury reduction using this community-based approach. The objective of this study was to determine if injury reduction was sustained through the 5 years following initial implementation of injury prevention (IP) efforts in Avondale compared to the same 3 control communities. During the 10 year study period, from 1999-2009, the injury rate in Avondale decreased 30% while that in the 3 control communities decreased 4.5%. From 2005-2009, the lower injury rate was sustained in Avondale compared to control communities. We will describe our techniques for implementation of the Injury Free method in our study community and how it was effective in reducing injuries.

This session will enable participants to:
1) Describe how to choose a study community.
2) Identify the importance of control communities and how to chose one.
3) Describe how to use the public health approach to drive prevention efforts.
4) Identify how to use the Injury Free method to drive interventions.
5) Recognize the success of interventions in reducing injury rates and sustaining the reduction over a ten year period.

9:30 am - 9:45 am

Break

Grand E, F & G

9:45 am - 11:15 am

Panel Discussion: **Motor Vehicle Safety: Using Epidemiologic Analysis, Educational and Collaborative Programs to Achieve Further Improvement**

Despite the attention pediatric and teen motor vehicle safety has received, it remains a significant public health issue. Research and interventions have focused on modifying behavior and strengthening laws related to night-time driving, teen passengers, alcohol and drugs, seat belt use and more recently on distracted driving. With four presentations addressing teen driver motor vehicle crashes and motor vehicle crashes of adult drivers with pediatric occupants, this session aims to identify additional factors

Agenda, cont.

Room

amenable to prevention, highlight effective educational modalities and showcase a collaborative program that may produce further improvements in serious pediatric MV injury. Issues associated with distracted driving is addressed in varying levels of detail by all presenters.

This session will enable participants to:
1) Recognize adult distracted driver behavior while driving with pediatric patients in the vehicle.
2) Describe crash factors associated with fatal crashes among teens compliant with GDL, alcohol and restraint laws at the time of the crash.
3) Identify behavioral and vehicle factors amenable to preventive interventions aimed at lowering serious MV crash in "compliant" teen drivers.
4) Describe a successful collaborative hospital-school pilot study addressing teen texting while driving.
5) Recognize the use of driving simulation as an effective educational tool in teen populations.

Panel Discussion Moderator: **Joyce Pressley, PhD, MPH**
Director of Injury Free Health Policy & Population Studies
Associate Professor of Epidemiology and Health Policy & Management
The Mailman School of Public Health, Columbia University

Panelists:

Joyce Pressley, PhD, MPH Characteristics of GDL Compliant, Belted, and Unimpaired Teen Drivers Involved in Fatal Motor Vehicle Crashes
Pina Violano, MSPH, RN-BC, CCRN, CPS, PhD (c) Do As I Say (and Not as I do): Distracted Driving Behaviors of Adults While Children are in the Car
Purnima Unni, MPH,CHES Hospital -School Collaboration to Address Teen Motor Vehicle Safety-Successes and Challenges-Pilot study
Mariann Manno Driving Yourself to Distraction- The Teen DRIVE (Distracted Reality Interactive Virtual Education) Experience

11:15 am - 11:30 am — Break

11:30 am - 1:00 pm — Grand E, F & G

Panel Discussion: **Tackling the Challenges of Child Passenger Safety**

Motor vehicle injuries are the leading cause of death among children in the US. Placing children in age- and size appropriate car seats and booster seats is a proven way to reduce serious injury and childhood fatalities. This panel will include four presentations. The first presentation will describe the implementation and evaluation of a successful child passenger safety program. The second and third presentations discuss the use of a computerized child passenger safety screening programs in the emergency department and in-patient settings. The final presentation presents the evaluation of a novel means of safely transporting casted or special needs patients.

This session will enable participants to:
1) Describe the challenges of child passenger safety.
2) Describe the development, implementation, and evaluation of a successful Child Passenger Safety Program.
3) Discuss the use of a computerized child passenger safety screening program to provide education and car seat distribution in the Emergency Department setting.
4) Discuss the use of a computerized child passenger safety screening program to provide education and car seat distribution in the In-patient setting.
5) Recognize a novel means of providing safe transportation for casted or special needs patients.

Agenda, cont.

Room

Panel Discussion Moderator: **Steve Rogers, MD**
Pediatric Emergency Medicine Specialist
Connecticut Children's Medical Center
Assistant Professor
University of Connecticut School of Medicine

Panelists:

Chris Vitale MSN, RN The Challenge of Child Passenger Safety
Lois Lee, MD, MPH A Computerized Child Passenger Safety Assessment Program in the Emergency Department
Barbara Digirolamo, M Ed An Inpatient Child Passenger Safety Program
Lindsey Elliott, RN, BSN, CPN The EZ-ON® Vest: A Cost Effective Alternative for Transportationof the Casted Child

1:00 pm - 2:30 pm	Lunch	Seville Ballroom
2:30 pm - 3:30 pm	Business Meeting	Grand E, F & G
3:30 pm - 4:30 pm	Toys"R"Us Projects	Plaza
4:30 pm - 5:30 pm	Kohl's Funding Group Discussion	Plaza

Accreditation Statement

Sponsored by Cincinnati Children's, a designated provider of continuing education contact hours (CECH) i n health education by the National Commission for Health Education Credentialing, Inc. This program is designated for Certified Health Education Specialists (CHES) and/or Master Certified Health Education Specialists (MCHES) to receive up to 15.5 total Category I contact education contact hours. Maximum advanced-level continuing education contact hours available are 0.

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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. All planning committee members and/or faculty members were determined to have no conflicts of interest pertaining to this activity.

2012 Forging New Frontiers:

"Keeping Children Safe at Home, at Play and on the Road"

The 17th Annual Conference of the Injury Free Coalition for Kids jointly sponsored with
Cincinnati Children's Hospital Medical Center
November 8 - 11, 2012

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FACULTY		FACULTY	
Helen Arbogast, MPH, CHES	NONE	Chris McKenna, MSN, RN, CRNP	NONE
Julie Bromberg, MPH	NONE	Michael J. Mello, MD, MPH	NONE
Paige Cahill	NONE	Beverly Miller, MEd	NONE
Christine Campbell, MD, MSPH	NONE	Ted Miller, PhD	NONE
Rebecca Cunningham, MD	NONE	Kathy Monroe, MD	NONE
Dawn Daniels, PhD, RN, PHCNS-BC	NONE	Mary Beth Moran PT, MS, MEd	NONE
Barbara Digirolamo, M Ed	NONE	Hope Mullins, MPH	NONE
Denise Dowd, MD	NONE	Donna O'Malley, PhD, RN	NONE
Lindsey Elliott, RN, BSN, CPN	NONE	Wendy Pomerantz, MD	NONE
Dawne Gardner-Davis, MBA	NONE	Joyce Pressley, PhD, MPH	NONE
Lynn Haas, RN, MSN	NONE	Kimberly A. Randell, MD, MSc	NONE
David Hemenway, PhD	NONE	Steve Rogers, MD	NONE
Donica Kulwicki, RN, BSN, CPN	NONE	Amy Teddy, BS	NONE
Anyah Land, MPH	NONE	Purnima Unni,MPH,CHES	NONE
Gary Lapidus, PA-C	NONE	Pina Violano, MSPH, RN-BC, CCRN,	NONE
Lois Lee, MD, MPH	NONE	CPS, PhD (c)	NONE
Rebecca Levin, MPH	NONE	Chris Vitale MSN, RN	NONE
Leticia Manning Ryan, MD	NONE	Brian Wagers, MD	NONE
Carol Mannings: MD	NONE	Joseph Wright, MD	NONE
Mariann Manno, MD	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.

2012 Forging New Frontiers:

"Keeping Children Safe at Home, at Play and on the Road"

Abstracts

Implementation of SBIRT in the Pediatric Trauma Center

Michael Mello, MD, MPH, Julie Bromberg, MPH, Dawn Daniels, PhD, RN, PHCNS-BC, Lynn Haas, RN, MSN, Donica Kulwicki, RN, BSN, CPN, Gary Lapidus, PA-C, Chris McKenna, MSN, RN, CRNP

Background:
There are an estimated 10 million underage (12-20 years) current alcohol users within the United States, 17% of whom engage in binge drinking and 5.1% of whom are heavy drinkers. Researchers have found thirty percent of hospitalized trauma patients aged 11-17 years to screen positive for alcohol misuse. Screening, Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive approach that utilizes universal alcohol screening to providing early intervention and treatment to those with risky alcohol use. As part of the American College of Surgeons verification to be a level 1 trauma center, centers are required to have the capacity to identify trauma patients with risky alcohol use and provide an intervention. While a number of SBIRT resources exist for health providers to promote the utilization of these services in caring for injured patients, most are focused on the adult trauma center.

Methods:
With funding provided by CDC's National Center for Injury Prevention and Control, the Injury Prevention Center at Rhode Island Hospital partnered with seven IFCK sites (Children's Hospital of Wisconsin; Children's Hospital of Michigan; Children's Hospital of Pittsburgh of UPMC ; Cincinnati Children's Hospital; Connecticut Children's Medical Center; Rady's Children's Hospital and Health Center and Riley Hospital for Children) in 2009 to translate SBIRT to the adolescent trauma patient. This group, known as the Pediatric Trauma SBIRT Workgroup, was engaged in a multi-year process which involved measurement of SBIRT services through medical record review, participation in SBIRT technical assistance activities, creation of institutional SBIRT policies, monitoring the opportunities and barriers to implementation and examining sustainability.

Results/ Conclusions:
There was an 81% participation rate in SBIRT technical assistance activities across all sites. According to medical record review, at baseline 11% of eligible patients were screened and received a brief intervention (if necessary) across all sites. After completion of the SBIRT technical assistance activities, all seven participating trauma centers had effectively developed and implemented SBIRT policies for injured adolescent inpatients. Further, across all sites 73% of eligible patients received SBIRT services. The experience and data accumulated from the seven sites was utilized to produce recommendations for the development and implementation of a SBIRT program at pediatric trauma centers. During this session, the Pediatric Trauma SBIRT Workgroup will present implementation recommendations related to a variety of topics including: SBIRT Site Leaders & Support Team, Target Population, Methods of Alcohol Screening, Integrating within Electronic Medical Records, Brief Interventions, Referral toTreatment, Confidentiality Issues and Sustainability.

Objectives:
Attendees will learn:
1. To describe the components of an alcohol screening, brief intervention and referral to treatment (SBIRT) program.
2. To describe adoption, implementation and sustainability of a SBIRT program for adolescent trauma patients.
3. To discuss potential strategies for overcoming barriers to SBIRT policy adoption, implementation and sustainability.

Creation of a Hospital-Based Violence Prevention Collaborative

Rebecca Levin, MPH, Jenifer Cartland, Karen Sheehan, MD

Background:
Following several high-profile violent deaths of youth in 2009, the hospital's CEO created an internal task force to examine the hospital's role in prevention. The task force concluded that many experts at the hospital were working on violence prevention and treatment, lack of coordination both within and outside the hospital was a challenge, and the problem of "youth violence" could not be addressed in isolation. The task force agreed to explore the extent to which other organizations experience these or other difficulties and how the hospital could play a role in enhancing violence prevention activities across the City.

Methods:
In 2011, a series of listening sessions with representatives of the nonprofit, research, foundation, medical, and policy communities in Chicago was held to gain a better understanding of how youth violence prevention efforts operate. A full-time director was hired in August 2011, and additional input was sought from various individuals and organizations involved in violence prevention in Chicago. The hospital's experience building a successful obesity prevention consortium was used as a model.

Results:
We found that many organizations in Chicago are doing excellent work to prevent and control youth violence, but listening session participants and key informants indicated that they could be more effective if coordination and communication among organizations were improved. A collaborative—Strengthening Chicago's Youth (SCY)—was convened by the hospital to build capacity among public and private stakeholders to connect, collaborate and mobilize around a public health approach to violence prevention, with a focus on promoting policy and environmental change.

The SCY kickoff meeting on February 1, 2012 was attended by 130 individuals representing 60 different organizations. In the 4 months since the kickoff meeting, development of SCY has proceeded rapidly. 130 organizations are engaged in the collaborative in various ways, 825 individuals are on the SCY mailing list, and a 25-member steering committee has been created to provide guidance on SCY's efforts and structure. Specific cross-sector collaborations include: SCY is an active participant in discussions with the City of Chicago and Cook County regarding their joint anti-violence and community stabilization efforts. SCY has applied for NIH funding for a project "Community-Academic Collaboration to Prevent Violence in Chicago."

SCY is a partner in an initiative to strengthen connections between community organizations and local reporters to improve media coverage of violence. SCY was one of 3 local organizations to participate in a "data dive," hosted by the White House and DataKind to build connections between community organizations and data scientists.

Conclusions:
There was a tremendous need for a group to address capacity building and coordination among violence prevention organizations in Chicago. A children's hospital is a logical institution to convene such a group because of its commitment to children, track record of success, philosophy of providing family-centered, culturally effective and developmentally appropriate care, strong reputation in the community, and neutrality as a non-governmental organization.

Objectives:
Attendees will learn:
1. How to demonstrate the need for hospital-based community violence prevention efforts.
2. How to develop a hospital-based community violence prevention collaborative.
3. How to describe early indicators of success in development of a violence prevention collaborative.

The Life Cycle of an Intimate Partner Violence Program in a Children's Hospital

Kimberly A. Randell, MD, MSc, Jennifer Stallbaumer-Rouyer, MSW, Brooke Nelson, MSW, M. Denise Dowd, MD, MPH

Background:
Childhood exposure to intimate partner violence (IPV) results in negative outcomes affecting multiple health domains. The pediatric hospital setting offers unique opportunities for IPV screening and intervention.

Methods:
Grant funding enabled development of an IPV program at a tertiary care children's hospital. Qualitative assessment of mothers' and providers' opinions of IPV screening was followed by healthcare provider IPV curriculum and an IPV screening and referral process development, then by process evaluation. After grant funding expired, there was decreased adherence to screening and referral processes. Subsequent development of a Council on Violence Prevention and an IPV Work Group enabled renewed and sustained IPV efforts.

Results:
Focus groups confirmed that IPV screening is acceptable to caregivers and provided critical components of screening protocols. It's Time to Ask, an IPV training curriculum, resulted in significant changes in provider attitudes and clinical practice regarding IPV screening. Initial implementation of screening in the pediatric emergency department (PED), resulted in increased IPV disclosure, advocate referrals and resource utilization. There was spontaneous spread of screening to other patient care areas, without screening mandates at the hospital level.

Adherence to screening protocols and identification of positive screens decreased after the funding period. Barriers to sustained efforts included lack of an identified individual or group to coordinate periodic education and process evaluation, lack of senior-level administrative support and implementation of an electronic medical record.

Several years later, the hospital Chief Operating Officer formed a Council on Violence Prevention to coordinate the hospital's response to violence. The Council identified IPV as a priority area. The IPV Work Group utilized the Delphi Instrument for Hospital-Based Domestic Violence Programs to reveal multiple provider and institutional barriers to IPV screening, limited patient care areas practicing universal screening and wide variation in screening processes and response to disclosure between patient care units and individual providers. The group recruited IPV Champions to assist with process improvement. The group created an IPV Tool Kit, which is available online. Staff educational opportunities are provided in multiple venues.

Standardized documentation improved family safety and allows detailed analysis of screening results and resource utilization. The screening process in the PED was revised, resulting in improved documentation of IPV screens (54% pre revision, 77% post), decreased unanswered screens (93% pre, 29% post) and a 20-fold increase in the number of IPV disclosures. Universal IPV screening on inpatient units will be trialed at the community hospital campus, with subsequent implementation at the tertiary care referral campus. A hospital IPV policy recommending universal screening is in development. All improvements have been made utilizing existing hospital resources.

Conclusions:
IPV programs in the pediatric hospital setting identify families experiencing IPV and enable resource provision but such programs face multiple barriers. Sustainability can be challenging. Key components of sustained IPV efforts are senior-level administrative support and a coordinated, multidisciplinary group that meets regularly to facilitate and monitor IPV efforts.

Objectives:
Attendees will learn:
1. To discuss Key components which enable children's hospitals to address intimate partner violence (IPV).
2. To describe Key barriers to addressing IPV within a children's hospital.
3. How to provide resources utilized by families seeking help for IPV.

Violence Prevention in the Children's Hospital: Leadership by a Multi-Disciplinary Council

Kimberly A. Randell, MD, MSC, Donna O'Malley, PhD, RN, Jennifer Stallbaumer, MSW, Karen Cox, PhD, RN, M. Denise Dowd, MD, MPH

Background:
Children's hospitals play a primary role in addressing violence exposure but frequently experience barriers to doing so, including lack of administrative support and poor coordination between individual efforts and across disciplines. A tertiary-care children's hospital developed a Council on Violence Prevention to address these barriers and reduce the impact of violence on families through coordination and support of existing and future hospital efforts.

Methods:
The hospital Chief Operating Officer initiated the Council, appointing physician and nurse co-chairs. Council co-chairs attended a unique leadership development program, building competencies which they brought back to the hospital to develop the Council. Critical conversations helped build involvement of key stakeholder from multiple departments. Stakeholders were invited to participate in an initial strategic planning session where they identified multiple areas in which to focus the Council's work.

They then used a modified electronic Delphi process to select three priorities (child abuse, intimate partner violence (IPV) and peer violence) for initial focus. The Chief Operating Office and Council co-chairs selected Council members from the group of stakeholders. The Council operates using a weak executive model to coordinate hospital efforts on violence prevention. It initially met on a monthly basis, switching to bi-monthly after the Council was well established. Work to date has been accomplished without dedicated funding from the hospital.

Results:
Initial meetings focused on developing the Council's

mission, vision and bylaws and forming work groups for the three priority areas. Initial accomplishments of the IPV Work Group include creation of a tool kit to guide screening and response to disclosure, development of an IPV policy, creation of Strong Moms, Happy Kids (a volunteer effort providing anticipatory guidance to mothers in shelter) and expanded IPV screening efforts. Initial accomplishments of the Child Abuse Work Group include substantial revision of the child abuse policy, implementation of The Period of Purple Crying abuse prevention program in the neonatal intensive care unit and efforts to develop an evidence-based home visitation program in collaboration with community agencies. The most significant barrier encountered was competing demands on hospital staff.

Frequently, individuals with interest in violence prevention work were unable to participate due to previous commitments. This barrier negatively impacted the Peer-to-Peer Violence Work Group's stability and progress. The Council compiled an inventory of hospital violence prevention efforts and areas of weakness. This was presented to the Chief Executive Officer with recommendations for formal strategic planning around violence prevention, with particular emphasis on violence prevention as a core research focus and development of prevention services for the hospital's Pediatric Care Network.

Conclusions:
A multi-disciplinary Council on Violence Prevention enabled a tertiary- care children's hospital to address violence at the level of primary, secondary and tertiary prevention in a more comprehensive, cohesive manner and expand efforts to include community agency partnerships. This model may enable other children's hospitals to do the same.

Objectives:
Attendees will learn:
1. To describe barriers to violence prevention within a large children's hospital.
2. To identify institutional resources used to create an interdisciplinary Council on Violence Prevention.
3. To name the 3 violence prevention focus areas made a priority by the newly formed Council on Violence Prevention.

Adolescent Dating Violence in the Pediatric Emergency Department—A Male Perspective

Brian Wagers MD, Michael Gittelman MD, Wendy Pomerantz MS MD, Berkeley Bennett MD, Jenna Gilb BS

Background:
It is recommended that the pediatric emergency department (PED) visit can serve as a unique opportunity to screen female teens for dating violence (DV). Studies have demonstrated that up to 56% of females are victims of DV. New literature supports that males may be victims of DV in rates similar to females. Our objective is to to determine the prevalence of male teens presenting to a Midwestern PED who screen positive for DV and to determine risk factors, types of injuries sustained and the desire for social service referral from those screening positive.

Methods:
A prospective screening study of 13-21 year old males presenting to a PED for any chief complaint were enrolled. Exclusions included: never dated, non-English speaking, critically ill, active psychosis, or caregiver non-willingness to leave during study participation. 152 participants were recruited by random cluster to approximate a true sample. A computerized survey was completed consisting of: demographics, a validated DV screen, and a risk factor assessment. At completion, all participants received DV educational materials and asked if they would like to speak with a social worker regarding their violence exposure.

Results:
152/230 (66%) of those approached for participation in the study enrolled. Reasons for declination included: 30 denied dating (38%), 27 not interested (35%), 12 too ill (15%), 8 for parental involvement (10%), and 1 already enrolled (1%). The mean age of participants was 16.1 years (SD 2.2 years), with 91 Caucasian (61%) and 61 African American (40%). 122 (80%) reported having a primary care doctor and 61 (40%) admit to having DV education in the past. 30 (20%) of enrollees screened positive for DV. The mean age of those screening positive was 17 years (SD 2.2 years).

Risk factors for those who screened positive included: 71 (47%) admitted to being involved in physical altercations with others, 10 (7%) endorse riding in a car with a dating partner who was driving under the influence, and 68 (45%) admitted to drinking alcohol. 15 (50% of those positive for DV) sought care in the PED for DV related complaints and only 2 (6.7%) desired social service intervention. The most common injuries sustained as a result of DV were scratches or scrapes (73%). Of note, no mental trauma was endorsed by any male who screened positive for DV.

Conclusions:
Our study shows a smaller DV prevalence in males compared to previous studies of women or males in larger cities. Injuries sustained were mild and did not require formal medical care. Many organizations have suggested screening females for DV in the PED setting, this study questions if males should be screened given

the small prevalence and minor injuries sustained.

Objectives:
Attendees will learn:
1. To recognize dating violence is a problem within adolescent relationships.
2. To describe the prevalence of dating violence among males in a pediatric emergency department.
3. To recognize risk factors for dating violence.

Computational Modeling Of Multiple Riders In All-Terrain Vehicle Crash Scenarios

Hope Mullins, MPH, Beverly Miller, MEd, Chandra Thoroble, PhD, Mary Aitken, MD

Background:
Since being introduced in the 1970s, the popularity of all-terrain vehicles (ATVs) continues to rise in the United States, especially among children and adolescents and in rural states. The burden of ATV-related injuries and deaths in this population has increased dramatically over the past decade. Although there are key "best practice" recommendations for ATV users, there is little published proof that the recommendations are based on scientific evidence. Therefore, better insights into ATV crash mechanisms are needed to facilitate effective prevention strategies. The development of computational models and corresponding animations to realistically simulate ATV crashes are among the first steps in developing interventions that can effectively portray the inherent risk of ATV use.

Methods:
In a previous study a computational computer module of a 450cc ATV was developed and validated with a single user. The current study expanded the computational modeling to include a driver and passenger. The two-rider simulation scenario was compared with single rider simulation on similar terrain and ATV speed to gain insight about the influence of this additional passenger weight on the crash kinematics of the ATV and the rider. Overall 16 simulations are conducted for downhill and lateral rollover crash scenarios to understand the influence of an additional rider on ATV dynamics. Constant trip load and variable trip load were tested.

Results:
Constant trip load is a more conservative estimate of crash scenarios, meaning a greater grade or higher velocity would be needed to meet the effects of a variable trip load (ie: worst case scenario), whereas a variable trip test considers movement of dirt and forgiveness of tires as would be encountered in a real world scenario. In the forward flip scenario, at a constant trip, ATVs with single or double riders will flip. Forward flip at a variable trip load indicates that the single user ATV will not flip completely but rather tilt and bounce back whereas the ATV with two riders will roll over completely. For the lateral roll with both constant and variable trip the ATV with a single rider will not roll, when in both scenarios the ATV with two riders will flip over.

Conclusions:
The study demonstrates that an ATV with two riders is more unstable and more likely to roll in forward flip and lateral rollover situations. This may be due to the initial counteracting moment arm which is greater in forward flip than the lateral flip. The idea of providing seatbelts and roll cages for an ATV should be carefully reviewed, as it may have the unintended result of increasing rollover propensity since the riders are attached to the ATV and the roll cage will tend to make the ATV top heavy. Further study of the engineering characteristics and performance of these vehicles is important to identify new prevention strategies.

Objectives:
Attendees will learn:
1. To recognize why key ATV safety recommendations need to be scientifically validated.
2. To determine how a computational computer model is validated by "real world" scenarios.
3. To recognize how multiple passengers change the riding dynamic of ATVs.

Knowledge Assessment of Sport-related Concussion among Parents of Children Aged 5-15 years Enrolled in Recreational Tackle Football

Carol Mannings, MD, Colleen Kalynych, MSH,EdD, Madeline Joseph, MD, Carmen Smotherman, MS, Dale Kraemer, PhD. University of Florida COM, Jacksonville, FL

Background:
Sports-related concussion among professional, collegiate, and more recently high school athletes has received much attention from the media and medical community. To our knowledge, there is a paucity of research in regard to sports-related concussion in younger athletes. The aim of this study was to evaluate parental knowledge of concussion in young children who participate in recreational tackle football.

Methods:
Parents/Legal guardians of children aged 5-15 years enrolled in recreational tackle football were asked to complete an anonymous questionnaire (23 questions)

based on the CDC's Heads Up: Concussion In Youth Sports quiz. Parents were asked about their level of agreement in regard to statements that represent definition, symptoms, and treatment of concussion. Additionally, parents were asked if they had received information in regard to concussion and from what source. Finally, parental and child demographic information was collected.

Results:
A total of 310 out of 369 parents voluntarily completed the questionnaire (84% response rate), where 43% were White, 48% Black, and 8% other. Most had more than a high school education (78%) with their child playing for the first time (33%), 1-2 years (28%), or 3 or more years (39%). Eighty-one percent of the children were aged between 8-12 years. Ninety-four percent of parents believed their child had never suffered a concussion. However, when asked to agree or disagree with statements addressing various aspects of concussion, only 13% (n=41) could correctly identify all 7 statements.

Most did not identify that a concussion is considered a mild traumatic brain injury and can be achieved from something other than a direct blow to the head. Race, gender, and zip code had no significant association with correctly answering statements. Education (.24; $p < .01$) and number of years the child played (.11; $p < .05$) had a small effect. Fifty-three percent of parents reported someone had discussed the definition of concussion with them and 58% the symptoms of concussion; about half the education came from a healthcare provider (56% and 53% respectfully). No parent was able to classify all symptoms listed as correctly related or not related to concussion.

However, identification of correct concussion definitions correlated with identification of correct symptoms (.25; $p < .05$).

Conclusions:
While most parents had received some education regarding concussion from a healthcare provider, important misconceptions remain among parents of young athletes regarding the definition, symptoms, and treatment of concussion. This study highlights the need for healthcare providers to increase educational efforts among parents of young athletes in regard to concussion.

Objectives:
Attendees will learn:
1. To describe the percentage of parents among a study population that could correctly identify the symptoms and various aspects of concussion.
2. To describe parental reporting of where information in regard to concussion was obtained.
3. To discuss factors that may influence parental knowledge of symptoms associated with concussion.

Protect UR Brain - Wear a Helmet - On the Slopes

Amy Teddy, BS

Background:
This statewide initiative, started in 2009, was inspired by a young trauma patient who suffered a serious brain injury while skiing without a helmet.

After receiving a large program gift, we developed a innovative program that would aim to increase helmet use on the slopes across Michigan.

Methods:
The goal of the program is to work with individual ski properties/resorts to identify opportunities for policy change that would directly influence helmet usage on the slopes.

In exchange, our program would provide a combination of new helmets for rental shops and/or educational signage across the property.

Results:
2008-09 (Pre-intervention season): 1303 helmets rented : 15,000 ski/board rentals (8% utilization)
2009-10 (1st year): 3425 helmet rented : 20,000 ski/board rentals (17% utilization)
2010-2011 (2nd year): 5387 helmets rented : 18,000 ski/board rentals (30% utilization)
All locations reported that the adult staff (ski patrol, ski school instructors, rental shop attendees, etc.) were experiencing a sense of "guilt" leading to a change in behavior/attitude regarding helmet use. Many locations have continued to improve their policies related to helmet use since program inception. Locations are reporting increase in revenue and sales.

Conclusions:
Protect UR Brain - Wear a Helmet on the slopes has proven to be very successful and exposed a novel way of increasing awareness, especially in times of a struggling economy. Working with small businesses to increase awareness can have its challenges. But, with a personalized and reasonable approach that establishes a mutually beneficial goal - the juice is definitely worth the squeeze!

Objectives:
Attendees will learn:
1. To describe a novel program to increase helmet use

on the slopes.
2. To identify two policy changes that may influence helmet use on the slopes.
3. To apply this novel program philosophy in their communities.

Grandmothers and Infant Safe Sleep

Alison Rose, MPH, Beverly Miller, MEd, Hope Mullins, MPH, Christopher Swearingen, PhD, Mary Aitken, MD

Background:
Sudden infant death syndrome (SIDS) and suffocation are leading causes of infant mortality. Supine sleep position and use of appropriate sleep surfaces reduce SIDS risk but are not universally practiced. Mothers' decisions about sleep position and environment may be influenced by guidance provided by grandmothers and other older female caregivers. It is therefore important to determine sleep safety practices and beliefs among grandmothers. This pilot study identifies core content that should be included in efforts to educate grandmothers about infant sleep safety.

Methods:
A survey was developed for a convenience sample of grandmothers aged 30-70 years who provide care at least weekly for an infant grandchild <6 months old. The survey was distributed through community partners of a university-based research team. Respondents received home safety items as compensation.

Results:
Among the 260 grandmothers who completed the survey, 45% reported placing infants to sleep supine on an appropriate sleep surface. Respondents were more likely to adhere to recommended guidelines when they did not believe supine position increased choking risk (OR 5.59, 95% CI (2.92, 11.01), p<0.001), did not believe infants are more comfortable or sleep longer when on their stomachs (Comfortable OR = 4.60, 95% CI (2.37, 9.21), p<0.001; Longer OR = 4.74, 95% CI (2.44, 9.49), or agreed that safety practices have changed over time (OR = 2.29, 95% CI (1.30, 4.04), p=0.002).

Conclusions:
Grandmothers do not universally observe evidence-based safe sleep practices. Interventions for senior caregivers focused on perceived choking risk, infant comfort in the supine position, and recent changes in recommended safety practices are warranted.

Objectives:
Attendees will learn:
1. To identify AAP guidelines regarding safe sleep practices for infant.
2. To describe grandmothers attitudes and beliefs regarding safe sleep for infant.
3. To discuss key talking points on which to educate senior caregivers about safe sleep for infants.

Prevention Of Child Injuries During Tornadoes: A Case Series From the 2011 Tornado Outbreak In Alabama

Christine M. Campbell, MD, MSPH; Mark D. Baker, MD, MPH; and Kathy W. Monroe, MD

Background:
Tornadoes and violent weather pose a hazard to children, yet little is known about the use of personal protective devices during storms. A devastating outbreak of tornadoes on April 27-28 2011 highlighted potential injury prevention measures.

Methods:
82 children were seen in a pediatric emergency department for evaluation following direct exposure to a tornado. Using a statewide trauma registry and chart reviews we identified three of these children who survived without physical harm, possibly as a result of the use of protective gear. Focused interviews with the children's families were conducted for this retrospective case series.

Results:
Of the three children, two were infants strapped into car seats and one child was wearing a helmet. Although the buildings in which they sheltered were destroyed and other household occupants were injured, these children were unharmed or suffered only minimal superficial abrasions.

Conclusions:
To our knowledge, this is the first report in the medical literature of helmet and infant car seat use as child injury prevention devices during a tornado. These findings suggest that children at risk of exposure to tornadoes may benefit from the use of personal protective devices that are commonly utilized as injury prevention tools in other settings, such as infant car seats and helmets, to reduce the potential for injury.

Objectives:
Attendees will learn:
1. To understand the mechanics of a tornado and how this leads to the types of injuries sustained during violent weather.
2. To review the evidence supporting the use of helmets and infant car seats to reduce injury during blunt force trauma.
3. To discuss a novel use of helmets and infant car seats

as protective equipment in the setting of a tornado.

Smoke Detector Installation Program Awareness and Home Fire Safety Practices in an Urban Pediatric Emergency Department Population

Leticia Manning Ryan, MD, MPH, Rachel Wood, BS, Stephen J. Teach, MD, MPH, Alexandra Rucker, MD, Ambika Lall, BS, Joseph L. Wright, MD, MPH
James M. Chamberlain, MD

Background:
Risk factors for residential fire death (young age, minority race/ethnicity, and low socioeconomic status) are common among urban pediatric emergency department (ED) patients. Community-based resources are available in our region to provide free smoke detector installation. The objective of our study is to describe awareness of these resources and home fire safety practices in this vulnerable population.

Methods:
In this cross-sectional study, a brief survey was administered to a convenience sample of caregivers accompanying patients 0-19 years of age in an urban pediatric ED in Washington, DC. Survey contents focus on residential fire injury risk factors and participant knowledge of available community-based resources. Descriptive epidemiologic analysis of responses was

Results:
This analysis included 401 caregivers (62% participation rate). Patients accompanying the caregivers were 48% male, 77% African American and had a mean age of 6.5 (± 5.9) years. Of study participants, 256 (63.8%) lived with children £ 5 years of age. A home smoke detector was reported by 396 respondents (98.7%); however, 346 (86.3%) reported testing these less than monthly. 256 (63.8%) lacked a carbon monoxide detector and 202 (50.4%) had no fire escape plan. 65 (16%) reported indoor smoking and 92 (22.9%) reported space heater use. When asked about available community-based resources, 240 (59.9%) were unaware of these programs, 319 (79.6%) were interested in participating, and 221 (55.1%) enrolled.

Conclusions:
While self-reported smoke detector prevalence rates are high in our study population, other fire safety practices are suboptimal. Our results also show limited awareness of community-based resources. Prevention strategies should focus on home smoke detector maintenance and carbon monoxide detector use.

Objectives:
Attendees will learn:

1. To identify populations at highest risk for injury or death from residential fire.
2. To list three risk factors that increase risk of injury or death from residential fire.
3. To describe three methods of smoke detector promotion.

Getting the Biggest Bang for your Buck- How to Build a Comprehensive Home Safety Education Program

Mary Beth Moran PT, MS, M.Ed.

Background:
Every year thousands of children are brought to emergency departments, hospitalized and die as a result of injuries in the home. Most injuries that occur in the home occur in children under age 5. Many of these injuries can be avoided by educating parents in modifications to the home environment, providing access to safety product at low cost, and recommending appropriate supervision. This presentation will outline how one injury prevention program leveraged successive grant funding and community collaborations to maximize community benefit.

Methods:
To develop an injury prevention program with an emphasis on home safety the organization solicited grant funding from various organizations. In 2003, The Kiwanis Foundation and NACHRI Get On Board programs provided seed money to develop a Safety Store and Community Education Program. This store has a physical location at the hospital and staff to enable a mobile safety store to bring product and education into the community. To build on the success of the Safety Store program the Kiwanis Foundation subsequently funded staff from the Safety Store to provide education to home visitation nurses to provide best practice on anticipatory guidance to high risk families.

In turn, these nurses refer parents for further education and personal counseling to the Safety Store, and thus both programs support each other. Concurrently, the local coalition of trauma centers-TREF (Trauma Research Education Foundation) funded a project that would benefit the most prevalent injury risk areas. This funding produced “Intergenerational Home Safety Makeover Video” That could be accessed by the public via the Internet, used for training and provide education during wait times at medical offices. To evaluate the effectiveness of parent and provider educational programs pre and post survey were implemented. These surveys investigated gaps in knowledge of child development, risk awareness and practice.

Results:
The Safety Store provided educational programs to 109 new and expectant parents of children up to 6 years of age. Results from pre-tests demonstrated that less than 40% were accurate in questions regarding normal child development, less that 20% were aware of high risk injuries and less than 30% correctly answered questions on best practice. Results from seminars provided to 75 Public Health Nurses demonstrated that only 50% of nurses accurately responded to questions in child development, high risk areas and practice. Only 48% of nurses received any training on injury prevention in nursing school. Post test scores demonstrated a score of 85% and higher overall.

Conclusions:
The programs described in this presentation have shown that there are many gaps in knowledge in childhood development, injury risk associated with stages of development, appropriate supervision and associated requisite environmental changes in both parents and providers that counsel them. This program demonstrates a multi-tiered approach to addressing access to safety education and product as one step towards solving this multifaceted risk group.

Objectives:
Attendees will learn:
1. To identify a strategy to identify injury trends and most prevalent mechanisms of injury.
2. To develop multimedia tools to assist providers and families in prioritization of needs.
3. To develop complimentary programs for maximum community benefit.

Pediatric Injury Prevention Scholars (PIPS) Summer Internship Program

Helen Arbogast, MPH, CHES, Kate San Mateo, MPH, Jeffrey Upperman, MD

Background:
Trauma is the leading cause of death and injury among children. Injury prevention is a critical approach for decreasing at-risk behaviors. A key element in mitigating injury is through peer education. We tested this hypothesis by designing and implementing the Pediatric Injury Prevention Scholars (PIPS) summer internship program.

Methods:
Annual trauma database reviews were used to identify the leading mechanisms of injury in children. Stakeholder meetings with members of the Injury Prevention Alliance of Los Angeles County (IPALAC) further identified existing gaps in home, sports, child passenger, bike, and pedestrian safety across Los Angeles County.

Students were recruited from universities and medical schools using electronic and print media. The highest quality candidates were selected for interviews.
A mix-method study design evaluated the PIPS program. We collected qualitative data using peer evaluations and exit interviews. Quantitative data was assessed using program benchmarks, which included contributions to the trauma program and academic research products.

Results:
In 2011, we conducted 15 interviews and selected 1 medical student, 4 graduate students and 2 undergraduate students. In 2012, we conducted 13 interviews and selected five students. The cohort included 4 graduate students and one undergraduate pre-medical student.

The PIPS program curriculum consisted of two tactical areas - a programmatic arm and a discovery arm. Program PIPS developed culturally sensitive injury prevention educational materials. They created hands-on educational resources, such as an interactive dollhouse to teach home safety to children and families. They created a “safety corner” within the hospital’s family pantry, which offers home safety devices at wholesale prices. These students also played a critical role in utilizing social media to spread injury prevention messages via Facebook and Twitter.

Discovery PIPS focused on translational research of injury prevention topics. Students assisted with institution review board (IRB) study submissions, literature reviews, study design, data collection, and data analysis. They published review articles focusing on pediatric trauma, conducted literature reviews to determine if trauma outcomes differed between rural and urban populations, and prepared a manuscript on effective car seat intervention strategies.
PIPS contributed over 2,000 hours to the field of injury prevention research and program implementation. Discovery PIPS contributed over 1,000 hours and program PIPS contributed over 500 hours to injury prevention related community outreach.

Students created a culmination presentation to summarize specific projects and activities they were involved with throughout the summer. Satisfaction surveys were used to determine if the PIPS program met their personal objectives.
Conclusions:

The PIPS summer internship program expanded CHLA’s programming capacity by utilizing a student base.

More importantly, it focused on garnering interest from students to become future injury prevention practitioners and provided them with an insight into the fields of Trauma. The inaugural PIPS class helped to refine the existing injury prevention curriculum for future PIPS. We conclude that there is interest in this modality of education and we intend to promote and expand the PIPS program.

Objectives:
Attendees will learn:
1. To explore nontraditional approaches to expand reach and manpower for injury prevention programs.
2. To describe best practices for injury prevention outreach, education and research.
3. To understand the importance of the injury prevention coordinator in training injury prevention practitioners and volunteers to capacity building.

An Effective Way to Utilize Daycare Organizations to Distribute Home Safety Equipment

Dawne P. Gardner-Davis, MBA, Wendy J. Pomerantz, MD, MS, Mike A. Gittelman, MD

Background:
Injuries in the home setting cause a significant amount of morbidity and mortality to US children < 5 years. Previous studies indicate that the installation of passive home safety devices can significantly reduce these injuries. The purpose of this study was to compare the use of safety equipment in the home after it was installed by an injury prevention specialist versus equipment dispersed at a local daycare and installed by the family.

Methods:
A prospective study involving two comparable daycare organizations located in a high-risk community was performed. Cases and controls consisted of families with children between 4 and 24 months and each received a packet consisting of: cabinet and drawer latches, CO detector with battery, a magnetic phone list, and 5 other items. After obtaining consent, both groups completed a pre-screen survey to determine current home equipment use and reasons for not having equipment. Cases consisted of families from one daycare organization that received education and one home safety equipment package.

Controls from another daycare organization received the same education; however equipment was installed for them in their home. Home visits were conducted 6-9 months after equipment was provided for both groups. Assessments of equipment usage and maintenance were performed at follow-up. 81 families were sought in each group to detect a 30% difference in home equipment use and maintenance. Frequencies and Chi Square analysis was used for comparisons.

Results:
Among the 167 families approached, 79 cases and 81 controls agreed to participate. Groups showed no difference in age, education, employment, or marital status. There were significantly more male caregivers in control group, fewer African Americans in case group and a higher level of income in case group. There was no difference in home equipment use between cases and controls before study enrollment with working CO detectors (11.4% vs. 12.3%), functioning cabinet locks (2.5% vs 11.1%), drawer locks (0% vs. 2.5%) or posted emergency numbers (24.1% vs 19.8%). Follow-up home visits occurred in 71(87.7%) cases and 75 (92.6%) controls; 14 families moved prior to follow-up. Home follow-up visits showed a significant increased use in cases and controls of working CO detectors (79.2% vs. 89.3%, $p=0.02$), functioning cabinet locks (38.0% vs 78.7%, $p<0.001$) and drawer locks (22.5% vs 62.7%, $p<0.001$); posted emergency number increased in both groups but the post use difference between groups was not significant (78.9% vs 89.3%, $p=0.11$).

Conclusions:
Home injuries are a problem. Both providing home equipment and installation of home equipment resulted in increased use. Installation of equipment resulted in increased use compared to equipment being given to families for self-installation. For some equipment, distribution in daycare settings can be almost as effective as the gold standard of home installation.

Objectives:
Attendees will learn:
1. To describe why previous research provides evidence that Installation of equipment results in increased use compared to equipment being given to families for self-installation; however, even after installation, no product was proven to be used/maintained at a rate of 100%.
2. To recognize how some equipment, distribution in daycare settings can be almost as effective as in home installation.
3. To recognize if families find value in product, distribution can occur anywhere.

Increasing Injury Prevention Knowledge among Children through an Interactive Pedestrian Safety Exhibit

Anyah Land, MPH, Nicole Kozma, MPH, Catherine Rains, MPH, Greta Todd-Moorhead, MA

Background:
Unintentional injuries are a common cause of emergency room visits at level one trauma center, St. Louis Children's Hospital. From 1999-2009, the rate of death due to unintentional injuries and poisoning among children ages 1-14 was higher in St. Louis City than the rate in Missouri. In 2002, the hospital's Child Health Advocacy and Outreach Department created the Safety Street exhibit to teach children in grades K-2 about pedestrian and bicycle safety, stranger and stray animal awareness. In 2011, a 3rd-5th grade curriculum was created from an analysis of the hospital's trauma registry. Curriculum topics include playground/sports, water, motor vehicle and bicycle safety along with recognizing fire, burn and poison hazards. Unused space within the existing exhibit display life-like scenarios allowing the program to leverage space and money. Students analyze each scenario and identify unsafe behaviors and hazards.

Knowledge tool development consisted of a literature review to identified best practices in assessment design and appropriate teaching objectives. Reading level was determined by the St. Louis Children's clinical lead for health literacy and was confirmed using the Flesch-Kincaid Grade Level Indicator. The language of each assessment tool is age-appropriate for the youngest grade targeted for each curriculum.

Methods:
This interactive walk-on pedestrian safety exhibit is evaluated using a pre-test post-test single group design measuring knowledge gained while participating in the event. Randomly selected classes completed a pre-test using Classroom Performance System (CPS) clicker prior to visiting the exhibit.

Of the 2,544 participants from 19 sites visited in 2011, a convenience sample of 1,101 children in kindergarten through second grade and 1,227 third through fifth graders completed the pre and post-test. Safety Street Program Specialists administer a post-test prior to the students exiting the exhibit.

Test results were analyzed using Microsoft Excel and SPSS 19.0. Mean test scores were computed using Microsoft Excel. Results were weighted by grade. A paired t-test was used to compare pre- and post-test scores for total score as well as each individual question.

Results:
Overall scores improved for participants in all grades. Overall scores improved 29% ($p<0.001$) for kindergarten to second graders. Overall scores improved 9% ($p<0.001$) for third to fifth graders.
Majority of the questions from both assessments showed a statistically significant increase in knowledge or participants scored above 80%.

Conclusions:
Safety Street is an effective way to teach school-aged children about pedestrian safety and identifying hazards. The exhibit incorporates Illinois and Missouri Departments of Education knowledge standards for decision-making, communication, health and safety, which is appealing to school administrators and is pedagogically enriching for students. With an expanded curriculum, this program tripled the number of participants and its impact in the community. We anticipate this program will continue to affect the number of unintentional injuries among school age children. The future evaluation plan for this program includes retention testing both assessment tools and expanding the program to educate pre-school children.

Objectives:
Attendees will learn:
1. To identify injury prevention topics most suitable for the population using national, state, and hospital data.
2. To identify safety knowledge among elementary students through outcomes evaluation methods.
3. To describe recommendations for adapting pedestrian safety programs to older elementary students.

Can Nurse Education In the Post-Partum Period Reduce Car Seat Misuse Among Newborns?

Steve Rogers, MD, Brendan Campbell, MD, MPH, Karen Gallo, MPH, Hassan Saleheen, MBBS, MPH, Garry Lapidus, PA-C, MPH

Background:
Correctly used car safety seats (CSS) substantially reduce injury morbidity and mortality. The objective of this study is to design, implement and evaluate a comprehensive educational newborn car safety seat training program for nurses and parents.

Methods:
In the pre-intervention phase (May 2010 – Oct 2010) we conducted a pre-survey among Hartford Hospital maternal/newborn unit nurses to measure CSS knowledge, attitude, and practice. We then enrolled 60 maternal/newborn dyads at discharge to survey

maternal CSS knowledge and observe CSS misuse rate. Our intervention phase (Nov 2010 – Aug 2011) included a one hour "mandatory" nurse CSS education class room session and a "nurse see 1, do 2" hands on CSS demonstration and practice in mothers room. During the post-intervention phase (Sep 2011– Jan 2012) we: 1) conducted a post-nurse survey to measure change in CSS knowledge, attitude, and practice, 2) enrolled 70 maternal/newborn dyads at discharge to survey maternal CSS knowledge and observe change in CSS misuse rate, and 3) conducted a follow-up at 2 weeks and 2 months to obtain maternal self-report CSS use (in process).

Results:

In the pre-intervention phase 43 of 59 (73%) of eligible nurses completed the pre- survey, 47 of 59 (80%) completed the "mandatory" CSS education and training program, and 13 of 59 (22%) completed the post-intervention survey. Comparing CSS pre/post surveys, more nurses report education is part of their routine (23% vs. 92%), have education materials (44% vs. 92%), feel comfortable providing education to parents (32% vs. 92%), feel trained (12% vs. 69%), have time (25% vs. 69%), identify misuse is a problem (84% vs. 92%), and received training (16% vs. 92%).

Enrolled mothers reflect maternal/newborn unit demographics. Maternal mean age = 29 years (range 16 – 48 years), White (54%), Black (11%), Hispanic origin (28%), English primary language (83%), HS degree (31%), college degree (30%), Medicaid (23%), private insurance (65%).

Of 70 post-intervention mothers, 44% report receiving no nurse education, 21% received a brochure only, and 31% received nurse education. CSS misuse among mothers who received RN education was not reduced compared to mother's who received a brochure only and those who did not receive CSS education. Comparison of pre (N= 60) vs. post (n= 70) observations of CSS misuse revealed average misuse (1.8 vs. 3.0), harness in lowest slot (95% vs. 87%), recliner clip at axilla level (63% vs. 33%), harness snug (50% vs. 27%), attached to vehicle (80% vs. 80%), 45 degree angle (60% vs. 19%), and moves (32% vs. 27%).

Conclusions:

Car safety seat misuse did not improve following implementation of a comprehensive nursing education and training program. CSS misuse in our study population was frequent and may increase injury risk in the event of a motor vehicle crash. Future work will develop novel approaches/settings and the innovative use of technology to reduce newborn CSS misuse.

Objectives:

Attendees will learn:

1. To identify the most common and important newborn car seat misuse issues.
2. To describe a nurse education and training program designed to reduce newborn car seat misuse.
3. To describe the limitations and barriers of a nurse education and training program and plans to address them.

Characteristics of Gdl Compliant, Belted, and Unimpaired Teen Drivers Involved In Fatal Motor Vehicle Crashes

Joyce Pressley, PhD, MPH, Diane Addison, MPH, MIA, Patrick Dawson, MPH, Barbara Barlow, MD, Sharifa Nelson

Background:
Teen driver safety has received much attention with research and interventions focusing on modifying behavior and strengthening laws related to night-time driving, teen passengers, alcohol and drugs, seat belt use and more recently on distracted driving. While multiple efforts and interventions have been associated with a lowering of teen driver fatalities, teens remain a vulnerable and high-risk group of drivers. Less is known about crash-related factors in non-drinking, restrained, and license compliant teen drivers. This study aims to examine fatal crash factors in the GDL compliant, unimpaired and belted teen driver with the objective being to identify factors that may produce further improvements in serious teen MV injury.

Methods:
The Fatality Analysis Reporting System (FARS) for 2007-2009 was used to examine compliant teen drivers (n=1,570) of noncommercial, four-wheeled passenger vehicles involved in a collision on a U.S. roadway in which an occupant died. Teens driving unbelted, non-GDL compliant or with the presence of any alcohol or drugs were excluded. Statistical analysis used Chi square, Fisher's exact and logistic regression. Relative risk (RR) is reported with 95% confidence intervals. Significance was defined as $p<0.05$.

Results:
Nearly one third (32.1%) of all teen drivers involved in a fatal four-wheeled passenger vehicle collision resulting in death of an occupant, were restrained, unimpaired and in compliance with their driver license restrictions. Of the "compliant" teen drivers, the majority held an intermediate level graduated driver license (90.6%). Driver violations were associated with higher driver mortality (38.8% vs. 12.1%, $p<0.0001$). When total driver fatalities (n=454) are analyzed by time, the highest peak occurs from 7-7:59 a.m. with smaller, but notable peaks from 3-3:59 p.m. and 4-4:59 p.m. School days and weekends show a distinctly different crash time pattern. Despite being a small number of crashes, slippery road conditions were associated with an increase in driver deaths (8.2% vs. 2.7%, $p<0.0001$).

Females comprised a minority of drivers (42.1%), a majority of cell users (70.0%) at the time of fatal crash and were more likely to be severely injured. Documented cell in vehicle (n=55) and cell use (n=10) was low, but cell use was significantly more common on school mornings (Fisher's Exact, 0.046). Drivers with cell in use were more likely to die (Fisher's Exact, 0.039). In multivariate models controlling for age, crash year, and occupants, independent predictors of severe incapacitating driver injury/death included being female, vehicle weight < 3,000 lbs, any driving violation, and documentation of a cell phone visible in the vehicle, with late model vehicles (2000 and later) tending to be associated with less severe driver injury ($p=0.057$).

Conclusions:
This study identifies several specific areas that could be informative to parents and injury prevention professionals with an interest in further improving teen driver safety for the nearly one-third involved in a fatal crash while license compliant, belted and unimpaired.

Objectives:
Attendees of this session will learn:
1. To discuss the proportion of teen driver crashes occurring in compliant, nondrinking and belted teens with and without associated driving errors violations.
2. To identify crash factors associated with fatal crashes among teen drivers who were compliant with GDL, alcohol and restraint laws at the time of the crash.
3. To discuss behavioral and vehicle factors amenable to preventive interventions aimed at lowering serious MV crash in "compliant" teen drivers.

Do As I Say (and Not as I do): Distracted Driving Behaviors of Adults While Children are in the Car

Linda Roney, MSN, RN-BC, CPEN; Pina Violano, MSPH, RN-BC, CCRN, CPS, PhD (c); Greg Klaus, RN, CEN; Rebecca Lofthouse, MS, RN

Background:
In 2010, 863 pediatric trauma patients were evaluated at Yale-New Haven Children's Hospital. Many had injuries that resulted from a vehicular crash yet our patients are too young to drive. To date, there is no known research published regarding the distracted driving behaviors of adults using cell phones while children are in their cars. The primary aims of the current study were to investigate whether drivers engage in distracted driving activities with children in the car and whether having a child in the car make drivers less likely to engage in distracted driving activities.

Methods:
A descriptive quantitative research design was used to explore the distracting driving behaviors. Three large pediatric practices in Connecticut agreed to serve as the setting for this research. This was a convenience sample of 539 adults (18+ years, have a driver's license, own a cell phone and drive children). Potential participants were approached by a member of the research team and invited to complete a brief survey while they visited one of three pediatric practices.

A 16-question survey was developed to address the variables explored in this study. Once data collection commenced, the McNemar's and Wilcoxon signed-rank tests were used to assess significant differences between the distracted driving behaviors engaged in by participants while driving alone or with other adults in the car and those while driving children.

Results:
Only about one-third of the sample used a bluetooth device often or always. More than 80% of respondents reported that they have used a cell phone in some way while driving children, however they were significantly less likely to do so with a child in the car when compared with their own behaviors while driving alone or with another adult in the car ($p<0.0001$). With children in the car, respondents were also less likely to do specific behaviors associated with cell-phone use ($p<0.001$), such as holding a cell phone in hand, reading, sending texts or e-mails anytime while driving on the road, or surfing the Internet while driving.

Conclusions:
Our study showed that a large majority of people use cell-phone while driving, with about a quarter using it in-hand, which is prohibited by law in CT. Transporting a child was associated with fewer such reported behaviors, however this protective effect was not overwhelming in magnitude. Trauma centers should partner with communities to provide educational activities to raise awareness among adults of this potentially dangerous practice.

Objectives:
Attendees of this session will learn:
1. To describe one definition of distracted driving.
2. To describe the general pattern of cell phone use by adults while driving children in the car.
3. To describe enforcement strategies that discourage distracted driving behaviors.

Motor Vehicle Safety-Successes and Challenges-Pilot study

Purnima Unni,MPH,CHES, Barbara Shultz ,RN,BSN, Stephen E. Morrow,MD

Background:
Distracted driving is a major contributor of motor vehicle crashes.This program is a primary prevention initiative to educate high school students about safe driving, with emphasis on dangers of texting while driving. The main goal was to improve teen driver safety among high school teens through a unique peer-generated anti-texting campaign. The program consisted of two phases. In Phase 1, student leaders from two high schools participated in a half-day, hospital-based experiential program that emphasized the message of safe teen driving with emphasis on dangers of texting while driving. This phase involved active participation from trauma surgeons, ED staff, physical and speech therapists, and social workers. In Phase 2, these students conceptualized and implemented an anti-texting while driving campaign during the school year. These student leaders were provided with detailed resource guides, and financial support.

Methods:
A high school each was selected from a rural and an urban county. These counties were selected based on hospitalization data from the trauma registry data of a level 1 pediatric trauma center. Thirty-two student leaders were nominated by their schools for the hospital-based intervention. At the beginning of Phase 1, students completed a short survey that assessed beliefs, attitudes, and behavior relating to texting while driving, and other driving behaviors. This phase consisted of presentations, video, interactive demonstrations, role-playing, first-person accounts, and Emergency Department simulation. At the end of the session, another survey assessed awareness and behavioral intentions. Students as well as staff participants provided qualitative feedback on the different aspects of this phase.Students also completed an online survey on driving behaviors after three months.

In Phase 2 students organized events that targeted the student body. They also involved local agencies such as the community medical center, fire department, police department, emergency medical services, and media. Student leaders maintained records of all activities. Observations of texting while driving were made before, during, and after the campaign. Observation logs were provided to students. A survey was also administered to a convenience sample of students (n=611).

Results:
Self-reported texting while driving came down significantly ($p<.05$) among the student leaders who attended the hospital-based intervention. Preliminary analysis of observation data indicates a decrease in texting while driving. The survey data from the larger student body confirmed the need to reinforce the message of no texting while driving. Qualitative feedback was useful in identifying modifications to the program.

Conclusions:
This pilot project is scalable and provides the foundation to reach larger number of at-risk teens. Evaluation data at different stages are vital for program improvements and supporting future grant proposals. Peer-led interventions are likely to be effective. However, close coordination is needed to ensure key milestones are achieved during the school year. It is critical to get buy-in from the school principals to ensure school-wide participation. A competition between schools and local media coverage goes a long way to raise motivation levels in the schools.

Objectives:
Attendees of this session will learn:
1. To describe core components of the " Be in the Zone" Teen Motor Vehicle Safety program.
2. To describe evaluation measures for this program.
3. To discuss critical success factors of hospital-school collaborations.

Driving Yourself to Distraction- The Teen DRIVE (Distracted Reality Interactive Virtual Education) Experience

Mariann Manno,MD, Allison Rook, Amanda Yano-Litwin, Francisca Turkson, Michael Hirsh, MD

Background:
Every year, approximately 6,000 teens die in motor vehicle crashes. Almost all of these could have been prevented since they are all the predictable result of dangerous choices of inexperienced drivers. While more than 60% of teens fear about getting into a car crash, they still admit to risky behaviors while driving: 82% of teens report using a cell phone and 23% admit drinking and driving. In an effort to change these attitudes and to reduce motor vehicle crashes, various initiatives have begun to use simulation as a way to educate students about the risks and consequences of driving distracted and impaired. Teen DRIVE (Distracted Reality an Interactive Virtual Education) is a simulation program geared towards high school students of driving age. The goal of the program is to influence how teens make decisions while operating a motor vehicle and raises awareness about the importance of making safe driving choices.

Methods:
Teen DRIVE uses a 30 minute interactive driving simulation program called One Simple Decision. It has the student experience impaired and distracted driving with activities such as texting, driving under the influence of alcohol and peer distractions. In addition, the simulation exposes students to the consequences of driving distracted: a DUI checkpoint, a trauma triage unit and sentencing in a court room. Immediately after each simulation experience, students respond to a survey that examines their attitudes towards distracted and impaired driving and whether or not their experience with Teen DRIVE will impact their future behaviors.

Results:
Between September 2010 and June 2012, Teen DRIVE visited 11 public high schools in Massachusetts and other public venues and events. Over 600 students between the age of 14 and 21 years participated in the simulation. Of these, 465 completed the survey immediately after the simulation (49% males). A majority of students (77%) drive in urban neighborhoods, while 23% drive in rural areas. Students reported that the consequences of texting while driving were the same (44%), worse (33%), or much worse (16%) than they anticipated before the simulation. Students said they will never (44%), rarely (42%), occasionally (15%) text and drive in the future. Similarly, students reported that the consequences of drinking and driving were the same (36%), worse (37%), and much worse (22%) than they anticipated. In the future, they reported that they would drink and drive never (84%), rarely (11%) and occasionally (3%). When asked which teaching approach is a more effective way of teaching distracted driving, more than half (64%) of the students believed using a simulation program is more effective than lectures (2%), presentations (8%), videos (25%), and brochures (2%).

Conclusions:
Our results suggest that simulation to teach teen drivers about distracted and impaired driving is a method of instruction that they feel is most effective. In addition, simulated experiences of the consequences of driving distracted and impaired may influence teen's future driving decisions.

Objectives:
Attendees will learn:
1. To identify risk factors that contribute to high rates of injury and death among young drivers.
2. To describe a simulation based educational program

(Teen DRIVE) used to teach safe driving practices among high school student.
3) To discuss the results of a survey administered to Teen DRIVE participants.

The Challenge of Child Passenger Safety

Chris Vitale MSN, RN, Karen Zuri, BA, Barbara Gaines, MD

Background:
The Child Passenger Safety (CPS) program started in 2002 on a limited basis and has grown over the years to a reach close to 1,000 children as they leave Children's Hospital of Pittsburgh of UPMC(CHP). Motor vehicle crashes are the leading cause of death to children in this country; the goal of this program is to assure that children leaving the hospital are leaving safely, often safer than when they arrived. CPS is not without it's challenges logistically and financially - many lessons have been learned as we continue to grow in this endeavor.

Methods:
The CPS program operates on a 24/7 basis for provision of a child restraint system as needed. There is a certified technician available Monday - Friday from noon to 4:00 PM to assist families and provide one to one education. The program is two-fold, loaner seats to families who already have one but it's unavailable at the time of discharge and a donation program to families who have been involved in a motor vehicle crash or are unable to afford one. In 2011, 880 seats were provided - approximately 10% were donated. Any family needing a seat is given one.Follow up calls are made to families receiving a donated seat.

Results:
Key findings have shown that the program has more than doubled every year for the past three years and awareness of CPS has greatly increased in the organization. In addition most of the children receiving loaner seats have been discharged from the emergency department for a cab ride home. Approximately 15% of the seats were given to siblings of patients. Follow up calls to families with donated seats reach 40% and have yielded positive results to the CPS program at CHP and direction for improvement.

Conclusions:
CPS continues to be a challenge but has become more manageable with the addition of community partners. This program will continue to evolve as circumstances dictate.

Objectives:
Attendees will learn:
1. To discuss the successes and challenges of a CPS program.
2. To describe the differences in operating a loaner and provider program.
3. To identify community partners necessary for CPS program success.

A Computerized Child Passenger Safety Assessment Program in the Emergency Department

Kathleen Kiley RN, BS, Fran Damian MS, RN NEA-BC, MS, Whitney MacClaren MPH, Jason Dupuis, Darlene Salvatore CCLS, Marie Nolan, BS, RN, Lois K. Lee, MD, MPH

Background:
Child passenger safety (CPS) is an important aspect of pediatric injury prevention. The emergency department (ED) can be an effective location for injury prevention initiatives for families, including CPS. Our ED is part of an urban tertiary care free-standing children's hospital. Forty percent of our population has government assisted health insurance; 22% of our population are black and 26% are Hispanic. The objectives of our ED CPS program were to: 1) screen all children less than eight years old for car seat safety; and 2) provide CPS education and car seats, as needed, to families.

Methods:
In May 2010 a comprehensive CPS program was implemented within the ED with funding support from our institution. The components of the program include: 1) CPS assessments screening for car seat use in children less than eight years old; 2) CPS education for families, including the Massachusetts state laws; and 3) distribution of age/size appropriate car seats for patients discharged from the ED. An ED nurse and child life specialist became certified CPS technicians to assist with car seat installations and become CPS resources to the ED staff.

To orient ED nurses about the CPS program and educate them about CPS, all ED staff nurses completed a mandatory online training module prior to program initiation. A car seat assessment was then implemented in paper form for use on an as needed basis (e.g. after a motor vehicle crash) for children less than eight years old. We chose this age group to be in compliance with Massachusetts state law, which requires every child younger than eight years old to ride in a federally approved child passenger restraint. In July 2011 this screening tool was computerized and embedded in the initial nursing assessment, but was not a mandatory

field. In January 2012, educational interventions were performed for nursing staff via email and staff meetings to review the screening tool and process of supplying a car seat. In March 2012 the computerized CPS screening tool was made a mandatory field within the initial computerized nursing assessment.

Results:
From August 1-December 31, 2011, 17% (2,270/13,637) of eligible children had computerized assessments performed; 18 car seats were distributed. From January 15-March 15, 2012, 32% (2,017/6,270) of eligible children were screened; nine car seats were distributed. From March 16, 2012-May 19, 2012, 56% (3,381/6,063) of eligible children were screened; 22 car seats were distributed. Nurses cited time constraints and lack of knowledge about child passenger safety as barriers to completing the assessments.

Conclusions:
ED staff are well positioned to provide education to families as well as to reinforce safety messages regarding the importance of always using an appropriate car seat. A CPS program including patient screening, education, and car seat distribution can be successfully implemented in the ED setting. A computerized assessment tool increases compliance with screening. Mandatory screening further increases compliance, which has resulted in increased car seat distribution.

Objectives:
Attendees of this session will learn:
1. To describe components of an emergency department based child passenger safety program.
2. To describe implementation of an emergency department based child passenger safety program.
3. To recognize effectiveness of computerized car seat assessment tool

An Inpatient Child Passenger Safety Program

Lindsey Elliott, RN, BSN, CPN, Maria McMahon, MS, cPNP-AC, Barbara DiGirolamo, M Ed, Evan Priestley, MPH, Fran Damian, MSN, RN, Marcie Brostoff, MS, RN, David Mooney, MD, MPH, Lois Lee, MD, MPH

Background:
The 2008 Massachusetts Child Passenger Safety law requires all children less than eight years old or 57 inches tall to be properly fastened and secured by a child passenger safety restraint when riding in a motor vehicle. Boston Children's Hospital, an urban tertiary care center, developed a child passenger safety (CPS) program for hospitalized children to improve child passenger safety services for this population.

Methods:
From 2008-2009 a needs assessment focusing on CPS needs within the hospital was completed with a multi-disciplinary group. State grant funding was obtained, and an inpatient CPS program was developed, which included patient assessment, family education, and car seat distribution. A pilot for this program was initiated on three inpatient units from February 2009-September 2010 after inpatient staff nurses completed an online educational module on CPS and the inpatient program. A computerized assessment tool, located within the discharge planning section of the nursing admission assessment, was developed.

This assessment tool identifies children less than 8 years old in need of a car seat at the time of hospital discharge and initiates a consult for the CPS program. A CPS program staff member then meets the family and child, provides CPS education, and can provide an appropriate car seat, if needed. Car seat installations can be performed by appointment. After the pilot program, the hospital wide inpatient CPS program was launched in September 2010. The inpatient CPS program also assists families with children with special needs by providing specialized seats or resources to obtain seats. Funding from the Massachusetts Executive Office of Public Safety and Security, institutional support and the Children's Hospital League provides financial support for the CPS program.

Results:
Since the hospital-wide CPS program was implemented in September 2010, 2,715 children have been screened by the computerized nursing assessment. Consults by CPS staff were performed for 506 children. Child passenger safety education alone was provided to 174 families, and 331 car seats provided. Of these seats, 68 car seats were installed by hospital based CPS technician staff. Screening tool use throughout the units is improving and continual audits provide CPS staff input on how to provide an effective and cost effective service to the hospital. The current program encompasses all inpatient units, including children with special health care needs and spica casts, which has resulted in the reduced use of ambulance transportation for these patients to be discharged home.

Conclusions:
Through strategic planning and identification of key team members a hospital wide inpatient CPS program was created and is being maintained. A computerized nursing assessment tool can be used to identify families, including those with children with special health care needs, for CPS services including

education and car seat distribution. Identifying goals and developing the program with needs specific to the hospital is crucial to long term success.

Objectives:
Attendees of this session will learn:
1. Describe the history of the car seat program at Boston Children's Hospital and the background of BCH.
2. Explain implementation of the car seat program and methods used.
3. Understand the current program at BCH and review of data collected.

The EZ-ON® Vest: A Cost Effective Alternative for Transportation of the Casted Child

Lindsey Elliott, RN, BSN, CPN, Diane Tubman, RN, Maria McMahon, MSN, PNP, Lois Lee, MD, MPH

Background:
A child passenger safety program for hospitalized children, including those with special needs or lower extremity casts, was implemented at Boston Children's Hospital in 2009 to ensure that all discharged patients can be transported home with the appropriate child passenger restraint. This program was instituted in accordance with the 2008 Massachusetts Child Passenger Safety law, which requires all children under the age of eight years or 57 inches to be properly fastened and secured by a child passenger safety restraint.

To reduce patient costs related to transportation home from the hospital for children with special needs or casts, the child passenger safety program researched alternative methods for transport home for children who would otherwise require an ambulance. The use of an ambulance also does not address the ability of safe transportation to and from appointments after the patient has returned to home. The EZ-ON® vest is a specific type of child passenger restraint, which allows patients to ride in a motor vehicle even with lower extremity casts (e.g. spica casts) or medical conditions that prevent them from riding while sitting upright (e.g. cerebral palsy).

Methods:
We performed a retrospective chart review of children who received the EZ-ON® vests for discharge home from January 2009 through March 2010. The cost of the EZ-ON® vest is $80.00. The average cost of ambulance travel was collected from ambulance companies based on the residential zip codes of the families. The difference in the costs between ambulance travel and the EZ-ON® vest was compared.

Results:
Twenty-four vests were distributed to children during the 14 month time period to be used for transport home. The cost savings from use of the EZ-ON ® vests instead of an ambulance for transport home was $10,848.

Conclusions:
Ambulances, though a safe method of travel for a casted or special needs patient at discharge, is costly to families and or the insurance companies. Using a device such as the EZ-ON® vest provides not only a cost effective option, but it allows the special needs or casted patient the option of traveling safely with their family. A hospital based child passenger safety program can be used to identify and provide appropriate restraints for special needs and casted patients for safe transport home.

Objectives:
Attendees of this session will learn:
1. Describe alternative means for safe automobile transport for children with special medical needs.
2. Demonstrate how an inpatient child passenger safety program can be used to help with transportation needs of these children.
3. Describe cost differences between ambulance transport and the use of alternative child passenger restraints.

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The 17th Annual Conference of the Injury Free Coalition for Kids jointly sponsored with
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FACULTY LIST

Course Instructor

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

Course Faculty

Helen Arbogast, MPH, CHES
Manager
Injury Prevention Trauma Program
Children's Hospital Los Angeles

Julie Bromberg, MPH, CCRP
Clinical Research Coordinator
Injury Prevention Center-Rhode Island Hospital

Paige Cahill
Constant Contact
Regional Development Director
Kansas, Missouri, Nebraska, & Arkansas

Christine Campbell, MD, MSPH
Pediatric Resident
Children's Hospital of Alabama

Rebecca M. Cunningham, MD
University of Michigan Injury Center Director
Associate Professor Department of Emergency Medicine School of Medicine
Associate Professor Department of Health Behavior & Health Education School of Public Health

Dawn M Daniels, PhD, RN, PHCNS-BC
Program Manager
Injury Prevention and Trauma Services
Riley Hospital for Children at Indiana University Health

Barbara DiGirolamo, M. Ed., CPST
Injury Prevention Specialist
Children's Hospital Boston

Denise Dowd, MD, MPH
Director of Research,
Division of Emergency and Urgent Care
Children's Mercy Hospital
Kansas City, MO

Lindsey Elliott, RN, BSN, CPN
Regional Trauma Educator
Boston Children's Hospital

Dawne Gardner-Davis, MBA
Program Coordinator
Injury Free Cincinnati
Cincinnati Children's Medical Center

Lynn Haas, RN, MSN, CNP
Trauma Program Manager
Cincinnati Children's Hospital

David Hemenway, PhD
Professor of Health Policy
Director, Harvard Injury Control Research Center
Harvard School of Public Health

Donica Kulwicki, RN, BSN, CPN
Children's Hospital of Michigan

Anyah Land, MPH
Evaluation and Analytics Coordinator
St. Louis Children's Hospital
Child Health Advocacy and Outreach
One Children's Place

Garry Lapidus, PA-C, MPH
Director, Injury Prevention Center,
Connecticut Children's Medical Center/Hartford Hospital
Associate Professor of Pediatrics & Public Health
Univ. of Connecticut School of Medicine
Injury Free Coalition for Kids of Hartford

Lois Lee, MD, MPH
Attending Physician , Division of Emergency Medicine Boston Children's Hospital
Assistant Professor Harvard Medical School
Medical Director Pediatric Injury Prevention Program

Rebecca Levin, MPH
Strategic Director, Injury Prevention and Research Center
Ann & Robert H. Lurie Children's Hospital of Chicago

Leticia Manning Ryan, MD, MPH
Assistant Professor
Division of Emergency Medicine, Children's National Medical Center
Departments of Pediatrics, Emergency Medicine, & Integrative Systems Biology
George Washington University School of Medicine & Health Sciences

Carol Mannings, MD
Pediatric Emergency Medicine Fellow
University of Florida COM/Jacksonville

Chris McKenna, MSN, RN, CRNP
Trauma Program Manager
Children's Hospital of Pittsburgh of UPMC

Michael J. Mello, MD, MPH
Injury Prevention Center Director
Rhode Island Hospital
Associate Professor of Emergency Medicine
Associate Professor of Health Services, Policy and Practice
Alpert Medical School of Brown University
Providence, Rhode Island
PI Injury Free Providence

Beverly Miller, MEd
Associate Director, Injury Prevention Center
Arkansas Children's Hospital & the University of Arkansas for Medical Sciences
Injury Free Coalition for Kids of Little Rock, Program Coordinator

Ted Miller, PhD
Principal Research Scientist
Pacific Institute for Research & Evaluation

Kathy Monroe, MD
Professor of Pediatrics
Medical Director ED
Childrens Hospital of Alabama

Mary Beth Moran PT, MS, MEd
Injury Prevention Program Manager
Rady Children's Hospital
Program Coordinator Injury Free San Diego

Hope Mullins, MPH
Program Manager
Injury Prevention Center
Arkansas Children's Hospital

Donna O'Malley, PhD, RN
Children's Mercy Hospital and Clinics
Nurse Researcher
Emergency and Urgent Care Services
Kanas City, MO

Wendy J. Pomerantz, MD, MS
Professor of Clinical Pediatrics
University of Cincinnati
Cincinnati Children's Hospital
Division of Emergency Medicine

Joyce Pressley, PhD, MPH
Director of Injury Free Health Policy and Population Studies
Associate Professor of Epidemiology and Health Policy and Management
The Mailman School of Public Health, Columbia University
New York, NY

Kimberly Randell, MD, MSc
Pediatric Emergency Medicine
Children's Mercy Hospitals & Clinics
Assistant Professor of Pediatrics
University of Missouri-Kansas City School of Medicine

Steven C. Rogers, MD
Pediatric Emergency Medicine Specialist
Connecticut Children's Medical Center
Assistant Professor
University of Connecticut School of Medicine

Amy Teddy, BS
Injury Prevention Program Manager
University of Michigan
C.S. Mott Children's Hospital
Ann Arbor, MI

Mariann Manno, MD
Director of Pediatric Emergency Services
UMass Memorial Children'S Medical Center,
Associate Prof. Of Pediatrics and Emergency Medicine
UMass Medical School
Co-Director, Injury Free Coalition of Worcester

Purnima Unni, MPH,CHES
Pediatric Trauma Injury Prevention Program Coordinator
Department of Pediatric Surgery/Trauma
Monroe Carell Jr. Children's Hospital at Vanderbilt
Nashville, TN

Pina Violano, MSPH, RN-BC, CCRN, CPS-T, PhD (c)
Injury Prevention Coordinator
Adult & Pediatric Trauma Programs
Yale-New Haven Hospital
Program Coordinator
Injury Free Coalition for Kids of New Haven

Chris Vitale MSN, RN
Injury Prevention Manager
Injury Free Pittsburgh Program Coordinator
Pittsburgh Children's Hospital

Brian Wagers MD
Children's Hospital Medical Center
Division of Emergency Medicine
Cincinnati, OH

Joseph Wright, MD, MPH
Acting Chief Medical Officer
Professor and Senior Vice President
Child Health Advocacy Institute
Childrens National Medical Center
Washington, DC

Conference Planning Committee

Program Committee

Committee Chair

Barbara Barlow MD
Injury Free Coalition for Kids
Executive Director and Founder
Mailman School of Public Health
Columbia University

Helen Arbogast, MPH, CHES
Manager
Injury Prevention Trauma Program
Children's Hospital Los Angeles

Dawn M Daniels, PhD, RN, PHCNS-BC
Program Manager
Injury Prevention and Trauma Services
Riley Hospital for Children at Indiana University Health

Terry McFadden, MD
Director of Ambulatory Pediatrics
Hughes Spalding Children's Hospital
Assistant Professor Emory University School of Medicine.
PI Injury Free Atlanta

Kyran Quinlan, MD, MPH
Associate Professor of Clinical Pediatrics
Feinberg School of Medicine
Northwestern University
Pediatrician
Erie Family Health Center
Chicago, IL

Publications Committee

Committee Chair

Michael J. Mello, MD, MPH
Injury Prevention Center Director
Rhode Island Hospital
Associate Professor of Emergency Medicine
Associate Professor of Health Services, Policy and Practice
Alpert Medical School of Brown University
Providence, Rhode Island
PI Injury Free Providence

Lois Lee, MD, MPH
Attending Physician , Division of Emergency Medicine Boston Children's Hospital
Assistant Professor Harvard Medical School
Medical Director Pediatric Injury Prevention Program

Kathy Monroe, MD
Professor of Pediatrics
Medical Director ED
Childrens Hospital of Alabama

L R Tres Scherer, III, MD
Volunteer Professor of Surgery
Indiana University School of Medicine
Trauma Director
St Luke's Children's Hospital

Pina Violano, MSPH, RN-BC, CCRN, CPS-T, PhD (c)
Injury Prevention Coordinator
Adult & Pediatric Trauma Programs
Yale-New Haven Hospital
Program Coordinator
Injury Free Coalition for Kids of New Haven

Staff:

Estell Lenita Johnson, MA
Marketing & Communications Director
Injury Free Coalition for Kids
Center for Injury Epidemiology and Prevention at
Columbia University

DiLenny Roca Dominguez, MPH
Columbia University Mailman School of Public Health
Program Administrator
Injury Free Coalition for Kids National Program Office

2012 Forging New Frontiers:

"Keeping Children Safe at Home, at Play and on the Road"

Bios

BIOS

Helen Arbogast, MPH, CHES

Injury Free Los Angeles

Helen Arbogast, MPH, CHES, is the Injury Prevention Coordinator, Injury Free Los Angeles. She graduated from California State University Long Beach with a masters degree in public health (MPH, has Community Health Education Specialist Certification (CHES) and is currently pursuing her doctorate of public health at UCLA. Helen comes to Children's Hospital Los Angeles from the Los Angeles County Department of Public Health, Division of Chronic Disease & Injury Prevention. Helen has more than 10 years of public health experience in the coordination of intervention programs, development of marketing materials, collection and analysis of data, development of education materials, curriculum and presentation development. Her passion to bridge providers, hospitals, local government and community stakeholders to build safer communities for children and families has led her to Childrens Hospital Los Angeles where she is building up our Injury Prevention Program under the tutelage of Dr. Jeffrey Upperman, Director of Trauma Program, Associate Professor of Surgery.

Julie Bromberg, MPH

Injury Free Rhode Island

Julie Bromberg is a clinical research coordinator at the Injury Prevention Center at Rhode Island Hospital. Ms. Bromberg holds a Masters in Public Health as well as certification as a Certified Clinical Research Professional. She has 10 years of experience in injury prevention research, with expertise in both community based research and clinical research studies. Currently Ms. Bromberg serves as the program manager for three federally funded studies at the Injury Prevention Center.

Christine Campbell

Injury Free Birmingham

Christine Campbell is a third year pediatric resident at Children's of Alabama, and is currently applying for fellowships in pediatric emergency medicine. Originally from Alabama, she studied psychological and brain sciences at Dartmouth College, then obtained her master of science in public health degree as well as doctor of medicine degrees at the University of Alabama at Birmingham. Her research focus been primarily in injury prevention and quality improvement.

Dawn Daniels, PhD, RN, PHCNS-BC

Injury Free Indianapolis

Dawn Daniels, PhD, RN, PHCNS-BC is the Program Manager for Injury Prevention and Trauma Services at Riley Hospital for Children in Indianapolis, Indiana. She has a Bachelor of Science degree in Nursing from Pensacola Christian College in Pensacola, Florida; a Master of Science Degree in Nursing (clinical nurse specialist pediatrics and clinical nurse specialist community health); and a Doctorate from Indiana University. Her doctoral work, which included an adolescent health fellowship, focused on injury prevention and public policy. Her clinical expertise includes pediatric trauma, pediatric critical care, and pediatric neurotrauma as well as community health.

Barbara DiGirolamo, MEd

Injury Free Boston

Barbara DiGirolamo, MEd, received her Bachelor's degree in Education and Liberal Studies from Emmanuel College in 2006 and her Masters in Administration of Higher Education from Suffolk University in 2008. Ms. DiGirolamo is the Injury Prevention Specialist at Boston Children's Hospital where she has a special interest in brain and spinal cord education, as well as Child Passenger Safety. She also sits on the National Board for ThinkFirst as their Secretary and is the State Chapter Director for ThinkFirst Massachusetts.

M. Denise Dowd, MD, MPH

Injury Free Kansas City

M. Denise Dowd, MD, MPH has been active in health care for over three decades. Beginning as a nurse in Detroit, her training and clinical practice trajectory has consistently been based in the urban core. For the past 17 years she has practiced pediatric emergency medicine at the Children's Mercy Hospital in Kansas City, Missouri and is Professor of Pediatrics at the University of Missouri-Kansas City School of Medicine. She attended St. Louis University School of Medicine with training in pediatrics at Northwestern Feinberg School of Medicine (Children's Memorial Hospital) in Chicago, and fellowships in pediatric emergency medicine at Children's Mercy Hospital in Kansas City and academic pediatrics at the University of Washington in Seattle.

Dr. Dowd serves as the Director of Research for the Division of Emergency and Urgent Care with current research interests in violence prevention and social determinants of health. Throughout the years she has served on city-level public-private projects and mayor's advisories which have as their common goal improving the health and well being of children. She is currently working with the American Academy of Pediatrics on a Department of Justice funded project which is helping ready the medical home to respond to children impacted by violence. .Her approach is to focus on practical solutions for the sustainability of interventions within busy clinical and community settings, understanding that real accomplishment requires rigorous and frequent evaluation balanced with an appreciation for the challenges of real world implementation.

Dawne Gardner-Davis, MBA

Injury Free Cincinnati

Dawne Gardner-Davis, MBA received her BBA from Northwood University and her MBA from Thomas More College. She has been the IFCK Program Coordinator at Cincinnati Children's Hospital Medical Center (CCHMC) for over four years, and has been instrumental in implementing effective IFCK programming in the communities of Avondale, Price Hill and now Norwood. Her expertise includes home and playground safety and she is currently involved in resident education in both areas. In her current role as Injury Prevention Coordinator for IFCK, she is working under the umbrella of the Comprehensive Children's Injury Center (CCIC) on its mission to fulfill the hospital's strategic plan of reduce injuries in Hamilton County, Ohio by 30% through community-based interventions.

Lindsey Elliott, RN, BSN, CPN

Injury Free Boston

Lindsey Elliott, RN, CPN Regional Trauma Educator:
Lindsey is a graduate of Baker Nursing School in Baldwin City, KS. She began her nursing career at Children's Mercy Hospital in Kansas City working with Orthopedic and Rehabilitation patients. After settling permanently at Boston Children's Hospital, she turned her passion for child passenger safety into helping to create their hospital-wide Car Seat program. The successful development of the program led Lindsey to her current role of Regional Trauma educator. Her role provides education, trainings and follow up to health care providers in the community. This role is complimented by her work as a staff nurse in the Emergency Department. Lindsey is currently a masters candidate in Nursing Administration from Northeastern University and will graduate in May 2013.

Lynn Haas, RN, MSN, CNP

Injury Free Cincinnati

Lynn Haas, RN, MSN, CNP has been the Trauma Program Manager at Cincinnati Children's Hospital for the past 22 year, an ACS verified Level I pediatric trauma center since 1993. She previously worked as a Trauma Program Manager for an adult trauma center and as an ICU nurse at The Ohio State University SICU. Lynn received her BSN from Ohio State University, a MSN in Burn/Trauma and Pediatric Nurse Practitioner degree in 2001 from the University of Cincinnati. Lynn is currently a pediatric nurse site reviewer for the American College of Surgeon Committee on Trauma.

Past / current leadership positions include: past president and secretary of the Ohio Society of Trauma Nurse Leaders; co-chair of the Society of Trauma Nurses (STN) Pediatric Special Interest group for 6 years; and is currently chair elect for the Pediatric Trauma Society.

E. Lenita Johnson, MA

National Program Office

E. Lenita Johnson, MA, is the Marketing & Communications Director for the Center of Injury Epidemiology and Prevention at Columbia University, Mailman School of Public Health and the Injury Free Coalition for Kids Natinal Program. As director of communications for the center she is responsible for oversight and development of printed and electronic collateral representing the center, including but not limited to newsletters, brochures, fliers, and the website. She also assists with the planning and development of regional symposiums, and audio-visual communications.

Ms Johnson has 20 years of reporting, producing and anchoring experience at major television network affiliates. The five time Emmy Award-winning Broadcast Journalist left the industry 12 years ago and began working for the Injury Free Coalition for Kids. As communications director she oversees the development of the Coalition's website, plans and develops the organization's annual conference including promotional materials, CME and CHES credits, develops printed and electronic collateral, maintains communications lines between the Coalitions 39 sites across the country, and organizes board communication efforts,

In addition to her communication efforts, Ms. Johnson oversees the execution of The Allstate Foundation Grant which provides Safe Play Places for children in communities recovering from disaster, and she executes the Toys"R"Us Children's Fund Project that helps 10 Coalition sites develop unique ways to address the safety of children in some of the country's most underserved neighborhoods.

Ms. Johnson received her Bachelor of Arts degree in News Editorial from the University of Texas, at Arlington and completed her Master's in Communications at Northern Illinois University of DeKalb. In March of 2000, Governor Mel Carnahan appointed her to a six-year term on the Board of Governors of Central Missouri State University. She became the first African American female president of the board. Among the nearly 50 awards acknowledging her work, she was recognized as one of Kansas City's Most Influential African Americans.

Donica Kulwicki, RN

Injury Free Detroit

Donica Kulwicki, RN, is the Trauma Program Coordinator at Children's Hospital of Michigan. She has a certificate in Health Systems Management from University of Detroit/Mercy (2008) and a Bachelor of Nursing from Wayne State University (1994). Donica has worked as a nurse at Children's Hospital in the emergency department in a variety of roles for more than 20 yrs. She received training on motivational interviewing in January of 2010 from a MINT trainer and is a provider for additional courses in Pediatric advanced Life Support, Emergency Nurse Course, Trauma Nursing Core Course, Advanced Trauma Nurse Course, Basic Disaster Life Support, and Advanced Disaster Life Support.

Anyah Land, MPH

Injury Free St. Louis

Anyah Land, MPH serves as an Evaluation and Analytics Coordinator in the Child Health Advocacy and Outreach Department for St. Louis Children's Hospital. In addition to evaluating various components of the department's community health programs, she also works with hospital leadership to report community benefit to the IRS and conducts community health research. She has also presented community health evaluation project at six conferences including the American Public Health Association, Children's Hospital Association Creating Connections Conference, Society of Trauma Nurses, and Injury Free Coalition for Kids.

Anyah earned her Bachelor of Science degree in Youth, Adult, and Family Services with an emphasis in Child Health and minor in Organizational Leadership and Supervision from Purdue University. She received a Master of Public Health Degree from Indiana University with an emphasis in healthcare administration, social and behavioral health. During her time in academia, she completed an internship at Indiana University Health Bloomington. She assisted the hospital's Community Health Department with completing their strategic plan and was involved in collaborations with area agencies and regional medical centers to develop community based health programs. She served as a graduate assistant for undergraduate courses, assisting with developing a student leadership curriculum, taught personal health and stress management courses. She also served as an undergraduate advisor with the Hudson and Holland Scholars Program and Center for Student Leadership Development. While working with these programs, she served as a program coordinator for the Holistic Philosophy for Scholar Success (HoPSS).

After graduation, she completed a two-year nonprofit leadership and management fellowship with El Pomar Foundation in Colorado Springs, CO. She worked with local agencies and regional healthcare systems to address the needs of the uninsured population. Anyah worked in the nonprofit sector advocating for children in various capacities during the past ten years. Her previous work experiences included working with Memorial Hospital in South Bend, IN and St. Elizabeth's Hospital Pediatric Unit in Lafayette, IN. She also worked with children and families with The Villages Adoption Agency, Child and Family Partners, and Stepping Stones Residential Housing for homeless teens. She enjoys giving back to the community by volunteering with Junior Achievement and mentoring undergraduate students with an interest in health professions.

Garry Lapidus PA-C, MPH

Injury Free Hartford

Garry Lapidus PA-C, MPH is the Director of the Injury Prevention Center, Connecticut Children's Medical Center and Hartford Hospital. He is an Associate Professor of Pediatrics and Public Health at the University of Connecticut School of Medicine. He currently chairs the New England Injury & Violence Prevention Research Collaborative and is an Injury Free board member.

Lois Kaye Lee, MD, MPH

Injury Free Boston

Lois Kaye Lee, MD, MPH is an attending physician in the Division of Emergency Medicine at Boston Children's Hospital and is an assistant professor of pediatrics at Harvard Medical School.
People are often surprised to hear she grew up in the deep South—Tallahassee, Florida to be exact, which is more like Georgia than Florida actually. She received her undergraduate degree from Emory University with majors in chemistry and music (piano). She says she kept moving northwards and received my MD from the University of Pennsylvania School of Medicine. She stayed in Philadelphia to complete her residency in pediatrics at the Children's Hospital of Philadelphia. She came to Children's Hospital Boston to complete my fellowship in Pediatric Emergency Medicine. During this time she met her husband who is a pediatric orthopedic surgeon, also working at Children's. They live in Wellesley, MA and have a 7 year old son and 4 year old daughter. As part of her fellowship she completed her MPH at the Harvard School of Public Health. Her clinical and teaching responsibilities are focused on caring for patients in the emergency department (ED) and teaching medical students, residents, and fellows. In addition, She conducts research in the areas of pediatric trauma care and injury prevention. As part of her injury prevention work she also participates in legislative advocacy and is currently involved in an effort to pass a primary seat belt law in the state of Massachusetts. She is happy to speak with anyone interested in emergency medicine, injury prevention, pediatric advocacy, and those with a young family.

Rebecca Levin, MPH

Injury Free Chicago

Rebecca Levin, MPH, is the Strategic Director of the Injury Prevention and Research Center at Ann & Robert H. Lurie Children's Hospital of Chicago. She is leading the Strengthening Chicago's Youth (SCY) violence prevention collaborative, which is building capacity among stakeholders in multiple sectors to connect, collaborate and mobilize around a public health approach to violence prevention. Before coming to Lurie Children's in 2011, Ms. Levin worked at the American Academy of Pediatrics for 12 years, overseeing all violence and injury prevention efforts. 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.

Leticia Manning Ryan, MD, MPH

Injury Free D.C.

Leticia Manning Ryan, MD, MPH, is an Assistant Professor in the Division of Emergency Medicine at Children's National Medical Center and the Departments of Pediatrics, Emergency Medicine, and Integrative Systems Biology in the George Washington University School of Medicine and Health Sciences in Washington, DC. After completing pediatric residency, pediatric chief residency, and a pediatric emergency medicine fellowship at Children's National Medical Center, Dr. Ryan joined the faculty at Children's National Medical Center in 2006 and completed a Master of Public Health degree at the George Washington University School of Medicine and Health Sciences in 2010. Her research interests include injury epidemiology and injury prevention. Dr. Ryan is the recipient of a K23 Mentored Patient-Oriented Research Ca-

reer Development Award from the National Institutes of Health National Center for Research Resources to investigate the role of bone health in forearm fractures in African-American children. Dr Ryan is an active member of the Society for the Advancement of Violence and Injury Research and the American Federation of Medical Research, where she currently serves as Chair-Elect for the Eastern Region. She has authored over thirty articles and book chapters in the fields of injury and emergency medicine.

Carol Mannings, MD

Injury Free Jacksonville, FL

Carol Mannings, MD completed medical school at the University of Miami Miller School of Medicine and her residency training in Pediatrics at the University of Florida College of Medicine in Jacksonville, Florida. Upon completing her residency, Dr. Mannings served as interim director of Kids 'n Care, a medical clinic for high risk children in the foster care system. Currently, Dr. Mannings is her final year of completing a Fellowship in Pediatric Emergency Medicine at the University of Florida College of Medicine in Jacksonville. As part of fellowship training, Dr. Mannings completed her research in the area of parental knowledge of concussion and has presented nationally at the Society of Academic Emergency Medicine (SAEM), regionally at the Southeastern SAEM Meeting, and locally at the University of Florida's Research Day as a platform presenter. Dr. Mannings has received several teaching awards from the University of Florida, served as chief resident during training, and completed training through the American Academy of Pediatrics in regard to advocacy and patient care.

Chris McKenna, MSN, CRNP

Injury Free Pittsburgh

Chris McKenna, MSN, CRNP is the Trauma Program Manager at Children's Hospital of Pittsburgh of UPMC. She currently serves as the Co-Chair of the Trauma Special Interest Group of the American Pediatric Surgical Nurses Association, and for three years previously as the Co-Chair of the Pediatric Special Interest Group of the Society of Trauma Nurses. Chris obtained her undergraduate degree from Indiana University, a Master of Science (M.S.) in nursing (pediatric acute care) from Boston College, and a Master of Science in Nursing (M.S.N.) in pediatric primary care from the University of Pittsburgh. Chris has devoted her entire career to the care of injured children and their families.

Michael J. Mello, MD, MPH

Injury Free Providence

Michael J. Mello, MD, MPH is Director of the Injury Prevention Center at Rhode Island Hospital and a practicing board certified emergency medicine physician with 22 years of clinical experience. He is an Associate Professor of Emergency Medicine and Associate Professor of Health Services, Policy and Practice at the Alpert School of Medicine of Brown University. He co-directs the medical school's required clerkship in community health and has additional experience as an educator as Director of the Collis Injury Prevention Research Fellowship for physicians. His research has focused on unintentional injury prevention. He has received PI research support from CDC, NIH, and several foundations. He is an associate editor for Academic Emergency Medicine, peer reviewer for several emergency medicine and public health journals, and served on scientific review panels for CDC and NIH.

As Director of the Injury Prevention Center at Rhode Island Hospital, he has been active in creating partnerships with state health departments, community groups, and other health providers to increase their attention to injury and violence prevention and has established several injury prevention community programs in Rhode Island. Dr. Mello is a past national president of the Society for Advancement of Violence and Injury Research, on the board of directors of New England Injury and Violence Prevention Research Collaborative, on the national board of directors of Injury Free Coalition for Kids, and has chaired the Injury Free Coalition for Kids Publication and Science Committee.

Beverly Miller, MEd

Injury Free Arkansas

Beverly Miller, MEd, is the Associate Director of the Injury Prevention Center at Arkansas Children's Hospital and the University of Arkansas for Medical Sciences. She was the founding program coordinator for Injury Free at Little Rock and has continued to work with faculty and communities to launch innovative injury prevention tailored to the rural, low income, and/or minority needs for Arkansas. Ms. Miller has extensive experience working to improve life-style behaviors of children and families through classroom, non-profit service, and public health settings. She received a Masters degree in education from the University of Arkansas.

Kathy Monroe, MD

Injury Free Birmingham

Kathy Monroe, MD is Professor of Pediatrics at the University of Alabama in Birmingham. She is the Medical Director of the Pediatric Emergency Medicine Department of the Childrens' Hospital of Alabama. Dr. Monroe is the Co-Director of the Injury Free Coalition for Kids of Birmingham Alabama. She is the Alabama AAP chair of the Injury Prevention committee. She is actively involved in the education of pediatric residents specifically in the injury prevention areas and is the Co-Residency Research Interest Group Mentor. Dr Monroe is also the research director for the pediatric emergency medicine division, and is a member of the Alabama Child Death Review Team. She has been a research mentor for NIH summer medical student research program and is co-sponsor for the medical school pediatric interest group.

Mary Beth Moran, PT MS MEd

Injury Free San Diego

Mary Beth 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 is a lifelong learner and began her education with a Bachelor of Science in Biology which she then applied towards another Bachelor of Science in Physical Therapy which she received from New York University in 1988. She continued her education with a Masters Degree in Education, focus International Education, from George Washington University in 1996. She used that degree to assist in the development of a new Physical Therapy program, developing clinical sites and teaching Health Promotion to graduate physical therapists. She concurrently served several tours of international work in both South Africa and Vietnam through Health Volunteers Overseas. Recently she completed another Master of Science Degree from Dartmouth College in Evaluative Clinical Sciences. She enjoys using every aspect of her education in further developing the injury prevention programs at Rady Children's Hospital.

Currently the injury prevention program is expanding their new Safety Store and its associated community outreach programs, implementing a Safe Routes to School program and developing Additional hospital based services. The center is focused on employing sound public health and scientific principles so that all programs can be evaluated and shared. Mary Beth has specific interest in disaster preparedness in low income families, sports injury prevention, injury prevention strategies for pre-teens and teens and bike safety advocacy.

Mary Beth is a recent transplant to the west coast after 21 years in large east coast cities. Taking full advantage of the perfect weather of San Diego she enjoys biking, hiking, scuba and horseback riding alongside her husband John. Together they hope to raise a dog to contribute to the canine therapy team.

Hope Mullins, MPH

Injury Free Arkansas

Hope Mullins, MPH, is a Program Manager for the Injury Prevention Center at Arkansas Children's Hospital. Her work emphasis is research and evaluation. Hope holds a Masters of Public Health from the Faye W. Boozman College of Public Health in Little Rock, Arkansas. She is also a certified child passenger safety technician and a certified research specialist.

Donna O'Malley, PhD, RN

Injury Free Kansas City

Donna O'Malley, PhD, RN is a Nurse Researcher with 18 years of Emergency and Urgent Care Services. She works across the disciplines and departments of Children's Mercy Hospital and Clinics, a large and complex organization. O'Malley welcomes the opportunity to utilize her skills, experience, and education to support collaborative interdisciplinary research efforts within the Emergency and Urgent Care Services Division. She successfully defended her doctoral dissertation "Understanding the Family Violence Assessment Practices of Pediatric Emergency Department Nurses and Physicians" in December 2011. Research related to family violence prevention is her personal and professional goal. She has a particular interest in the biology of adversity and decreasing exposure to toxic stress in young children. While she feels addressing daunting public health problems like family violence is difficult; she believes Children's Mercy offers the opportunity to make a significant contribution to science. The Division of Emergency and Urgent Care

Services research team along with institutional resources and their unique culture positions them to take a leadership role in keeping the children in the community safe and healthy.

Wendy J. Pomerantz, MD, MS

Injury Free Cincinnati

Wendy received her undergraduate degree from the University of Texas at Austin and her medical school degree from the University of Texas Southwestern Medical School in Dallas, Texas. She completed a Pediatrics Residency at Children's Medical Center of Dallas, a Pediatric Emergency Medicine Fellowship at Children's Hospital Medical Center in Cincinnati, and a Master's of Science in Epidemiology at the University of Cincinnati. Currently, she has a faculty appointment as a Professor of Clinical Pediatrics at the University of Cincinnati School of Medicine and Children's Hospital Medical Center in Cincinnati, Ohio. Her interests include poison prevention, ATV and motorbike injuries, program evaluation, education, and geographic information systems. Besides being the Co-director of Injury Free Coalition for Kids in Greater Cincinnati, she is a member of the Ohio EMS Board and Chairperson of the Ohio EMSC Committee, Chairperson of the Ohio AAP Emergency Medicine Committee, a member of AAP State of Ohio Committee of Injury and Poison Prevention, and a member of the American Red Cross Medical Assistance Team.

Kimberly Randell, MD, MSc

Injury Free Kansas City

Kimberly Randell, MD, MSc is an attending physician in pediatric emergency medicine at Children's Mercy Hospitals & Clinics and an assistant professor of pediatrics at the University of Missouri-Kansas City School of Medicine. She graduated from the University of Oklahoma College of Medicine, followed by a pediatrics residency and year as chief resident at Children's Mercy Hospitals & Clinics. She completed a fellowship in pediatric emergency medicine at the University of Louisville, where she obtained a master's of science in clinical investigation sciences. She is board-certified in general pediatrics and pediatric emergency medicine. She currently co-chairs Children's Mercy's Council on Violence Prevention. Her areas of interest are intimate partner violence screening and intervention, resilience and vicarious trauma.

Steven C. Rogers, MD, CPST

Injury Free Hartford

Steven C. Rogers, MD, CPST, is an Attending Physician in the Emergency Department at Connecticut Children's Medical Center and serves as Co-Principal Investigator for the Injury Free Coalition for Kids of Hartford, a community-based childhood injury prevention program. Dr. Rogers is an Assistant Professor at the University of Connecticut School of Medicine and is currently enrolled in the Masters of Science in Clinical and Translational Research program. He is a Child Passenger Safety Technician (CPST) and focuses much of his academic and research efforts on child motor vehicle safety.

Amy Teddy, BS

Injury Free Michigan at Ann Arbor

Amy Teddy has been the Injury Prevention Program Manager at the University of Michigan - C.S. Mott Children's Hospital since 2007. In this position, Amy develops and facilitates community-based interventions that prevent injuries to children, 17 years of age and under. These efforts involve creating safe environments, advocating for effective laws, research and educating adults and children.

Prior to this position, she served as Public Education Specialist for South Metro Fire Rescue in Centennial, Colorado for six years. Amy also served as Injury Prevention Specialist and Safe Kids Coordinator with the El Paso County Health Department in Colorado Springs, Colorado.

Mrs. Teddy has a Bachelor of Science in Community Health Education from Central Michigan University.

Amy has served on the abstract review committee for the National Child Passenger Safety Conference (Kidz in Motion), and currently serves on the Safe Kids Advisory Council for Safe Kids USA and the Michigan Child Passenger Safety Advisory Council. Mrs. Teddy is a Certified Child Passenger Safety Technician/Instructor and Fire and Life Safety Educator I-II-III and Instructor.

Purnima Unni, MPH, CHES

Monroe Carell Jr. Children's Hospital at Vanderbilt

Purnima Unni, MPH, CHES has been the Pediatric Trauma Injury Prevention Coordinator for the Monroe Carell Jr. Children's Hospital at Vanderbilt since 2008. She works to get the message of keeping kids safe both within the hospital and outside. She has a Bachelors degree in Psychology and Education, a Masters in Public Health Education and is a Certified Health Education Specialist. She is very active in injury prevention research and has presented at several national conferences. Her publications can be found in the American Journal of Emergency Medicine, Journal of Pediatric Surgery and Journal of Trauma (forthcoming). She currently serves on the Injury Prevention Advisory Board for the Children's Hospital Association. Her research interests focus on the areas of Pediatric Falls, Pediatric ATV Safety and Teen Motor Vehicle Safety. She has recently started and co-chairs the Tennessee Coalition for ATV Safety .

Pina Violano, RN-BC, CCRN, CPS, PhD (c)

Injury Free New Haven

Pina Violano, RN-BC, CCRN, CPS, PhD (c) is the Injury Prevention Coordinator for Yale-New Haven Hospital's Trauma Department. Inspired by the injured children she once cared for in her past role as a Critical Care registered nurse, Pina now extends her reach by developing injury prevention strategies on a local, state and national level.

Her collaboration with the city of New Haven on the Street Smarts Pedestrian Safety Initiative helped the Yale-New Haven Children's Hospital receive the designation of Injury Free Coalition for Kids of New Haven. The current focus of her injury prevention programs include establishing a car seat program that has provided over 350 car seats to high-risk families in need; the TXT U L8R campaign, a unique peer-to-peer initiative focused on the dangers of texting while driving, funded by the Allstate Foundation; and the Walk Safe Program, a program that educates children on safe pedestrian practices that is funded by the American Trauma Society.

Pina most recently received the 2011 Child Passenger Safety Technician of the Year Award for outstanding service to the field by the National Child Passenger Safety Board. Past awards received include: Marie Hippensteel Lingeman Award for Excellence in Nursing Practice- a founders award from Sigma Theta Tau; 40 under Forty Award from the New Haven Business times, CPR Excellence Award by AHA and nurse of the year award from YNHH.

Pina received an AD and BSN from Quinnipiac College and a MS in Public Health from Southern Connecticut State University. She is currently working on her dissertation to complete the requirements for her doctorate in Public Health. Her research focus is racial and ethnic disparities in children < 12 years of age that are involved in Motor Vehicle Crashes.

Pina's past roles include: 12 years staff/charge nurse in the Pediatric Intensive Care Unit, 2 years cross coverage in the Pediatric Catherization Lab,3 years Shoreline Emergency Room, 14 years Clinical Nurse Educator for the Yale-New Haven Children's Hospital and most recently Injury Prevention Coordinator, Adult and Pediatric Trauma Programs, Yale-New Haven Hospital and Program Coordinator and Principal Investigator Injury Free Coalition for Kids of New Haven, Yale-New Haven Children's Hospital.

Chris Vitale, MSN, RN

Injury Free Pittsburgh

Chris Vitale, MSN, RN is the injury prevention manager for Children's Hospital of Pittsburgh of UPMC and has been the program coordinator for Injury Free Coalition for Kids in Pittsburgh for the past ten 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." She is a certified Child Passenger Safety technician and also a member of a variety of state, county and community boards as the injury prevention representative.

Brian Wagers, MD

Injury Free Cincinatti

Brian Wagers, MD is a fellow in pediatric emergency medicine at Cincinnati Children's Hospital Medical Center in Cincinnati, Ohio. He completed his undergraduate work at Hanover College in Hanover, Indiana and his medical school at the University of Cincinnati in Cincinnati, Ohio. He completed his pediatric residency and chief residency at

Cincinnati Children's Hospital Medical Center.

Currently his research focuses on dating violence among adolescents with a focus on males. His other interests are pediatric transport medicine, injury prevention, and trauma management education.

Nancy Franke Wilson, MS

Injury Free Minneapolis

Nancy Franke Wilson started Franke Wilson Consulting in 2000 after holding positions for the State of Minnesota in which she was responsible for bringing prevention programs, policies and laws to the public. She was either party to creating campaigns or adapted them from national models in order to fit the Minnesota culture. Her work has included creating and branding a demonstration project for the US Department of Transportation (one of four in the nation), development of a federally funded drug-free campaign, providing technical assistance to over twenty community-based coalitions for nearly four years that included numerous media and public education campaigns within each coalition yearly and the newly completed tool kit for the Center for Alcohol Policy where Nancy and a colleague created and branded the program for national use.

Nancy has been involved with the Injury Free Coalition for Kids of Minneapolis, located at the Hennepin County Medical Center, since its first meeting. She initially met Julie Philbrook, RN, MA while managing the US Department of Transportation's National Highway Traffic Safety Administration (NHTSA) funds for the State of Minnesota. Nancy saw how Julie's idea for widening the scope of child passenger safety to paramedics and working in collaboration with new partners was an entirely new way of thinking for prevention in Minnesota. The two quickly joined forces and have enjoyed working as a team on projects since that time.

Nancy holds a M.S. in Health Science, Public Administration and a BA degree in Industrial Psychology. She has taught at Anoka Ramsey Community College, serves as a guest lecturer at Minnesota State University, Mankato and currently serves on the Governing Council for the Minnesota Public Health Association.

2012 Forging New Frontiers:

"Keeping Children Safe at Home, at Play and on the Road"

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 visit our website, www.injuryfree.org to share your comments.

Accreditation

Attendees of this year's conference are eligible for up to 16.25 *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

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